Country Programme Action Plan (CPAP) Timor-Leste

2009-2013

The Government of the Democratic Republic of Timor-Leste
and The United Nations Population Fund (UNFPA)

Dili, Timor-Leste
January 2009

Timor-Leste

UNFPA
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List of Acronyms

ANC	Antenatal care
ARV	Antiretroviral drug
AusAID	Australian Agency for International Development
AWP	Annual Work Plan
BCC	Behaviour Change Communication
BSP	Basic Services Package for Primary Health Care and Hospitals
CEDAW	Convention on the Elimination of Discrimination against Women
CP	Country Programme
CPA	Country Population Assessment
CPAP	Country Programme Action Plan
CPR	Contraceptive Prevalence Rate
DHS	Demographic and Health Survey
EmOC	Emergency Obstetric Care
GBV	Gender-Based Violence
GCA	Government Coordinating Authority
GDP	Gross Domestic Product
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
ICPD PoA	Programme of Action of the International Conference on Population and Development
IDP	Internally Displaced Person
ILO	International Labour Organization
IOM	International Organization for Migration
IP	Implementing Partner
LoU	Letter of Understanding
MDG	Millennium Development Goals
MoH	Ministry of Health
NDP	National Development Plan
NPC	National Population Commission
NSD	National Statistics Directorate
NZAID	New Zealand's International Aid & Development Agency
PCM	Programme Component Manager
PDS	Population and Development Strategies
PNTL	Poliçia Nacional Timor-Leste (Timor-Leste National Police)
RHCS	Reproductive Health Commodity Security
SEPI	Secretario de Estado da Promoção da Igualdade (Secretariat of State for the Promotion of Equality)
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TLSLS	Timor-Leste Survey of Living Standards
UNCT	UN Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNMIT	United Nations Integrated Mission in Timor-Leste
UNTL	Universidade Nacional Timor-Lorosa'e (National University of Timor-Leste)
USAID	United States Agency for International Development
VPU	Vulnerable Persons Unit
WHO	World Health Organization

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COUNTRY PROGRAMME ACTION PLAN
BETWEEN
THE GOVERNMENT OF
THE DEMOCRATIC REPUBLIC OF TIMOR-LESTE
AND
UNITED NATIONS POPULATION FUND

The Framework

1. The Government of the Democratic Republic of Timor-Leste, hereinafter referred to as "the Government", and the United Nations Population Fund, hereinafter referred to as "UNFPA", are in mutual agreement to the content of the Country Programme Action Plan (CPAP) and accept their respective responsibilities in the implementation of the Second Country Programme; and

2. Furthering their mutual agreement of cooperation for the fulfillment of the International Conference on Population and Development (ICPD) Programme of Action, the Beijing Women's Conference, and the Millennium Declaration and Millennium Development Goals (MDGs);

3. Building upon the experience gained and the progress made during the implementation of the previous Programme of Cooperation and the country's needs as assessed through the 2007 Country Population Assessment (CPA), the priorities identified in the 2009-2013 United Nations Development Assistance Framework (UNDAF) and other national development documents;

4. Entering into a new period of cooperation from January 2009 to December 2013;

5. Declaring that these responsibilities will be fulfilled in a spirit of mutual cooperation;

6. Have agreed as follows:

Part I. Basis of Relationship

1.1. The Standard Basic Assistance Agreement (SBAA) between the Government and the United Nations Development Programme (UNDP), dated 20th May 2002, and the exchange of letters between the Government and UNFPA, also dated 20th May 2002, constitute the legal basis for the relationship between the Government and UNFPA.

Part II. Situation Analysis

2.1. Timor-Leste's current population of 1,080,742 people is one of the fastest growing in the world. By 2012, the population is expected to reach in excess of 1,219,992.[1] Growing at an annual rate of 3.2%, the population is likely to double within the next 17 years. The population of Timor-Leste is predominantly rural: 74% of the population lives in rural areas. Those in urban areas are concentrated in a few cities, with the capital by far the densest: 64% of urban dwellers live in Dili. The population is also predominantly young: over 43% of the population is under 15 years old, and 16% are under the age of five. Life expectancy for East Timorese is low by regional standards: 60.5 years for females and 58.6 years for males. Mortality rates remain high, and children are particularly vulnerable, with under-five mortality estimated at 130 per 1,000 live births.

1 National Statistics Directorate & UNFPA (2008), Population Projections for Districts 2004 – 2012.

2.2. Overall, literacy and education levels are low, and are lower among women; more than half the women and more than 40% of men in Timor-Leste are illiterate. However, literacy rates are higher among the younger generations, reflecting the spread of education with time. Primary enrolment rates have increased significantly from pre-1999 levels, especially for girls. However, since 2005 they have fallen slightly again, and repetition and drop-out rates are high. Dependency ratios are very high, as only 36.6 % of the total population make up the labour force. The 2004 Census of Population and Housing showed that majority of the working population (70%) are involved in agriculture or other subsistence activities. Only 11% are employed in the formal sector.

2.3. MDG 1 – Poverty: Measured by both income and broader human development indicators, Timor-Leste is the poorest country in the Asia Pacific region. Timor-Leste was ranked 150 out of 177 countries in the 2007-2008 Human Development Index (HDI) and fares poorly on key indicators such as life expectancy, literacy and gross domestic product (GDP).[2] About 42% of the population currently lives below the poverty line of less than US$1 a day.

2.4. The main factor driving population growth is the high levels of fertility. The total fertility rate (TFR) of 6.95 children per woman is the third highest in the world, with significant variation among districts ranging from 5.2 in Dili to 9.2 in neighboring Aileu district. Fertility rates are higher in rural than urban areas, and highest for women who are poor and have low levels of education. The 2003 Timor-Leste Demographic and Health Survey (2003 DHS) revealed a strong desire by Timorese women to have several children, the ideal family size being 5.7 children per family. However, certain segments of the population expressed a desire for family planning services, especially for birth spacing. The unmet need for family planning was reported at 3.8%, with 3.7% for spacing and only 0.1% for limiting[3].

2.5. Taking into account age-specific fertility rates, the 2003 DHS estimated that one third of Timorese women aged 20-34 years are having a baby in any given year. High levels of fertility are limiting women participation in higher education or formal employment. The 2003 DHS revealed a common pattern of fertility among Timorese women, pointing to a common thread of poverty, malnutrition and poor access to basic social services like health and education. These are the same missing elements of human development that would otherwise have enabled them to aspire for smaller family sizes.

2.6. Since 1999, Timor-Leste has been characterized by significant internal migration as well as in-migration from abroad. The vast proportion of rural-urban migration has been to the capital Dili and neighboring Liquiça, the magnitude of which has had a significant impact on the demographic profile of the area. Dili now has a much higher population of young men compared to the rest of the country. Consequently, unemployment rates for males are nearly four times as high in Dili as in the rural areas.

2.7. Timor-Leste's economic performance since independence has been severely affected by instability and fluctuations in the political climate. Although by the end of 2005 the country had achieved a modest economic growth rate of 2.3%, growth contracted sharply (-2.9%) following the political crisis of 2006. The return of a significant number of international personnel with the establishment of the United Nations Integrated Mission in Timor-Leste (UNMIT) was expected to lead to a higher growth rate for the 2007–08 period. Despite Timor-Leste's modest economic performance, the country has started to benefit from the commercial exploitation of its petroleum reserves. The Government is seeking to use its oil revenues in support of long-term economic development, economic diversification and poverty reduction and has established an International Petroleum Fund to manage its revenues in a transparent and sustainable manner.[4]

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2 United Nations Development Program (2007), *Human Development Report, 2007/2008 Report, Timor-Leste.*

3 Ministry of Health and National Statistics Office, Timor-Leste, and University of Newcastle, The Australian National University, ACIL Australia Pty Ltd, Australia, 2004. *Timor-Leste 2003 Demographic and Health Survey.*

4 Asian Development Bank (2007), *Key indicators of Developing Asian and Pacific Countries, Timor-Leste.*

2.8. Population issues are becoming a major concern in Timor-Leste. High fertility levels and the subsequent rapid and substantial population growth is a major problem that cannot be left aside in any development plan not only for the economic impact at the macro-economic level but also for the impact on the family. Related to this are rural-to-urban migration and the consequent increase in urban poverty. Any rural development plan should consider the impact on population mobility. Hence, of major importance is the preparation and formulation of a national population policy that will promote a sustainable and harmonious balance between population growth, population distribution, the economy and the environment.

2.9. MDG 3 – Gender: Women account for 49% of the Timorese population and are the heads of approximately 19% of the country's private households. The Constitution of Timor-Leste affirms the equality of men and women in all spheres. In recent years, Timor-Leste has made considerable progress towards achieving gender equality, in particular, through its signature of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the establishment of the Secretariat of State for the Promotion of Equality (SEPI). Situated in the Office of the Prime Minister, the Secretariat focuses on gender mainstreaming in government, empowering women, preventing gender-based violence, including the development of a draft Law Against Domestic Violence and the establishment of a referral network of support services for survivors, as well as promoting a culture of equality.

2.10. In the area of political participation, women are now represented on village councils and account for 28% of the members of the National Parliament. In addition, women in Timor-Leste are very active in civil society and have a strong voice in advocacy. Cross-cutting issues, including gender, have been included in preparations for the development of Timor-Leste's Second National Development Plan (NDP) 2009-2013; however, the degree of integration of gender concerns in sectoral policies and plans varies.

2.11. Despite these achievements gender disparities persist at all levels in many sectors, especially health, education and employment. Overall, Timorese women suffer from high rates of malnutrition and have lower literacy rates than men. Participation rates for girls at secondary level drop to below 60% and there are at least three males for every female who holds a tertiary-level certificate. Women's participation in the workforce is also lower than that of men, as is their representation in the formal employment sector. Seven out of every ten women working in the agricultural sector and 46% of non-agricultural women workers do not receive any payment for their labour. Under traditional inheritance systems, women rarely have access to land rights.

2.12. Gender-based violence (GBV), notably domestic violence, is still a pervasive problem at all levels of society in Timor-Leste. In a 2003 study, 47% of the women interviewed reported having experienced some form of intimidation or violence from an intimate partner. Very few GBV cases are reported to the police; of these few, only a handful are referred to the Office of the Prosecutor-General and even less reach the Courts. Sentences for crimes of domestic violence are generally light. Data collection on GBV cases is currently not standardized or systematic. Progress towards establishing a legal framework against GBV has been hampered by delays in promulgating Timor-Leste's Penal Code.

2.13. Since the socio-political crisis of 2006 and the creation of IDP camps, women and young girls have become more vulnerable to exploitation and attempted trafficking, both internally and overseas. As a dollar economy, with a high presence of internationals and a weak justice system, Timor-Leste may be an attractive destination country for human trafficking, the sex trade and forced labour. The few studies that have been carried out on female sex workers place their numbers at approximately 500-800 nationwide, concentrated in Dili and the border districts of Covalima and Bobonaro. Very few services are available for sex workers, the majority of whom are Timorese women who entered this trade for economic reasons.

2.14. MDG 5 – Maternal Health: The Health Sector Strategic Plan (HSSP) 2008-2012 provided a summary of twelve key challenges in the health sector. These include: a) low utilization of cost-effective public health interventions; b) poor attitudes and practices among some service providers in communicating with consumers; c) misdistribution of health service providers, especially skilled midwives and community nurses; d) inconsistent quality of care exacerbated by inconsistent application of approved policies

and protocols; e) the continuing high maternal and child mortality and morbidity rates coupled with the emerging public health issue of adolescent health; f) high need for family planning advice and commodities; g) low salaries of health staff in the public sector and lack of incentives to work in rural and remote areas; h) limited access to essential services among the poor and in remote areas; i) inadequate management and leadership, especially in monitoring, evaluation, supervision and for evidence-based, delegated decision making; j) inadequate capacity in human resource development including education, training and personnel management practices; k) limited harmonization of external funding of the health sector resulting in unnecessarily complicated budget development; and l) limited integration of services and programmes to the detriment of effectiveness and efficiency.[5]

2.15. A major health problem facing the country is the high maternal mortality ratio estimated at 660 deaths per 100,000 births, one of the highest in Southeast Asia.[6] Approximately 2/3 of maternal deaths are due to direct causes from pregnancy, delivery and post-delivery, and the other 1/3 is due to indirect causes such as anemia, malaria or malnutrition. The 2003 DHS estimated infant mortality at 88 per 1,000 live births, and neonatal mortality at 42 per 1,000 live births. Peri-natal mortality, an important indicator of care during pregnancy and delivery, was estimated at 43 per 1,000 pregnancies.

2.16. Two major factors contribute to the high rates of maternal death: the lack of access to basic and comprehensive emergency obstetric care (EmOC) and the low utilization of skilled assistance for delivery.[7] Three quarters of women report that they have difficulty accessing health care; over 60% cite distance to facilities as a major barrier. The 2003 DHS reported that 90% of all births took place at home, and that only 19% of births in Timor-Leste were attended by a skilled health professional. While the percentage of deliveries attended by skilled health personnel was estimated to have increased by 10.1% in the last year alone, it remained less than ideal at 37.3%.[8] Likewise, rates of antenatal and post natal care are improving but remain low. About 6 out of every 10 pregnant women (55.4%) made a first antenatal care (ANC) visit in 2007, with the percentage declining to 31% for the fourth ANC visit. An average of 1.6 ANC visits per pregnant woman was observed in 2007. Only 21.2% of pregnant women made postnatal care visits within one week of delivery.

2.17. The lifetime risk of death during pregnancy for Timorese women is about 1 in 16. Pregnancy in adolescence has a higher risk of death, and in Timor-Leste the adolescent fertility rate is 58.5 per 1,000 adolescent women. Only 34% of births are spaced by three years, and only one in five women who requires a Caesarean section has access to one. Despite progress made in the past five years, the lack of midwives remains a major constraint to increasing skilled birth attendance. Statistics from the Ministry of Health revealed a total of 295 midwives working in the public sector in 2007, with less than 40% of health posts staffed by midwives.[9] Hence, improving maternal health is a key national and sectoral priority as reflected in the First NDP 2002-2007, the Basic Services Package (BSP) for Health 2007 and the HSSP 2008-2012.

2.18. According to the 2003 DHS, a large majority of married men and women of childbearing age had a very low knowledge of contraceptive methods, with over 60% of the women and 70% of the men failing to recognize any of the twelve methods listed during the survey. When asked whether they knew where to obtain contraceptives, nearly 70% of women and 80% of men replied that they had no knowledge of sources of family planning. Less than 20% of women of reproductive age (15-49 years) had ever used any method of contraception, and less than 10% (9.7%) were currently using any contraception. Use of contraception was related to economic status: wealthier, more educated and women living in urban areas were more likely to be current users. Among the few women who did use contraception, injectables were the most popular method, a legacy of the Indonesian family planning program from the past two decades. The vast majority of women received their family planning supplies from the public sector health centers.

5 Ministry of Health (2007), *Health Sector Strategic Plan 2008-2012.*
6 UNFPA (2007), *Country Population Assessment, Timor-Leste 2007.*
7 Ibid.
8 Ministry of Health (2008), *Annual Health Statistics Report: January-December 2007*
9 UNFPA (2007), *Country Population Assessment, Timor-Leste 2007.*

Nearly half the women not using contraception had visited a health facility in the past six months preceding the survey, almost none of them had received family planning advice from health workers, representing many missed opportunities for reproductive health information and services, including provision of family planning.

2.19. The 2003 DHS made policy recommendations for the promotion of knowledge of family planning methods and provision of accessible contraceptive supplies and services in response to the lack of information about family planning and lack of access to contraceptives that it noted at the time the survey was conducted. The Ministry of Health initiated the development of a national family planning programme in 2004 following the drafting of the National Reproductive Health Strategy and the National Family Planning Policy.

2.20. Updated information on the use of contraception was included in the 2007 Timor-Leste Survey of Living Standards 2007 (TLSLS). This survey reported a contraceptive prevalence rate (CPR) for all methods of 19.8%, a clear increase from the 8% reported in the 2001 Timor-Leste Suco Survey (TLSS).[10] This also represents a near doubling of the corresponding figure from the 2003 DHS. Although the trend towards increasing uptake of contraception is encouraging, the Ministry of Health has to sustain these early gains by ensuring contraceptive security, improving the quality of services including counseling, and creating demand for family planning.

2.21. MDG 6 - HIV/AIDS: Timor-Leste is considered to be a low prevalence country with less than 0.2% of the adult population estimated to be HIV-positive. There are 24 people currently receiving antiretroviral (ARV) drugs in Dili, the only place in the country where it is possible to access ARVs.[11] With its proximity to countries experiencing localized epidemics and its unfavorable social conditions such as cross-border migration, high unemployment and poor access to health services, Timor-Leste is at risk of an emergent HIV/AIDS outbreak. Young people in Timor-Leste are not well-equipped with the knowledge and life skills to manage HIV risk in an increasingly challenging environment. Knowledge on reproductive health, sexually transmitted infections (STIs) and HIV/AIDS is limited, especially in rural areas. The 2007 TLSLS indicated that only 66.1% of the population between 15-24 years old had heard about HIV/AIDS.[12] Among those who had heard of HIV/AIDS, 73% believed that HIV/AIDS could be avoided, with only 44.8% responding that the disease could be avoided through the use of condoms. A nationwide study conducted by the Dili Institute of Technology (DIT) in 2007 found that young men engaged in behaviors that put them at risk of contracting STIs including HIV/AIDS, with 67% of sexually active young men reporting sex with more than one partner but only 33% reported having used a condom during their last intercourse.[13]

2.22. In the light of these key challenges, policy measures would therefore need to focus on: (a) reducing the fertility and mortality rates; (b) providing increased opportunities for education and training to utilize the 'demographic bonus,' having a more trained and larger labour force; (c) reducing gender disparities in health, education and employment; (d) increasing opportunities for productive employment and improving living conditions in the rural areas to stem out-migration from the districts; and (e) addressing issues related to the rapid increase in Dili's population. Given the youthful population structure, if national stability and development of human capital is to be ensured, young people require youth-friendly reproductive health information and services as well as increased opportunities for education, employment and empowerment.

10 National Statistics Directorate (2008), *Final Statistical Abstract: Timor Leste Survey of Living Standards 2007*
11 Timor-Leste Red Cross (2008) *Overview: HIV/AIDS in Timor-Leste.*
12 NSD (2008), *Final Statistical Abstract: Timor Leste Survey of Living Standards 2007.*
13 UNICEF/Dili Institute of Technology (2007). *HIV/AIDS in Timor-Leste: A National Baseline Survey of Young People.*

Part III. Past Cooperation and Lessons Learned

3.1. During the First Country Programme (CP) covering the period 2003-2005, UNFPA assistance contributed towards developing the institutional framework, establishing basic social services and generating baseline socio-demographic data for newly-independent Timor-Leste. The First CP consisted of three inter-linked projects in the area of reproductive health, population and development strategies, and gender-based violence, respectively, with a total allocation of US$5million.

3.2. The First CP was initially extended for a two-year period (2006-2007) to synchronize it with the National Development Plan. Following the political crisis in 2006, the programme cycle was extended for another year up to December 2008. This enabled the UNCT to complete the development of the Second UN Development Assistance Framework (UNDAF) from late 2007 to early 2008. The country programmes of the other Executive Committee (ExComm) agencies in Timor-Leste were also extended for the same reasons over the same period.

3.3. In the area of reproductive health, UNFPA supported the provision of comprehensive reproductive health services and training in Timor-Leste, with a focus on safe motherhood particularly EmOC and family planning. Major achievements include support towards: (a) the development of the policy framework of the health sector, notably the National Reproductive Health Strategy 2004-2015, the National Family Planning Policy 2004 and the National Behavior Change Communication Strategy for Reproductive Health 2008-2012; (b) ensuring quality of reproductive health services with the development of clinical standards and national protocols on basic EmOC and family planning; (c) ensuring RH commodity security (RHCS) through the procurement of contraceptives, equipment and supplies and the development of the Logistics Management Information System (LMIS); (d) strengthening supervision and monitoring with increased human resources at the district level; (e) building the capacity of service providers and programme managers on basic EmOC, family planning and logistics management; (f) providing comprehensive EmOC with the deployment of OB-GYN specialists at the two major hospitals in the country; and (g) developing human resources in the medium-term by offering fellowships for Timorese doctors to undergo OB-GYN specialty training in Malaysia.

3.4. Lessons learned include the need to: (a) rationalize the expansion of the reproductive health programme with the capacity of national counterparts to deliver these activities and the need to foster greater ownership by national counterparts at all levels; (b) involve the district level health services and the health facility managers in the annual planning and budgeting process and the need to increase their capacities in strategic planning and results-based management; (c) respond to changing sectoral priorities, notably the implementation of the Servisu Integradu Saude Comunitaria (SISCA, or Integrated Community Health Services) and the rolling-out of the BSP, to ensure the inclusion of reproductive health in these initiatives; and (d) strengthen the supervision, monitoring and evaluation framework including the identification of indicators and establishment of baselines and targets.

3.5. In the area of population and development, UNFPA provided support to the National Statistics Directorate (NSD) over a wide spectrum of activities including: (a) office refurbishment and renovations including the establishment of the Census Office and Mapping laboratory; (b) drafting of the Statistics Decree - Law No.17/2003 of 1st October 2003 to provide the legal basis for the 2004 census; (c) all activities pertaining to the successful completion of the 2004 census, including planning, enumeration, data processing, in-depth analyses of thematic topics and the publication and dissemination of the results; (d) hiring and capacity building of national staff by international consultants and through funding select staff to attain post graduate university qualifications in demographic fields; and (e) preparatory activities for the 2010 Census and the 2009 Demographic and Health survey.

3.6. Lessons learned from the PDS component are as follows: (a) the need to train Timorese personnel in relevant census and management areas; (b) the need to expeditiously undertake activities of the census like development of instruments and to complete all census activities as recommended by the United Nations Statistics Division, for example, in the 2004 census, a post enumeration survey was not undertaken; and (c) the need to hire inter-

national consultants for longer periods to maintain continuity in project activities and institutional knowledge.

3.7. In the area of gender, UNFPA: (a) helped to develop the draft Law Against Domestic Violence; (b) advocated and provided support for raising awareness of domestic violence; (c) helped national non-governmental organizations (NGOs) provide services to victims of gender-based violence, including developing a Medical Forensic Protocol for victims of domestic violence, sexual assault and child abuse; (d) strengthened the capacity of the Secretariat of State for the Promotion of Equality to address gender issues, and prevent gender-based violence; and (e) supported the participation of ministers, parliamentarians and civil society organizations in international conferences to advance national gender issues.

3.8. Lessons learned from the Gender component are as follows: (a) the need for more technical backstopping support for planning and policy development on gender equality and gender based violence prevention policies ; (b) the need to strengthen the supervision, monitoring and evaluation framework including the identification of indicators and establishment of baselines and targets; (c) the need to train national personnel in gender policy and GBV prevention areas, and programme management skills; (d) the need to involve the gender focal points in the line-ministries in the annual planning exercise and results-based management; (e) the need to assess the capacity of counterpart organizations in the number of activities expected to implement as lack of qualified human resources, and (f) the need to strengthen the link between national and local development processes to ensure access to services for the most vulnerable by supporting service providers (e.g. NGOs, district-level government) and building broader national and local systems to deliver services in the long run.

3.9. A key constraint during the previous programme cutting across all three programme components was the lack of qualified human resources. The development of human and institutional capacities at all levels will be critical for managing the next programme and ensuring the attainment of national development goals.

3.10. Insecurity was another crosscutting constraint identified during the previous programme, making it difficult for activities to be carried out for protracted periods. While implementation targets have mostly been achieved, most beneficiaries tend to be people in Dili and those living at the district level, it is necessary to increase access and services to the suco and aldeia levels as accessibility to RH services and GBV assistance is difficult in the remote areas.

Part IV. Proposed Programme

4.1. The Government and UNFPA formulated the Second Country Programme of Assistance based on the Country Population Assessment conducted in September 2007 and on reviews of the current programme. The latter includes the end-of-project evaluation conducted in January 2008 and the periodic reviews (annual and mid-year reviews) held since 2006. These transparent and participatory consultative processes ensured alignment of the programme with national development priorities and validation of the recommendations by the Government and other major stakeholders.

4.2. The proposed programme responds to the priority national development challenges identified in the national planning frameworks of Timor-Leste. It also responds to the UNFPA Strategic Plan 2008-2011, in particular operationalizing the development results framework at country level, in order to accelerate progress and promote national ownership of the ICPD Programme of Action. It builds on the 2009-2013 UNDAF, which is guided by the goals and targets of the Millennium Declaration and aligned with the Programme of the IV Constitutional Government for 2007-2012 and other relevant documents.

4.3. The programme will contribute to the three UNDAF outcomes, namely: (a) By 2013, stronger democratic institutions and mechanisms for social cohesion are consolidated; (b) By 2013, vulnerable groups experience a significant improvement in sustainable livelihoods, poverty reduction and disaster risk management within an overarching crisis prevention and recovery context; and (c) By 2013, children, young people, women and men have improved quality of life through reduced malnutrition, morbidity and mortality, strengthened learning achievement and enhanced social protection.

4.4. In addition, the proposed programme will respond to the four special initiatives identified in the UNDAF to meet specific country needs but which fall outside the common UNDAF results matrix. UNFPA will take the lead role in the first of these initiatives, the undertaking of the 2010 Census, primarily through support to the National Statistics Directorate (NSD). UNFPA will also be involved in two Joint Programmes within the UNCT addressing gender inequality and improving human security, respectively. The 2010 Census has been highlighted as a crucial area for support to Timor-Leste, recognizing the unique challenges of its very high fertility rate and its young population structure in a post-crisis environment.

4.5. The programme has three components: reproductive health and rights; population and development strategies; and gender equality. These programme components are in accordance with the UNFPA mandate and the three results areas of its Strategic Plan 2008-2011 towards achieving the ICPD goals and contributing to the MDGs. The programme will be implemented with an emphasis on national capacity development and national ownership, and with an increased focus on results-based management and accountability.

4.6. UNFPA will continue to promote South-South cooperation, including triangular cooperation, as a means of maximizing aid effectiveness, sharing best practices and forging partnerships between Timor-Leste and other developing countries. South-South cooperation will be integrated into support for national capacity development. Implementation will also be guided by a rights-based and culturally sensitive approach to programming, ensuring gender equality and women's empowerment across all levels and with particular attention to the most vulnerable groups in society including those living in poor rural areas.

Reproductive Health (RH) Programme Component

4.7. The reproductive health programme component responds to national health sector priorities as identified in the Health Sector Strategic Plan 2008-2012; the Basic Services Package for Primary Health Care and Hospitals: Achieving the MDGs by Improved Service Delivery (May 2007); the National Reproductive Health Strategy 2004-2015; the National Family Planning Policy 2004; the National HIV/AIDS Strategic Plan 2006-2010; and the National Behavior Change Communication Strategy for Reproductive Health 2008-2012. The 2007 CPA and the 2008 end-of-project evaluation provided specific recommendations for the programme component.

4.8. In addition, the RH programme component builds on the UNFPA Strategic Plan 2008-2011, the UNFPA Reproductive Rights and Sexual and Reproductive Health (SRH) Framework (May 2008), and the UNFPA Framework for Action on Adolescents and Youth (December 2006). The proposed programme will respond to all five RH outcomes in the UNFPA Strategic Plan under the overarching goal of universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life.

4.9. The RH programme component will support the two health sector priorities identified during the preparation of the Second National Development Plan. The education and health sectors comprise the National Priority 5 Working Group in the NDP formulation process. The two goals stated for the health sector are: (1) improved accessibility and delivery of quality maternal and child health care through the Integrated Community Health Services (SISCA); and (2) strengthened Basic Services Package (BSP).

4.10. The two outcomes under this component are: (a) increased access to and utilization of comprehensive reproductive health services, including those focusing on maternal health, family planning, and the prevention of sexually transmitted infections and HIV, especially for vulnerable groups; and (b) enhanced life skills for young people, including skills to prevent sexually transmitted infections, HIV and adolescent pregnancies. Support for integrating SRH issues into emergency preparedness and humanitarian response frameworks as well as ensuring linkages between SRH and services aimed at preventing STIs and HIV will be cross-cutting elements of this component.

4.11. Two outputs will contribute to the achievement of each outcome under this programme component. Outputs 1 & 2 on maternal health and family planning, respectively, will contribute to the achievement of Outcome 1 on comprehensive reproductive health services. Similarly, Outputs 3 & 4 on STI & HIV prevention and youth-friendly RH information and services, respectively, will contribute to the achievement of Outcome 2, which focuses on adolescent reproductive health and development and behavior change for other at-risk populations.

4.12. Output 1: Increased demand for and access to high-quality maternal health services, including emergency obstetric care. The programme will: (a) support the development of human resources in the health sector, including pre-service, in-service and post-graduate training, with emphasis on supportive supervision and mentoring; (b) support government efforts to provide basic emergency obstetric care in community health centers nationwide; (c) support the provision of high-quality basic and comprehensive EmOC services and training; (d) increase access to skilled birth attendance through the establishment of a midwifery school; and (e) promote demand for skilled birth attendance and deliveries at health facilities through behavior change communication (BCC) interventions.

4.13. Supporting the achievement of MDG 5 on maternal health at country level is one of the central roles of UNFPA. Building on the SRH Framework, four main strategies will be used to achieve this output, namely: undertaking advocacy and policy dialogue for improving maternal health; building strategic and multisectoral partnerships; strengthening national capacity to develop and implement national plans to ensure quality maternal health care; and empowering communities to demand and support access to quality maternal health care.

4.14. Provision of Basic EmOC and facility-based delivery are essential steps towards maternal mortality reduction as identified in the BSP document. The Ministry of Health has designated the BSP as the basis

for planning, implementing and managing programmes and monitoring progress towards achieving the health-related MDGs (MDGs 4, 5 & 6). Thus, the UNFPA-supported programme will assist the Timorese Ministry of Health in implementing the proposed basic service package for reducing maternal mortality. This includes support for human resource development and supervision, monitoring and evaluation.

4.15. A major activity under this output will be support towards the reorganization and sustained operations of the Faculty of Health Sciences at the National University of Timor-Leste (UNTL). At the time of writing, technical experts from the Philippines had just conducted a midwifery training assessment at the request of the Ministry of Health. This is a promising South-South initiative facilitated by UNFPA, which will require considerable follow-up and financing in the next five-year period. Initially, the focus will be on supporting community-oriented and competency-based midwifery training to increase the number of midwives working at the suco level. The development of a new cadre of community midwives will increase the number of skilled birth attendants especially in remote rural areas.

4.16. A stepladder curriculum is being introduced at the National University to produce multi-skilled health workers willing to serve in underserved regions of Timor-Leste and able to deliver a basic package of services, including reproductive health, at the health post level. The Diploma in Midwifery is a three-year course that will provide secondary school graduates with basic midwifery competencies. Graduates of the basic diploma course will have the option to return for higher education in midwifery, nursing or medicine after at least two years of service in underserved health posts. Graduates will also be eligible to take licensure examinations in midwifery once the accreditation system for health professions is established.

4.17. Building on the achievements of the previous programme, other key activities include continued support for the provision of basic and comprehensive EmOC in government health facilities, in response to the recommendations of the 2008 EmOC needs assessment; and the design, implementation and monitoring of BCC interventions to promote ANC, skilled attendance at birth and facility-based delivery, under the framework of the National RH BCC Strategy. The focus on EmOC will include investments in training, a functional emergency referral system, upgrading of facilities, ensuring security of vital drugs, supplies and equipment, and strengthening supervision, monitoring and evaluation for quality of care. The programme will also work towards ensuring linkage with and incorporation of essential newborn care into EmOC. The Basic EmOC training will underscore the importance of newborn resuscitation as a signal function for basic emergency obstetric care.

4.18. The programme will include activities for the prevention and treatment of obstetric fistula as part of the Global Campaign to End Fistula. Activities will include advocacy and awareness creation at all levels, screening of reported cases in the districts, transportation assistance for patients to come to Dili for surgical repair at the national hospital, and training of hospital staff in pre- and post-operative care. An obstetric fistula module will be drafted and incorporated into the Basic EmOC training curriculum for general practitioners and midwives.

4.19. The formulation of the National Behavioral Change Communication Strategy for Reproductive Health 2008-2012 was an important achievement towards the end of the previous programme. The RH BCC Strategy overall goal is to promote and increase the practice of key behaviors for the four components of the NRHS namely: safe motherhood; family planning; adolescent reproductive health; and general reproductive health including HIV/AIDS, cervical cancer, obstetric fistula and male involvement. The RH BCC Strategy has identified key behaviors and behavioral and communication objectives to ensure that young people, men and women receive accurate, culturally acceptable and age appropriate information.

4.20. In line with this output, the RH/BCC Strategy communication objectives emphasize on the need for families and communities to prepare a birth preparedness plan, including identification of transport mechanisms, telephone communication, and the nearest health facility with a midwife; the need for husbands to organize delivery with a skilled birth attendant for their wives; and the need for husbands and family members to express positive attitudes towards and facilitate postnatal care visits from a midwife. The programme will support implementation of key activities proposed within the strategic communication framework of the RH BCC Strategy, which includes edutainment, community mobilization, mass me-

dia and advocacy, interpersonal communication and advertising among its communication approaches.

4.21. Output 2: Increased access to and demand for high-quality family planning services. To achieve this output, the programme will: (a) enhance the capacity of training institutions to increase the skills of health providers for high-quality family planning counseling and services, including community outreach; (b) strengthen the logistics management and information system to improve forecasting and the distribution of commodities to health facilities; (c) raise awareness on the availability and effectiveness of modern family planning methods through BCC interventions; and (d) coordinate with and support the role of NGOs in the provision of integrated RH and FP services.

4.22. The UNFPA-supported programme will focus on positioning the family planning programme as part of comprehensive RH services, including ensuring RH commodity security. Building on the SRH Framework, three main strategies will be used to achieve this output, namely: undertaking advocacy and policy support for quality family planning as part of SRH services; developing capacity within the health system, particularly among providers, for the provision of quality family planning services; and integrating family planning within SRH services.

4.23. The proposed programme will facilitate the five-year review of the NRHS 2004-2015 in collaboration with the Ministry of Health and other stakeholders in reproductive health. The general objectives of the review will be: 1) to review progress to date in the four components of RH identified in the NRHS, particularly safe motherhood and family planning, including identifying lessons learned and documenting good practices; 2) to harmonize the NRHS with the evolving health policy framework, including the National HSSP 2008-2012, the BSP for Primary Health Care and Hospitals, and the National RH/BCC Strategy, and new initiatives such as SISCA and Suco Parteira; and 3) to review indicators, identify baselines and set targets. The National Family Planning Policy and the National Family Planning Guidelines will be reviewed alongside the NRHS to ensure that these documents remain relevant and responsive to the national and local context. A module covering post-partum and post-abortion family planning will be added during the revision of the National Family Planning Guidelines.

4.24. Technical, financial and logistic assistance for national capacity development in programme management, training on family planning counseling and clinical skills for health workers, and logistics management for RH commodities will be provided. The programme will position family planning as a primary prevention strategy for maternal mortality and morbidity including abortion by reducing unintended pregnancies. Training on family planning counseling will emphasize the need to advise clients about other RH services offered on-site when they attend the clinic for any purpose (and vice-versa) and will include counseling for post-abortion and post-partum family planning. Resources will be channeled from the UNFPA RH Commodity Security Trust Fund to strengthen the Logistics Management Information System (LMIS) of the Ministry of Health and ensure access to quality contraceptives and other RH supplies at all levels of the health system.

4.25. UNFPA will partner with the Promotor Saúde Familia (PSF) programme of the Ministry of Health to ensure the inclusion of family planning in the training curriculum of village health workers and the integration of family planning within the SISCA initiative. UNFPA will continue ongoing negotiations with the International Planned Parenthood Federation (IPPF) Regional Office in Kuala Lumpur towards the establishment of a national reproductive health association affiliated with IPPF. The proposed NGO will involve professional associations and the private sector in the provision of RH services including family planning and adolescent reproductive health.

4.26. The programme will support implementation of the RH/BCC Strategy creative proposal to create demand for comprehensive RH services, with a focus on family planning. Communication messages in both English and Tetum have been designed based on the need to space children by at least three years, which was the key behavioral objective on family planning identified during the RH/BCC Strategy formative assessment. Supported activities includes edutainment pieces (a radio soap opera serial and a theater performance piece); mass media advocacy pieces (TV and radio pub-

lic service announcements); advertising (billboards and posters); and informative pieces (wall charts and brochures). A mobile communications unit (MCU) will be established to mobilize communities to discuss and learn about reproductive health, family planning and safe motherhood issues.

4.27. Output 3: Increased availability of information, counseling and services for populations most at risk, to promote healthier and safer behavior. Through this output, the programme seeks to reduce sexually transmitted infections and HIV/AIDS and to provide training to service providers on reproductive health. Building on the SRH Framework, two main strategies will be used to achieve this output, namely: undertaking advocacy and policy dialogue for STI and HIV prevention and diagnosis and management of STIs; and developing capacity within the health system, particularly among providers, for the provision of integrated SRH and HIV services, including quality STI prevention and treatment.

4.28. The overall goal of the National HIV/AIDS Strategic Plan 2006-2010 is to maintain Timor-Leste as a low-prevalence HIV nation and to minimize the adverse consequences for those infected with HIV. Four strategy components have been outlined to achieve the goal, namely: Prevention and education, Voluntary Counseling and Testing (VCT), Multi-sectoral action, and Clinical Services. The strategic plan targets the entire population of Timor-Leste, especially youth and women of reproductive age. UNFPA will partner with the Ministry of Health and NGOs both international and national to support the implementation of the HIV/AIDS Strategic Plan, with a focus on prevention and education for young people and most-at-risk populations (MARPs).

4.29. The proposed programme will support a national baseline behavioral study for the RH/BCC Strategy at the beginning of programme implementation, since behavior-specific data on reproductive health including HIV/AIDS is currently unavailable. Findings will be communicated to policymakers and opinion leaders to place HIV/AIDS on the national agenda and to strengthen the environment for HIV prevention. The programme will also utilize the findings of the recently completed Health Seeking Behavior Survey (HSBS) and the National HIV Behavioral Surveillance Survey (BSS) once they are released.

4.30. The proposed programme will expand partnerships with local NGOs on HIV prevention among sex workers and their clients, men having sex with men (MSM), young people and the general population. In December 2007, UNFPA was awarded Sub-Recipient status by the Ministry of Health for its Global Fund HIV/AIDS programme grant to build the institutional capacity of the local NGO Fundasaun Timor Hari'i and backstop implementation of its prevention activities among MARPs in Dili and four other districts. The intervention package targeting sex workers and their clients as well as MSM consists of information and BCC messages, condom promotion and skills building on its correct use and negotiation with clients, and prompt referral for STI diagnosis and treatment and Voluntary Counseling and Testing (VCT) services. These activities are designed and implemented in close collaboration with the target groups using a network of peer educators and peer leaders.

4.31. Priorities for the proposed programme include building capacity of local NGO partners; scaling up activities to increase coverage of prevention approaches to national level and steadily expand prevention efforts to other populations perceived as having lower risk behavior; and maximizing opportunities for integration with the reproductive health programme, particularly to reach young people. The proposed programme will facilitate training for health workers on STI diagnosis, management and counseling including condom promotion and VCT services in collaboration with the Ministry of Health, WHO and UNICEF and in accordance with national protocols. The programme will also liaise with the referral network to address the negative health outcomes of gender based violence with STI services, emergency contraception and post-exposure prophylaxis (PEP) for HIV prevention.

4.32. Apart from general HIV prevention campaigns and peer education, young people in both school and out-of-school settings will be reached through the adolescent reproductive health programme, simultaneously dealing with prevention of teenage pregnancy, providing access to adequate information on contraception and safe sex and prevention and treatment of STIs. Inter-sectoral collaboration will be strengthened between the Ministries of Health and Education and the respective Secretariats

of State for Youth and Sports and for Professional Development and Employment, and partnerships will be sought with local NGOs, faith-based organizations, women's groups and youth organizations.

4.33. UNFPA will continue its engagement with the National Parliament, the National HIV/AIDS Commission and the Country Coordinating Mechanism (CCM) to support the national HIV/AIDS response, and its leadership role within the UN Theme Group on HIV/AIDS on condom programming and programming for MARPs especially sex workers. UNFPA has also been requested by the UNCT to initiate HIV prevention interventions for prisoners, mainly providing IEC materials and BCC messages through peer-to-peer outreach and ensuring access to condoms, in collaboration with a local NGO and two faith-based organizations. Although anecdotal reports indicate a minimal IDU population, BCC messages also include the need to use sterile piercing and tattooing instruments since these activities are known to occur in the prison setting.

4.34. Scaling up will require sustained advocacy for greater resources. Resource mobilization remains a challenge in a low-prevalence country where all funding for HIV/AIDS activities comes from external sources and where HIV/AIDS is still deemed a low priority in the face of many other urgent competing priorities. The proposed programme will provide technical assistance to the Ministry of Health and local NGOs in collaboration with other UN agencies for the development of sound funding proposals for submission to the Global Fund and for the review of the National HIV/AIDS Strategic Plan including resource allocation.

4.35. Output 4: Increased access to high-quality reproductive health information and services for young people. The programme will: (a) support the Ministry of Education to ensure that life skills-based sexual and reproductive health education is integrated into the curricula of both the national secondary schools and teacher training colleges; (b) support the establishment of youth-friendly services and a referral system linking schools to health facilities; and (c) support capacity-building for youth organizations and community advocacy. The programme will also target out-of-school youth and youth in vocational training schools.

4.36. The UNFPA Framework for Action on Adolescents and Youth provides overall strategic guidance for the fund's work on adolescent reproductive health and development. The UNFPA-supported programme will focus on four key areas as identified in the framework: creating a supportive policy environment; supporting life-skills based education; provision of youth-friendly RH services; and promoting young people's leadership and participation. Building on the SRH Framework, four main strategies will be used to achieve this output, namely: undertaking advocacy for a supportive policy environment; strengthening education and health sectors to provide life skills-based education; strengthening the capacity of the health system, particularly providers, to offer appropriate SRH services for young people; and enabling young people's leadership and participation.

4.37. The National RH Strategy recommends two strategic approaches for adolescent reproductive health: a) to strengthen the provision of information and skills to young people, families and communities in order to achieve an optimal level of health and development in young people; and b) to increase easy access to a broad range of suitable youth-friendly services. Main activities under the proposed programme include technical assistance to the Ministry of Health for the development of national guidelines for the provision of youth-friendly services (YFS); the development of training materials and job aids for health workers based on the YFS guidelines; and the development of a training programme for health workers on YFS provision. Timor-Leste will draw on international best practices for the development of the YFS guidelines and adapt them to the national and local context. The programme will support the phased introduction of youth-friendly services in health facilities as well as other settings.

4.38. The 2007 Country Population Assessment identified two priority issues for the adolescent reproductive health programme, namely, the need to address high adolescent fertility and the prevention of STIs and HIV/AIDS, particularly among young men with risk behaviors. The programme will build capacity at the Ministry of Health for planning and managing BCC interventions targeting young people at national, district and local levels focussing on delaying sexual debut, delaying childbearing and preventing high risk sexual behavior.

4.39. Similarly, technical assistance will be provided to the Ministry of Education for the integration of adolescent reproductive health education into the curriculum of pre-secondary and secondary schools and vocational training institutes; the development of modules, syllabi and a teacher's manual to operationalize the ARH curriculum; and the development of a training programme on ARH education for teachers in active service at the Institute for Professional Development and for student teachers in teacher training institutions. In 2009, Timor-Leste will implement nine years of free and compulsory basic education (six years of primary and three years of pre-secondary education). Advocacy for integration of reproductive health information into basic education will enable schools to reach young people before they leave school and before onset of sexual activity.

4.40. Timor-Leste has not had any experience in the implementation of an adolescent reproductive health programme. Hence, the proposed programme will provide technical assistance and support strategic planning for capacity development in managing ARH programmes at the Ministries of Health and Education, the Secretariats of State for Youth and Sports and for Professional Development and Employment and other government agencies working with the youth. The five-year review of the NRHS presents a good opportunity to situate the ARH programme in relation to the NRHS, the BSP, the HSSP, the RH BCC Strategy, the Family Health Promoter Programme, the SISCA initiative and other relevant strategic documents and initiatives within the health sector as well as the National Youth Policy. An Adolescent Reproductive Health Strategy will be drafted as the absence of policies and guidelines on adolescent health was cited as an important gap in the HSSP.

4.41. Reaching out-of-school youth is a challenge that has to be addressed given the high drop-out rates in the country. The proposed programme will coordinate interventions targeting out-of-school youth with the Ministry of Health, the Secretariat of State for Youth and Sports, UN agencies and civil society. Youth centers in selected school and out-of-school settings will be piloted as venues for young people to access RH information, personal counseling and clinical services. Peer educators will be trained to provide age-appropriate and gender-sensitive information in both school and out-of-school settings. Meaningful youth involvement will be encouraged by mobilizing youth organizations on ARH issues and strengthening the capacity of suco youth representatives to advocate for ARH education and YFS service provision at the local level. Support will also continue for ARH advocacy workshops targeting youth, parents, religious and community leaders at regional, district and local levels. The workshops, which are jointly conducted by the Ministries of Health and Education with representation from the National Statistics Directorate, culminate with the drafting of district-level action plans on ARH.

4.42. The RH programme component will support supervision, monitoring and evaluation across all outputs to ensure post-training follow up and quality of services. The programme will also support the Health Management Information System (HMIS) and support data collection activities particularly for maternal health and family planning. At the request of the Ministry of Health, UNFPA will take the lead in coordinating the 2009 Demographic and Health Survey. The 2009 DHS will include optional modules on maternal mortality and domestic violence, in order to address critical information gaps on maternal mortality and morbidity as well as gender-based violence. The DHS will be conducted by the National Statistics Directorate in collaboration with the Ministry of Health.

Population and Development Strategies (PDS) programme component

4.43. The overarching objectives of this component are firstly to make available data on population dynamics, gender, young people, sexual and reproductive health, and HIV/AIDS; and secondly to analyse, make it more accessible and use this data at the national and sub national levels in the development, implementation and monitoring of policies and programmes.

4.44. Output 1: Policymakers and planners at national and sub national levels are sensitized on the need to strengthen and operationalize institutional mechanisms to improve the coordination and monitoring of population and reproductive health programmes and strategies. To achieve this output, the programme will (a) strengthen institutional mechanisms to facilitate the integration of population issues in the development of programmes and plans, and (b) assist in the establishment of a National Population Commission and technical working group, to formulate a National Population Policy that ensures population, reproductive health and gender concerns are integrated into all sectoral programmes.

4.45. The first strategy will be to sensitize key policy makers in government on the need to establish a mechanism to coordinate population and development issues and to integrate them in policies and programmes. The programme will support, among other things: (a) the establishment of a National Population Commission (NPC) as a body in government; (b) the technical and institutional capacity development of the NPC as an overarching coordinator of all issues pertaining to population policy; and (c) the promotion of regular meetings on population and development issues for the NPC, implementing agencies and development partners.

4.46. The second strategy will be to support the NPC in the development of a National Population Policy and a clear plan for its implementation in line with the ICPD PoA and national policies. This will ensure that population issues are mainstreamed into the Government's ministerial and sectoral policies and programmes. To achieve this strategy, the following steps will be carried out: (a) the provision of technical support and capacity building for members of the NPC in the development of the policy and its implementation plan, (b) awareness raising among policy makers and implementing partners on the need to support the development of the policy and its subsequent approval by the Government; and (c) disseminate the policy to various stakeholders at the national and sub-national levels following its approval by the Government.

4.47. Output 2: Strengthened analytical capacity at national and sub national levels for utilizing data on population, reproductive health and gender, in order to develop, implement and monitor policies and programmes. To achieve this output, the programme will: (a) build national capacity for planning, implementing and monitoring population programmes; (b) support the introduction of courses on population and development at a national university; (c) promote the use of existing data generated by the household based surveys and censuses; and (d) support planners and public officers in relevant ministries to undertake national and international training on population and development issues.

4.48. The strategies used to achieve Output 2 will focus on developing the knowledge of East Timorese nationals in the areas of population studies and related fields. Activities include: (a) the development, in collaboration with national universities, of a training course focused on national population studies or a related field; (b) short-term trainings in the analysis of population data including gender analysis; and (c) discussions with at least one of the national universities regarding incorporating a demography subject into an undergraduate studies curriculum.

4.49. Output 3: Improved availability of disaggregated demographic and socio-economic data at national and sub national levels. The strategy to achieve Output 3 will focus on strengthening the institutional and technical capacity of the NSD to collect, analyses, publish, disseminate, and use quality data. To achieve this objective, the PDS programme component will: (a) support the planning, implementation, data capture, analysis, publication and dissemination of the 2010 Population and Housing Census, (b) carry out training on data management to encourage utilization of existing data; (c) support the Health Management information (HMIS) team in analysing data and publishing its annual reports; (d)

support the development of systems to facilitate population registers; and (e) support the implementation of 2009 Demographic and Health Survey (DHS) in partnership with other development partners.

4.50. The realization of this output will be: (a) an increase in the use of population, RH and socioeconomic data by government ministries, NGOs, and the private sector; and (b) an increase in the number of users accessing data for planning, implementing, monitoring and evaluating population and RH programmes.

Gender programme component

4.51. The overarching goal of the Gender programme component is to contribute to the achievement of gender equality and women's empowerment in Timor-Leste through the elimination of gender-based violence. The Gender programme component will support an environment to establish legal frameworks to end gender-based-violence and to operationalize programmes, i.e. services, outreach mechanisms, social protection scheme to reduce vulnerability of women and girls as well as improving protection for them, and to advocate and to build national capacity for the implementation of the UN Security Council Resolution 1325 on Women, Peace and Security. The outcome of this component is: strengthened national capacity to promote gender equality and prevent gender-based violence through improved policies, protection systems, the enforcement of laws and the provision of reproductive health services.

4.52. Output 1: Contribute to implementing the national domestic violence law. The programme will: (a) advocate the need to promulgate and implement the draft Law Against Domestic Violence among key line ministries, the National Parliament and civil society; and (b) produce information, education and communication (IEC) materials to educate the population on its benefits. The main strategic approach to implement this output would be continued support to the Secretariat of State for the Promotion of Equality (SEPI) to strengthen national capacity to address gender-based violence. Activities planned under this output include: a) Lobby for the promulgation of the Law Against Domestic Violence and; b) Conduct a national campaign to raise awareness and inform the general public about the Law once it has been promulgated; and c) Training of the police, prosecutors, judiciary, suco chiefs, key partners in the referral network of support services and other stakeholders on the use and application of the Law.

4.53. Output 2: Increased access to emergency medical, shelter, counseling and legal services for victims of domestic and gender-based violence in Dili and other districts. To achieve this output, the programme will: (a) support awareness-raising and training for communities, police, the legal sector and health workers on gender-based violence and support services; (b) support initiatives to expand services to victims of gender-based and domestic violence; and (c) develop protocols and operating procedures to regulate the existing referral network of services and reinforce data collection on cases of domestic and gender-based violence.

4.54. The main strategic approaches to implement this output would be strengthening mechanisms for coordination, information-sharing and complementarity of services, especially between the Ministry of Social Solidarity, SEPI, Ministry of Health and the NGO service providers; and increasing the capacity of the Ministry of Social Solidarity to strengthen and coordinate existing case management and data collection systems. Activities planned under this output include: a) Expansion of the referral network of support services to the districts and improvement in the quality of information and services provided to victims of violence; b) Formulation of regulations and protocols governing the referral network; c) Systemization of data collection, monitoring and evaluation of cases of GBV, including identification of a core of GBV indicators which will regularly be monitored and analyzed, and installation of a GBV database; d) Partner with men's organizations such as the Assosiasaun Mane Kontra Violensia (AMKV) in initiatives aimed at changing the attitudes of men towards women and the use of violence; e) Improve women's access to formal legal mechanisms and access to information about their legal rights, formal justice processes and support services; and f) Ensure that women and children's issues are represented in discussions on justice and legal protection in both the formal and traditional justice systems.

4.55. Output 3: Contribute to developing a national action plan on Security Council Resolution 1325 (on women, peace and security). The programme will: (a) raise awareness of the Security Council Resolution and the need to draft a national action plan; (b) strengthen national capacity to monitor the implementation of international human rights legislation that protects the rights of women and young girls, including reproductive rights; (c) provide gender-sensitive training to military and civilian personnel in the peacekeeping operation; and (d) provide training on Security Council Resolution 1325 for civil society. UNFPA will facilitate South-South cooperation with countries such as Nepal and Sri Lanka to enable Timor-Leste to benefit from other country experiences on developing a national plan of action for SCR 1325. UNFPA will work in partnership with IOM and UNICEF for strengthen policies against trafficking and provide services to victims of trafficking.

4.56. The Joint Programme "Supporting Gender Equality and Women's Rights in Timor-Leste" is a three-year programme supported by the MDG Spanish Fund to build institutional capacity to eliminate gender-based violence and human trafficking and to improve allocation of resources using gender–responsive budgeting. The joint programme will be implemented by five UN Agencies (UNFPA, UNIFEM, UNDP, IOM and UNICEF) in partnership with government agencies and in collaboration with relevant civil society organizations and individuals.

Part V. Partnership Strategy

5.1. UNFPA Timor-Leste will build on its existing partnerships with the key Government counterparts during the First Country Programme. The Ministry of Health, the National Statistics Directorate and the Secretariat of State for the Promotion of Equality will continue to be the key implementing partners for the Second Country Programme. The Government and UNFPA have also identified the Ministry of Education, the Ministry of Social Solidarity, the Ministry of Economy and Development, the Secretariat of State for Youth and Sports and the National University of Timor-Leste as potential partners.

5.2. Under the PDS programme component, the main implementing partner will be the National Statistics Directorate under the Ministry of Finance, particularly for data collection activities. For the implementation of capacity building initiatives under the proposed programme, partnerships will be established with training institutions such as UNTL and DIT. Undertaking the 2009 DHS, the 2010 Census, and other planned surveys will require an expanded partnership with different ministries, sister UN agencies and other development partners. UNFPA will take the lead for supporting the 2010 Census within the UNCT. From the Government, the leadership of the Office of the Prime Minister and the involvement of the respective Ministries of Finance, Economy and Development, Health and Education are crucial for the success of the 2010 Census. As the Census is a special initiative under the 2009-2013 UNDAF, there will be close collaboration with other UN agencies notably UNICEF, WHO, UNDP and ILO. Bilateral organizations with a major presence in Timor-Leste, such as USAID, AusAID and NZAID, are among the other development partners that will be tapped for technical and financial assistance to the 2010 Census and the 2009 DHS.

5.3. The Secretariat of State for the Promotion of Equality (SEPI) will be the principal counterpart of the UNFPA Gender programme component. The implementation of this programme component also requires an expanded partnership including all actors working on gender issues in Timor-Leste. The main partners from the UN system will be UNIFEM, UNDP, IOM and UNICEF. Several NGOs that were supported during the First Country Programme will continue to be assisted to strengthen their capacities to deliver services to victims of gender-based and domestic violence, among them PRADET, JSMP, FOKUPERS and AMKV. Key partners for the implementation of the Domestic Violence Law will be the Ministry of Social Solidarity and the Vulnerable Persons' Unit (VPU) of the National Police of Timor Leste (PNTL). Other partners include the Justice and Peace Commission (JPC) and the Dioceses of Dili and Baucau for the organization of events for the promotion of gender equality including the International Peace Day and Pascua Joven (Youth Easter) celebrations.

5.4. The main partner for the implementation of the RH programme component will be the Ministry of Health (MoH), particularly the Maternal and Child Health (MCH) and Health Promotion Departments under the National Directorate for Community Health. UNFPA will work with the Central Pharmacy and the Institute of Health Services for RH commodity logistics management and in-service training of health workers on reproductive health, respectively. A new partnership will be established with UNTL for the Department of Midwifery within the reorganized Faculty of Health Sciences. UNFPA will co-ordinate its support for fellowships and pre-service training, including the midwifery school at UNTL, with the National Directorate for Human Resources at MoH.

5.5. Close coordination and partnership for the implementation of the RH programme component will continue with WHO and UNICEF. To promote and ensure civil society involvement in RH service provision, greater collaboration with and support for NGOs will be required. In collaboration with the IPPF Regional Office in Kuala Lumpur, UNFPA will provide support for the establishment of a national reproductive health association affiliated with IPPF.

5.6. UNFPA will strengthen its existing partnerships with faith-based organizations (FBOs), particularly the Catholic Church, to address gender-based violence, expand access to RH services including information in family planning. This includes working with faith-based service delivery networks such as Caritas Diocesana Dili.

5.7. UNFPA will work with the Ministry of Education to ensure the inclusion of life skills-based sexual and reproductive health education in the national secondary school curriculum. Other partners include UNICEF, WHO, UNESCO and the Ministry of Health.

5.8. UNFPA will strengthen its engagement with Parliamentarians in order to mobilize national resources for population and development, galvanize support towards the promulgation and implementation of the Draft Law Against Domestic Violence, and advocate universal access to reproductive health information and services.

5.9. UNFPA will engage in joint programming with WHO and UNICEF in the area of data collection, including strengthening the HMIS, implementing the next DHS and developing the national vital registration system. UNFPA will explore joint programming and continue its close collaboration with UNIFEM, UNICEF and UNMIT on gender-based and domestic violence. UNFPA will also participate in two Joint Programmes identified in the UNDAF, on girls' and women's empowerment and on improving human security, respectively.

Part VI. Programme Management

6.1. The Government and the UNFPA will be jointly responsible for the effective management and delivery of results of the CPAP. The Ministry of Finance will assume the role of the Government Coordinating Authority (GCA) and will be responsible for overall coordination of the Second Country Programme.

6.2. The role of Programme Component Manager (PCM) will be assumed by the lead Government agencies for the respective programme components under the CPAP. The Ministry of Health will be designated the PCM for the RH programme component, the National Statistics Directorate will be the PCM for the PDS programme component, and the Secretariat of State for the Promotion of Equality will be the PCM for the Gender programme component. Resources will also be allocated to ensure support for other government institutions, NGOs, FBOs and civil society organizations.

6.3. An agency or organization to which UNFPA entrusts funds for the implementation of activities under a CP output and which, in turn, reports back to UNFPA on financial and substantive aspects is referred to as an Implementing Partner (IP). Selection of IPs is based on criteria related to: management systems including financial management; institutional and technical capacities; past experience in implementing related activities including experience from the First Country Programme; and potential to contribute to the realization of the CP outcomes and outputs.

6.4. The PCM will be responsible for coordinating the Annual Work Plans (AWPs) of several IPs working towards the realization of CP outputs under a programme component. The coordinating role of the PCM include responsibilities such as preparing the Annual Component Progress Report (ACPR) and organizing component level meetings with IPs in the context of the UNDAF annual review. The PCM will also facilitate information-sharing of lessons learned and best practices among IPs and lead discussions to address any constraints encountered in the implementation of the AWPs under the programme component.

6.5. Implementing Partners will assume responsibility for implementing CP activities by signing an AWP and a Letter of Understanding (LoU) with UNFPA. Key responsibilities of an IP include cooperating and coordinating with other IPs working towards the achievement of the same CP output, with the PCM for the programme component, and with UNFPA; establishing and operating arrangements for financial management and accountability, including preparing requests for advances and expenditure reports; and fostering M&E activities and outputs listed in the AWP through field monitoring visits, participation in annual UNDAF review meetings, preparation of the AWP monitoring tool, contributions to the Standard Progress Report (SPR), and participation in other M&E events. The IP will also communicate to concerned parties the official activation of the AWP and ensure its closure when all operational activities have been completed.

6.6. Preparations for the AWP will commence in October/November each year, and will be finalized and approved in December following the annual programme review. These AWPs will be reviewed and revised in June/July following the mid-year programme review, and will be adjusted according to implementation experience including budget execution and the identification of opportunities and constraints.

6.7. During the First CP, the Country Office successfully mobilized financial resources from thematic and humanitarian funding and from joint programming initiatives as well as human resources from other UNFPA offices, the United Nations Volunteers (UNV) and the Junior Professional Officer (JPO) Programme. The Country Office will continue to mobilize financial and human resources from these and other sources for the next programme cycle, using advocacy and strategic communication strategies and fostering South-South collaboration.

6.8. All cash transfers to an Implementing Partner are based on the AWPs agreed between the Implementing Partner and UNFPA.

6.9. Cash transfers for activities detailed in AWPs can be made by a UN agency using the following modalities:

1. Cash transferred directly to the Implementing Partner:
   a. Prior to the start of activities (direct cash transfer), or
   b. After activities have been completed (reimbursement);
2. Direct payment to vendors or third parties for obligations incurred by the Implementing Part ners on the basis of requests signed by the designated official of the Implementing Partner;
3. Direct payments to vendors or third parties for obligations incurred by UN agencies in support of activities agreed with Implementing Partners.

6.10. Direct cash transfers shall be requested and released for programme implementation periods not exceeding three months. Reimbursements of previously authorized expenditures shall be requested and released quarterly or after the completion of activities. The UNFPA shall not be obligated to reimburse expenditure made by the Implementing Partner over and above the authorized amounts.

6.11. Following the completion of any activity, any balance of funds shall be reprogrammed by mutual agreement between the Implementing Partner and UNFPA, or refunded.

6.12. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may depend on the findings of a review of the public financial management capacity in the case of a Government Implementing Partner, and of an assessment of the financial management capacity of the non-UN Implementing Partner. A qualified consultant, such as a public accounting firm, selected by UNFPA may conduct such an assessment, in which the Implementing Partner shall participate.

6.13. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may be revised in the course of programme implementation based on the findings of programme monitoring, expenditure monitoring and reporting, and audits.

6.14. The UNFPA Country Office in Timor-Leste consists of a Representative, two national Programme Officers, a Programme Assistant and four administrative and financial support staff, as per the approved country office typology. Funds will be allocated for three international programme posts and other national project personnel to ensure effective programme implementation. Project personnel will be based in the respective counterpart offices. The UNFPA Asia and Pacific Regional Office (APRO) in Bangkok will provide technical backstopping support.

Part VII. Monitoring & Evaluation

7.1. The Government and UNFPA will be responsible for ensuring continuous monitoring and evaluation of the Country Programme for efficient utilization of programme resources as well as promoting accountability, transparency and integrity. Under the Second Country Programme of Assistance, mandatory monitoring and evaluation activities include:

- Preparation of a CPAP Monitoring & Evaluation Plan, which includes the CPAP Planning and Tracking Tool and the CPAP M&E Calendar;
- Establishment of key performance indicators with baselines and targets;
- Undertaking regularly scheduled field monitoring visits to monitor programme implementation;
- Completion of the Work Plan Monitoring Tool for each AWP at least once a year;
- Submission of Standard Progress Reports for each programme component on a biannual basis (every six months);
- Conducting periodic reviews to assess results, document lessons learned and plan for the following year's AWPs;
- Submission of a Country Office Annual Report (COAR); and
- Evaluation of progress towards achievement of the country programme outcomes during the midterm and final CP review to be carried out within the five-year CP cycle.

7.2. The CPAP has two main instruments to guide monitoring and evaluation of the CP, namely: the CPAP Planning and Tracking Tool (Annex II); and the CPAP M&E Calendar (Annex III). Both these tools are linked to the UNDAF M&E Plan that captures the major monitoring and evaluation activities across UN agencies and organizations. In addition, each Implementing Partner should identify routine monitoring activities and planned evaluations in their respective AWPs.

7.3. Implementing partners agree to cooperate with UNFPA for monitoring all activities and will facilitate access to relevant financial records and personnel responsible for the administration of cash provided by

UNFPA. To that effect, Implementing Partners agree to the following:

- Periodic on-site reviews and spot checks of their financial records by UNFPA or its representatives;
- Programmatic monitoring of activities following UNFPA's standards and guidance for site visits and field monitoring; and
- Special or scheduled audits. UNFPA, in collaboration with other UN agencies will establish an annual audit plan, giving priority to audits of Implementing Partners with large amounts of cash assistance provided by UNFPA, and those whose financial management capacity needs strengthening.

7.4. To facilitate assurance activities, Implementing Partners and the UN agency may agree to use a programme monitoring and financial control tool allowing data sharing and analysis.

7.5. The audits will be commissioned by UNFPA and undertaken by private audit services. Assessments and audits of non-government Implementing Partners will be conducted in accordance with the policies and procedures of UNFPA.

Part VIII. Commitments of UNFPA

8.1. The UNFPA Executive Board approved a total commitment not to exceed the equivalent of the sum of US$10.50 million over a 5-year period beginning January 2009 and ending December 2013. Of the total amount pledged, US$7.5 million will come from UNFPA regular resources subject to availability of funds. UNFPA will do its best to raise another US$3.0 million from other sources to finance the country programme subject to donor interest. These regular and other resources are exclusive of funding received in response to emergency appeals. The distribution of funds among the component areas will be as follows:

Reproductive Health and Rights	US$ 4.00 million
Population and Development	US$ 3.25 million
Gender equality	US$ 2.50 million
Programme coordination and assistance	US$ 0.75 million

8.2. UNFPA support for the development and implementation of activities within this CPAP may include supplies and equipment, medicines and contraceptives, procurement of services on behalf of the government, transport, technical staff and support, funds for advocacy work, research and studies, consultancies, improvement of facilities, information and communication programme, fellowships, participation in international conferences, study tours, orientation and training activities, monitoring and evaluation, programme development, and coordination and management. UNFPA shall appoint programme staff and consultants for programme development, programme support and technical assistance as well as monitoring and evaluation activities. Part of the funds will be provided to NGOs and civil society organizations within the framework of the individual AWPs.

8.3. The funds will support priority programmes as identified in the Results & Resources Framework (RRF) attached to this document (see Annex I). Changes in the programme activities are subject to review by the Government and UNFPA. Funds will be committed annually based on the AWP to be signed by the respective Implementing Partners and UNFPA. Disbursement of funds will be made on a quarterly basis following UNFPA financial rules and procedures.

8.4. UNFPA maintains the right to request the return of any cash, equipment or supplies furnished by it which are not used for the purpose specified in the AWPs. Therefore, in consultation with concerned government agencies, UNFPA maintains the right to request a joint review of the use of commodities supplied but not used for the purpose specified in this CPAP or the AWPs, for the purpose of reprogramming those commodities within the framework of the CPAP. UNFPA will keep the Government informed about the Executive Board policies and any change occurring during the programme period.

8.5. In case of direct cash transfer or reimbursement, UNFPA shall notify the Implementing Partner of the amount approved by UNFPA and shall disburse funds to the Implementing Partner within a reasonable time.

8.6. In case of direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner; or to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with Implementing Partners, UNFPA shall proceed with the payment within a reasonable time.

8.7. UNFPA shall not have any direct liability under the contractual arrangements concluded between the Implementing Partner and a third party vendor.

8.8. Where more than one UN agency provides cash to the same Implementing Partner, programme monitoring, financial monitoring and auditing will be undertaken jointly or coordinated with those UN agencies.

Part IX. Commitments of the Government

9.1. The Government will provide the necessary support to UNFPA and concerned implementing agencies to carry out the Second Country Programme of Assistance. The Government's contribution to the Country Programme will include personnel, office space and logistics support as available in the project areas. The Government is committed to support UNFPA in its efforts to raise funds required to meet the financial needs of the Country Programme. The Government is also committed to organize periodic programme review and planning meetings and to facilitate the participation of donors and NGOs where appropriate and agreed.

9.2. Each of the UNFPA-assisted institutions shall maintain proper accounts, records, and documentation with respect to funds, supplies, equipment and other assistance provided under this Country Programme. Authorized officials of UNFPA shall have access to all relevant accounts, records and documents concerning the distribution of supplies, equipment and other materials, experts on mission, and persons performing services for UNFPA, to observe and monitor all phases of the programme of cooperation.

9.3. All supplies and equipment procured by UNFPA for the Government shall be transferred to the Government immediately upon arrival in the country. Final legal transfer shall be accomplished upon delivery to UNFPA of a signed government receipt. Should any of the supplies and equipment thus transferred not be used for the purposes for which they were provided as outlined in the AWPs and this CPAP, UNFPA may require the return of those items, and the Government will make such items freely available to UNFPA.

9.4. With respect to the use of programme funds, UNFPA and the heads of respective Government agencies as indicated in the AWP will sign separate letters of understanding and approval providing details on accountability, use of funds provided by UNFPA, banking arrangements, accounting and financial reports, audit and control mechanisms, and closing procedures. Any balance of funds unutilized or which could not be used according to the original plan should be reprogrammed through mutual consent between the Government and UNFPA, or returned to UNFPA. Failure to do so will preclude UNFPA from provid-

ing further funds to the same recipient. Funds used for travel, stipends, honoraria and other costs shall be set at rates commensurate with those applied in the country, but not higher than those applicable to the United Nations System, as stated in the International Civil Service Commission (ICSC) circulars.

9.5. A standard Fund Authorization and Certificate of Expenditures (FACE) report, reflecting the activity lines of the Annual Work Plan (AWP), will be used by Implementing Partners to request the release of funds, or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditure. The Implementing Partners will use the FACE to report on the utilization of cash received. The Implementing Partner shall identify the designated official(s) authorized to provide the account details, request and certify the use of cash. The FACE will be certified by the designated official(s) of the Implementing Partner.

9.6. Cash transferred to Implementing Partners should be spent for the purpose of activities as agreed in the AWPs only.

9.7. Cash received by the Government and national NGO Implementing Partners shall be used in accordance with established national regulations, policies and procedures consistent with international standards, in particular ensuring that cash is expended for activities as agreed in the AWPs, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds. Where any of the national regulations, policies and procedures is not consistent with international standards, the UN agency regulations, policies and procedures will apply.

9.8. In the case of international NGO and IGO Implementing Partners cash received shall be used in accordance with international standards in particular ensuring that cash is expended for activities as agreed in the AWPs, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds.

9.9. To facilitate scheduled and special audits, each Implementing Partner receiving cash from UNFPA will provide UN Agency or its representative with timely access to:

- All financial records which establish the transactional record of the cash transfers provided by UNFPA;
- All relevant documentation and personnel associated with the functioning of the Implementing Partner's internal control structure through which the cash transfers have passed.

9.10. The findings of each audit will be reported to the Implementing Partner and UNFPA. Each Implementing Partner will furthermore:

- Receive and review the audit report issued by the auditors.
- Provide a timely statement of the acceptance or rejection of any audit recommendation to UNFPA that provided cash.
- Undertake timely actions to address the accepted audit recommendations.
- Report on the actions taken to implement accepted recommendations to the UN agencies on a quarterly basis.

Part X. Other Provisions

10.1. This CPAP enters into force on the date signed by the Government and UNFPA, but will be understood to cover programme activities to be implemented during the period 1st January 2009 to 31st December 2013.

10.2. This CPAP may be modified by mutual consent of both parties based on the recommendations of the joint strategy meeting or annual reviews.

10.3. Nothing in this CPAP shall in any way be construed to waive the protection of UNFPA accorded by the contents and substance of the United Nations Convention on Privileges and Immunities to which the Government is a signatory.

IN WITNESS THEREOF the undersigned, being duly authorized, have signed this Country Programme Action Plan on this day (..... March 2009) in Dili, Timor-Leste.

For the Government of the Democratic Republic of Timor-Leste	For the United Nations Population Fund in Timor-Leste
_____	_____
H.E. Mrs. Emilia Pires	Dr. Hernando Agudelo
Minister of Finance	UNFPA Representative

Annexes

Annex I: The CPAP Results & Resources Framework

Annex II: The CPAP Planning & Tracking Tool

Annex III: The M&E Calendar

Annex I: CPAP RESULTS AND RESOURCES FRAMEWORK

National Priorities: Improved access to basic social services throughout the country. These include health and nutrition, education, water and sanitation, and social protection and social welfare.

Relevant MDGs: MDG 1: Eradicate extreme poverty and hunger; **MDG 2:** Achieve universal primary education; **MDG 3:** Promote gender equality and empower women; **MDG 4:** Reduce child mortality; **MDG 5:** Improve maternal health; **MDG 6:** Combat HIV/AIDS, malaria and other diseases; and **MDG 7:** Ensure environmental sustainability

UNDAF outcome (3): By 2013, children, young people, women and men have improved quality of life through reduced malnutrition, morbidity and mortality; strengthened learning achievement; and enhanced social protection

Country Programme Outcome	Country Programme Output	Output Indicators	Implementing Partners	Indicative resources by output (per annum in thousands of USD)					
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total
Reproductive Health Programme Component **Outcome 1:** Increased access to and utilization of comprehensive reproductive health services, including those focusing on maternal health, family planning, and the prevention of sexually transmitted infections and HIV, especially for vulnerable groups	**Output 1:** Increased demand for and access to high-quality maternal health services, including emergency obstetric care	**Output 1 indicators:** • % of facilities providing high-quality emergency obstetric care • % of women who know at least three signs of obstetric complications; • Human resource development plans reflect reproductive health management and service delivery requirements • Caesarean sections as a percentage of all live births	Ministry of Health; Ministry of Education and Culture; Secretariat of State for Youth and Sports Faith-based organizations; National and international NGOs; University of Timor-Leste; Bilateral donors; United Nations organizations	**Regular resources**					
				200	200	200	150	150	900
				Other Resources					
				20	20	20	20	20	100
			Total this Output						**$ 1,000,000**
Outcome 1 indicators: • Maternal mortality ratio • Total fertility rate • Increased contraceptive prevalence rate • Increased % of births by skilled attendants	**Output 2:** Increased access to and demand for high-quality family planning services	**Output 2 indicators:** • % of facilities with stocks and trained providers offering at least three modern methods of contraceptio • Up-to-date database on contraceptive stocks • % of facilities experiencing a stock-out of any method during previous year • % of women and men with knowledge of at least three modern contraceptive methods	As above	**Regular resources**					
				200	200	200	150	150	900
				Other Resources					
				20	20	20	20	20	100
			Total this Output						**$ 1,000,000**

Outcome 2: Enhanced life skills for young people, including skills to prevent sexually transmitted diseases, HIV and adolescent pregnancies **Outcome 2 indicators:** • Decreased adolescent fertility rate (15-19 years) % of youth with comprehensive knowledge on HIV/AIDS	**Output 3:** Increased availability of information, counseling and services for populations most at risk, to promote healthier and safer behavior	**Output 3 indicators:** • % of populations most at risk who have knowledge of key sexual and reproductive health information, including on HIV • % of service delivery points that provide information, counseling and services on preventing sexually transmitted infections and HIV	As above	**Regular resources**					
				200	200	200	150	150	900
				Other Resources					
				20	20	20	20	20	100
			Total this Output	**$ 1,000,000**					
	Output 4: Increased access to high-quality reproductive health information and services for young people	**Output 4 indicators:** • Number of adolescents receiving sexual and reproductive health education • Number of service delivery points providing youth-friendly services • Life skills-based reproductive health information integrated into the national secondary school curriculum	As above	**Regular resources**					
				200	200	200	150	150	900
				Other Resources					
				20	20	20	20	20	100
			Total this Output	**$ 1,000,000**					
Total planned support per year and for 5 years for this component programme				**880**	**880**	**880**	**680**	**680**	**4,000**

National Priorities: Development of institutional capacity, transparency and accountability; stabilisation of the justice and security sectors; promotion of social cohesion; Effective fight to improve living conditions of Timorese, with a focus on environmental conservation, disaster risk reduction and management, balanced regional development, and vulnerable groups including IDPs, youth and women, in a post-conflict context; Improved access to basic social services throughout the country. These include health and nutrition, education, water and sanitation, and social protection and social welfare.

Relevant MDGs: MDG 1: Eradicate extreme poverty and hunger; **MDG 2:** Achieve universal primary education; **MDG 3:** Promote gender equality and empower women; **MDG 4:** Reduce child mortality; **MDG 5:** Improve maternal health; **MDG 6:** Combat HIV/AIDS, malaria and other diseases; and **MDG 7:** Ensure environmental sustainability

UNDAF outcome: The Census has been identified as a cross-cutting initiative outside the UNDAF Results Matrix.

Country Programme Outcome	Country Programme Output	Output Indicators	Implementing Partners	Indicative resources by output (per annum, USD)					
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total
Population & Development programme component **Outcome:** Data on population dynamics, gender equality, young people, sexual and reproductive health and HIV/AIDS are available, analyzed and used at national and sub national levels to develop, implement and monitor policies and programmes	**Output 1:** Policymakers and planners at national and sub national levels are sensitized on the need to strengthen and operationalize institutional mechanisms to improve the coordination and monitoring of population and reproductive health programmes and strategies	**Output 1 indicators:** • Blueprint for a high-level national population commission to oversee integration of population, reproductive health and gender data into public policies, plans and programmes • National population policy drafted for approval and adoption by the Government	Ministry of Planning and Finance; National Statistics Directorate Media; University of Timor-Leste; Bilateral donors; UNICEF; WHO	**Regular resources**					
				80	80	80	80	80	400
				Other Resources					
				50	50	100	100	100	400
			Total this Output						**$ 800,000**
	Output 2: Strengthened analytical capacity at national and sub national levels for utilizing data on population, reproductive health and gender in order to develop, implement and monitor policies and programmes	**Output 2 indicators:** • National experts sponsored for higher education in the area of population and development • National expertise in population and development issues increased	As above	**Regular resources**					
				100	100	120	120	120	560
				Other Resources					
				100	100	100	100	100	500
			Total this Output						**$ 1,060,000**

	Output 3: Improved availability of disaggregated demographic and socio-economic data at national and sub national levels	**Output 3 indicators:** • 2010 Population and Housing Cnsus conducted analyzed and disseminated • 2009 Demographic and Health survey conducted • Annual reproductive health and family planning monitoring indicators available through the health management information system	As above	**Regular resources**					
				150	280	150	150	150	880
				Other Resources					
				100	160	100	100	50	510
			Total this Output						**$ 1,390,000**
Total planned support per year and for 5 years for this component programme				**580**	**770**	**650**	**650**	**600**	**3,250**

National Priorities: Improved access to basic social services throughout the country. These include health and nutrition, education, water and sanitation, and social protection and social welfare.

Relevant MDGs: MDG 1: Eradicate extreme poverty and hunger; **MDG 2:** Achieve universal primary education; **MDG 3:** Promote gender equality and empower women; **MDG 4:** Reduce child mortality; **MDG 5:** Improve maternal health; **MDG 6:** Combat HIV/AIDS, malaria and other diseases; and **MDG 7:** Ensure environmental sustainability

UNDAF outcome (3): By 2013, children, young people, women and men have improved quality of life through reduced malnutrition, morbidity and mortality; strengthened learning achievement; and enhanced social protection

Country Programme Outcome	Country Programme Output	Output Indicators	Implementing Partners	Indicative resources by output (per annum, USD)					
				Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Total
Gender programme component **<u>Outcome:</u> Strengthened national capacity to promote gender equality and prevent gender-based violence through improved policies, protection systems, the enforcement of laws and the provision of reproductive health services**	**<u>Output 1:</u>** Contribute to implementing the national domestic violence law	**<u>Output indicators:</u>** • Translation of final amended version of the law in Portuguese and Tetum (indigenous language) is completed • Briefing kits on the law for council of ministers, national parliament and civil society completed in Portuguese and Tetum • Presentation of the domestic violence law to the council of ministers, parliament and promulgation by the President	National police; Ministries of: Health; Justice; and Social Solidarity; Secretariat of State for National Security; Secretariat of State for the Promotion of Equality; Churches; National NGOs; Media; Bilateral donors; UNICEF; UNIFEM	**Regular resources**					
				90	90	90	90	90	450
				Other Resources					
				30	20				50
			Total this Output						**$ 500,000**
<u>Outcome indicators:</u> • Adoption and implementation of the domestic violence law • Strengthened network of services to support victims of gender-based violence • Increased public awareness on gender-based violence • Adoption of a national action plan on Security Council resolution 1325	**<u>Output 2:</u>** Increased access to emergency medical, shelter, counseling and legal services available for victims of domestic and gender-based violence in Dili and other districts	**<u>Output indicators:</u>** • Number of service providers • Number of referrals to service providers • Number of domestic violence cases reported to police • Referral protocols adopted and database recognized by the Government	As above	**Regular resources**					
				70	70	90	90	90	410
				Other Resources					
				220	220	200	100	80	820
			Total this Output						**$ 1,230,000**

	Output 3: Contribute to developing a national action plan on Security Council resolution 1325	**Output indicators:** • Consultation meetings with key ministries on formulating the national action plan on Security Council Resolution 1325 completed • Design, translation and printing of the national action plan completed • Training on Security Council Resolution 1325 for key stakeholders within the Government and civil society in Dili and district levels is completed	As above	**Regular resources**					
				90	90	90	90	90	450
				Other Resources					
				40	40	80	80	80	320
			Total this Output						**$ 770,000**
Total planned support per year and for 5 years for this component programme				540	530	550	450	430	2,500
Programme Coordination and Assistance (PCA)									**$ 750,000**
GRAND TOTAL Country programme funds									**$ 10,500,000**

Annex II: The CPAP Planning and Tracking Tool

Country: Timor-Leste
CP Cycle: Second (2009-2013)

Reproductive Health Programme Component

RESULTS	Indicator	MoV	Responsible party	Baseline	Target	Achievement
UNDAF Outcome (3)						
By 2013, children, young people, women and men have improved quality of life through reduced malnutrition, morbidity and mortality; strengthened learning achievement; and enhanced social protection	• Under-five mortality rate	• HMIS • Timor-Leste DevInfo	MoH, NSD	• 130 per 100,000 live births (2004)	• To be established in consultation with Ministry of Health	
	• Maternal mortality ratio	• HMIS • Timor-Leste DevInfo	MoH, NSD	• 660 per 100,000 live births (2000)	• 40% MMR reduction by 2014 from 2004 baseline (National RH Strategy target)	
	• Underweight prevalence among children under five	• HMIS • Timor-Leste DevInfo	MoH, NSD	• 50% (2007)	• As above	
	• Prevalence of stunting among children under five	• HMIS • Timor-Leste DevInfo	MoH, NSD	• 49.9% (2007)	• As above	
	• Prevalence of wasting among children under five	• HMIS • Timor-Leste DevInfo	MoH, NSD	• 18.8% (2007)	• As above	
	• Learning achievement of Grade 5 students	• EMIS	MoEd	• 20% (2006)	• To be established in consultation with Ministry of Education	
	• % of vulnerable children and women who received social safety net	• Ministry of Social Solidarity MIS	Ministry of Social Solidarity	• Not available	• To be established in consultation with Ministry of Social Solidarity	

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
CP Outcome 1								
Increased access to and utilization of comprehensive reproductive health services, including those focusing on maternal health, family planning, and the prevention of sexually transmitted infections and HIV, especially for vulnerable groups	• Maternal mortality ratio	HMIS, Census 2010	MoH, NSD	660/100,000 Live Births	Reduce between 40-50% (2007: Reduce by 40%; 2010: Reduce by 50% - NDP target cited by HSSP)			
	• Total fertility rate	Census 2010, DHS 2009, HMIS	MoH, NSD	6.95	To be established in consultation with Ministry of Health			
	• Contraceptive prevalence rate (modern methods)	DHS 2009, LMIS, HMIS	MoH, NSD	Baseline for CPR modern methods to be established from 2009 DHS; latest available figure is 8.6 (DHS 2003). TLSLS 2007 cites 19.8 for all methods.	25% (2009); 40% (National RH Strategy target for 2014)			
	• % of births attended by skilled attendants	HMIS, DHS 2009	MoH, NSD	27.2% (2007 HMIS), 41.3% (TLSLS 2007)	50% National RH Strategy target for 2009)			
Output 1.1								
Increased demand for and access to high-quality maternal health services, including emergency obstetric care	• % of facilities providing high-quality emergency obstetric care	Health facility records, HMIS, District Health Services registry	MoH, District Health Services	6 Referral hospitals	All referral hospitals plus CHC levels (67)			
	• % of women who know at least three signs of obstetric complications	BCC Strategy baseline survey	MoH	Baseline to be established from 2008 BCC Strategy baseline survey	50%			

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
	• Human resource development plans reflect reproductive health management and service delivery requirements	MoH annual reports	MoH	1	To be established in consultation with Ministry of Health			
	• Caesarean sections as a percentage of all births	Hospital/facility records	MoH	1%	5% (minimum international standard for EmOC)			
Output 1.2								
	• % of facilities with stocks and trained providers offering at least three modern methods of contraception	HMIS, LMIS, District Health Services registry	MoH, SAMES	100%	100%			
	• Up-to-date database on contraceptive stocks	LMIS	MoH, SAMES	10%	80%			
	• % of facilities experiencing a stock-out of any method during previous year	LMIS	MoH, SAMES	20%	0%			
	• % of women and men with knowledge of at least three modern contraceptive methods	DHS 2009	MoH, NSD	29% (DHS 2003)	40% (NRHS target by 2009) 80% (NRHS target by 2015)			

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
CP Outcome 2								
Enhanced life skills for young people, including skills to prevent sexually transmitted diseases, HIV and adolescent pregnancies	• Adolescent fertility rate (15-19 years)	Census 2010	MoH, NSD	58.5/1000 (Census 2004)	To be established in consultation with Ministry of Health; 30% reduction from 2004 baseline targeted for 2015 (NRHS target)			
	• % of youth with comprehensive knowledge on HIV/AIDS [% of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major/local misconceptions about HIV transmission]	BCC Strategy baseline survey	MoH, MoEd, NSD	Baseline to be established from 2008 BCC Strategy baseline survey; available surveys on knowledge of youth about HIV/AIDS did not construct this indicator as per its UNAIDS/ UNGASS definition	To be established in consultation with Ministry of Health			
Output 1.3								
Increased availability of information, counseling and services for populations most at risk, to promote healthier and safer behavior	• % of populations most at risk who have knowledge of key sexual and reproductive health information	National HIV Sentinel Survey, HMIS	MoH/Global Fund, NSD	Baseline to be established from National HIV Sentinel Survey (report forthcoming)	To be established in consultation with Ministry of Health			

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
	• % of service delivery points that provide information counseling and services on preventing sexually transmitted infections and HIV	National HIV Sentinel Survey, MoH, facility records	MoH/Global Fund	Baseline to be established from National HIV Sentinel Survey (report forthcoming) [144 Health staff trained; 40 STI services sites; 9 VCT centers]	To be established in consultation with Ministry of Health			
Output 1.4								
Increased access to high-quality reproductive health information and services for young people	• Number of adolescents receiving sexual and reproductive health education	EMIS, HMIS, Programme reports	MoH, MoEd	None (No youth-friendly services currently being provided)	To be established in consultation with Ministry of Health			
	• Number of service delivery points providing youth-friendly services	HMIS, Programme reports	MoH, MoEd	None (No youth-friendly services currently being provided)	Six (Dili, Baucau, Viqueque,Suai, Maliana and Oecusse)			
	• Life skills-based reproductive health information integrated into secondary school curriculum	EMIS, Programme reports	MoEd, MoH	None (LSBE on RH not integrated into secondary school curriculum)	LSBE on RH integrated into secondary school curriculum and taught in schools			

Population and Development Programme Component

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
CP Outcome 1								
Data on population dynamics, gender equality, young people, sexual and reproductive health and HIV/AIDS are available, analyzed and used at national and sub national levels to develop, implement and monitor policies and programmes	• Number of programs and policies developed, implemented and monitored with the use of data.	• National Policies • Project Progress reports • Minutes of meetings	NSD, relevant Government Ministries, bilateral partners, NGOs, multilateral organizations and civil society.		8		15	
Output 1								
Policymakers and planners at national and sub national levels are sensitized on the need to strengthen and operationalize institutional mechanisms to improve the coordination and monitoring of population and reproductive health programmes and strategies	• Blueprint for a high-level national population commission to oversee integration of population, reproductive health and gender data into public policies, plans and programmes • National population policy drafted for approval and adoption by the Government	Minutes of meetings, Project progress reports, Annual monitoring tools	NSD, relevant Government Ministries, UNFPA.	* Population, RH and gender are starting to be considered as a matter to be taken into account in the country for planning purposes within certain institutions of the state, the UN and bilateral agencies * Not existing	All government ministries and development partners take into account population, RH and gender date into their plans and programmes.		All government ministries and development partners	
		Communication from Government creating NPC, Minutes of NPC meetings, Annual reports	Prime Minister's Office, Ministry of Finance, UNFPA		A NPC is in place with support of Govt.		NPC is established and functioning	

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
		Copy of the draft report, Minutes of the consultation meetings, Government and parliament reports		Commission	Discussion on draft NPP is initiated		Draft National Population Policy developed and being discussed with partners	
Output 2								
Strengthened analytical capacity at national and sub national levels for utilizing data on population, reproductive health and gender in order to develop, implement and monitor policies and programmes	• Numbers of national experts sponsored for higher education in the area of population and development • National expertise in population and development issues increased	Project Progress reports, UNFPA monitoring tools	NSD and UNFPA	3	Two national staff trained in 2009		Two national staff trained Five training sessions on relevant material	
		Project reports, UNFPA monitoring tools, Certificate of attendance	NSD & relevant Government Ministries, UNFPA		Five trainings sessions on relevant material			
		Course curriculum, MOU, University report, UNFPA monitoring tools	National University of TLS, UNFPA	Initial consultations have been held	Consultations commenced with national universities regarding demography coursework		Curriculum developed and course start being offered at University	

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
Output 3								
Improved availability of disaggregated demographic and socio-economic data at national and sub national levels	• 2010 Population and Housing Census conducted, analyzed and disseminated	Progress reports, Census publications, dissemination workshop reports	NSD, relevant Government Ministries & UNFPA	Preparatory activities of census done in 2008	Mapping, census instruments developed, pilot census undertaken and results used to fine-tune census planning		Enumeration done in July 2010, data capturing started and preliminary results released	
	• 2009 Demographic and Health Survey conducted analyzed and disseminated	2009 DHS report, Minutes of Meetings	ORC MACRO NSD, relevant Government Ministries and bilateral partners	Initial preparatory activities initiated in 2008	The data collection and data capture phases finalized		Survey Report produced and results disseminated at national level	
	• Annual reports produced through the health management information system (HMIS) and Population Registration System.	HMIS annual reports	MoH & UNFPA	HMIS (2007)	HMIS annual report (2008) published and disseminated		HMIS annual report (2009) published and disseminated	

Gender Programme Component

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
CP Outcome 1								
Strengthened national capacity to promote gender equality and prevent gender-based violence through improved policies, protection systems, the enforcement of laws and the provision of reproductive health services	• Adoption and implementation of the domestic violence law	• Drafted DV Legislation at the level of Council of Ministers and UNFPA CPA Report	SEPI & UNFPA	• No Penal Code, No Domestic Violence legislation, Gender Equality Law,	Key legislation in place and implemented; socialization of the laws amongst the public. Regular public awareness campaigns,			
	• Network of services to support victims of gender-based violence Strengthened	• Reports from from the Ministry of Social Solidarity and the referral network • Annual programme review/reports	SEPI, Ministry of Social solidarity & UNFPA	• 5 Service Providers	1 provider per district minimum			
	• Public awareness on gender-based violence increased	• DHS • GBV surveys from UNIFEM and UNFPA	SEPI, Min. Social Solidarity & UNFPA	N/A	At least 50% percent of the population are aware of GBV issues and the existence of the DV law.			
	• Adoption of a national action plan on Security Council resolution 1325	• Annual project report	SEPI & UNFPA	3 Trainings on SCR 1325	Action plan developed and in implementation			

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
Output 1								
Contribute to implementing the national domestic violence law	• Translation of final amended version of the law in Portuguese and Tetum (indigenous language) is completed • Briefing kits on the law for council of ministers, national parliament and civil society completed in Portuguese and Tetum • Presentation of the domestic violence law to the council of ministers, parliament and promulgation by the President	• Actual DV law documents available • Project monitoring Reports	SEPI & UNFPA	• Translation to Tetum is ongoing. Briefing kits are to be prepared.	DV law enacted and implemented			
Output 2								

RESULTS	Indicator	MoV	Res. Party	YR1			YR2	
				Baseline	Target	Achievement	Target	Achievement
Increased access to emergency medical, shelter, counseling and legal services available for victims of domestic and gender-based violence in Dili and other districts	• Number of service providers • Number of referrals to service providers • Number of domestic violence cases reported to police • Referral protocols adopted and database recognized by the Government	• Service providers reports • Reports from the Vulnerable Persons Unit • Actual documents produced	SEPI & UNFPA	• 5 shelters in 3 districts • No Referral protocols available • No proper referral system and data	• Referral protocol in use • Systematized referral network reports on cases of DV • Database available			
Output 3								
Contribute to developing a national action plan on Security Council resolution 1325	• Consultation meetings with key ministries on formulating the national action plan on Security Council resolution 1325 completed • Design, translation and printing of the national action plan completed • Training on Security Council resolution 1325 for key stakeholders within the Government and civil society in Dili and district levels is completed	• Project report and monitoring tools • Actual documents available	SEPI & UNFPA	• Not applicable (NAP on SCR 1325 not prepared)	• Consultations meetings held • National action plan in produced and implemented • X number of key stakeholders on Gender and Key government officials trained			

Risks and Assumptions

State major risks and assumptions that could influence achievement of CP outputs and outcomes as indicated in the CP document. Assess whether risks materialized, whether original assumptions were correct and highlight factors which facilitated or constrained results achievement.

Risks	Assumptions
• Reduced government allocation to health sector. • Reduced resource mobilization to UN agencies. • Prolonged security and political instability. • Inadequate attention to health promotion, Behavior Change Communication and Primary Health Care • Limited capacity for improvement of Human Resource Development. • Lack of quality data for monitoring of indicators	• Continuing economic growth, especially in rural areas. • Improved security and political stability. • Political and bureaucratic will by the MOH to ensure functioning of the necessary organizational structures in support of service delivery. • Capacity building and training of health staff and managers implemented. • Continuity of resource availability (government and international donors)
• NSD will be overburdened by implementation of two major surveys within two years • Security concerns amidst political instability will hamper fieldwork • Natural disaster will hamper fieldwork (i.e., flooding)	• Resources will be mobilized to conduct the 2010 Census • Resources will be mobilized to conduct the 2009 DHS
• Uncertainty as to the time-frame for promulgation of draft laws e.g., Law Against Domestic Violence and the Penal Code and regulations relating to the referral network for victims of GBV. • Insufficient funds in place for socialization of laws • Lack of VPU/PNTL, MSS and local NGO logistical capacity to carry out regular monitoring visits and support efforts in the districts • Links to other sectors e.g., education and health for outreach (especially community-based programmes in the districts, to ensure information flow about reporting mechanisms, available services and outreach campaigns) to victims are weak • Advocacy takes many years to shift attitudes and beliefs about women and girls' status in society • Gender based violence cases not processed quickly enough through the formal justice system • Support required for capacity building is long term in a new nation where little to no structures are in place in rural areas for service deliveries • Changing political and security climate	• Evidence of political will and strong UN and civil society support for the promulgation of key missing legislation as soon as possible • Commitment of UN agencies to undertake continued, well-planned and strategic advocacy takes place with variety of stakeholders over extended periods • Commitment of UN agencies to a sustained systems-building approach with clear leadership adopted by Government • Training of more national staff on GBV in the justice sector and PNTL continues • SEPI will have sufficient capacity to fulfill its mandate • Security situation allows for regular travel to districts and capital.

Annex III: The CPAP Monitoring and Evaluation Calendar

Country: Timor-Leste

CP Cycle: Second (2009-2013)

		Year 1 (2009)	Year 2 (2010)	Year 3 (2011)	Year 4 (2012)	Year 5 (2013)
M&E activities[1]	Surveys/studies	• Demographic & Health Survey [NSD, MoH, UNFPA, UNICEF, WHO] • Baseline Survey for the National BCC Strategy [UNFPA, MoH, MoEd, NSD] • Review of National Reproductive Health Strategy [UNFPA, MoH] • Review of National FP Policy [UNFPA, MoH] • ICPD@15 Regional Survey [UNFPA APRO/CO, Government & IPs]	• Census of Population & Housing [NSD, UNFPA]			• End-line survey [UNFPA, NSD, MoH, SEPI]

		Year 1 (2009)	Year 2 (2010)	Year 3 (2011)	Year 4 (2012)	Year 5 (2013)
M&E activities[1]	Monitoring systems	• Timor-Leste DevInfo [NSD, UNICEF, UNCT] • Health Management Information System [MoH, WHO, NSD, UNFPA, UNICEF] • Logistic Management Information System [UNFPA, MoH] • Education MIS [MoEd, World Bank, UNICEF, UNESCO] • UNFPA CP Database [UNFPA, Government & IPs] • UNFPA CP monitoring tools* [UNFPA, Government & IPs] • UNDAF monitoring tools** [UNCT, Government]	• Timor-Leste DevInfo [NSD, UNICEF, UNCT] • Health Management Information System [MoH, WHO, NSD, UNFPA, UNICEF] • Logistic Management Information System [UNFPA, MoH] • Education MIS[MoEd, World Bank, UNICEF, UNESCO] • UNFPA CP Database [UNFPA, Government & IPs] • UNFPA CP monitoring tools [UNFPA, Government & IPs] • UNDAF monitoring tools [UNCT, Government]	• Timor-Leste DevInfo [NSD, UNICEF, UNCT] • Health Management Information System [MoH, WHO, NSD, UNFPA, UNICEF] • Logistic Management Information System [UNFPA, MoH] • Education MIS [MoEd, World Bank, UNICEF, UNESCO] • UNFPA CP Database [UNFPA, Government & IPs] • UNFPA CP monitoring tools [UNFPA, Government & IPs] • UNDAF monitoring tools [UNCT, Government]	• Timor-Leste DevInfo [NSD, UNICEF, UNCT] • Health Management Information System [MoH, WHO, NSD, UNFPA, UNICEF] • Logistic Management Information System [UNFPA, MoH] • Education MIS [MoEd, World Bank, UNICEF, UNESCO] • UNFPA CP Database [UNFPA, Government & IPs] • UNFPA CP monitoring tools [UNFPA, Government & IPs] • UNDAF monitoring tools [UNCT, Government]	• Timor-Leste DevInfo [NSD, UNICEF, UNCT] • Health Management Information System [MoH, WHO, NSD, UNFPA, UNICEF] • Logistic Management Information System [UNFPA, MoH] • Education MIS [MoEd, World Bank, UNICEF, UNESCO] • UNFPA CP Database [UNFPA, Government & IPs] • UNFPA CP monitoring tools [UNFPA, Government & IPs] • UNDAF monitoring tools [UNCT, Government]

		Year 1 (2009)	Year 2 (2010)	Year 3 (2011)	Year 4 (2012)	Year 5 (2013)
M&E activities[1]	Evaluations			• Midterm CP evaluation [UNFPA APRO/CO, Government & IPs] • Joint Programs Evaluation (Human Security Trust Fund, MDG Spanish Fund) [UNFPA,UNDP, UNICEF, UNIFEM, ILO, Government & IPs]	• Final CP evaluation [UNFPA APRO/CO, Government & IPs]	
	Reviews	• Midyear CP Review [UNFPA, Government & IPs] • Annual CP Review [UNFPA, Government & IPs]	• Midyear CP Review [UNFPA, Government & IPs] • Annual CP Review [UNFPA, Government & IPs]	• Midyear CP Review [UNFPA, Government & IPs] • Annual CP Review [UNFPA, Government & IPs]	• Midyear CP Review [UNFPA, Government & IPs] • Annual CP Review [UNFPA, Government & IPs]	• Midyear CP Review [UNFPA, Government & IPs] • Annual CP Review [UNFPA, Government & IPs]
	Support activities	• Technical & programmatic backstopping visits by Regional Advisers, Programme Specialists, external consultants, national counterparts and other technical/programme staff • Field monitoring visits by CO staff • CO Audit***	• Technical & programmatic backstopping visits by Regional Advisers, Programme Specialists, external consultants, national counterparts and other technical/programme staff • Field monitoring visits by CO staff • CO Audit	• Technical & programmatic backstopping visits by Regional Advisers, Programme Specialists, external consultants, national counterparts and other technical/programme staff • Field monitoring visits by CO staff • CO Audit	• Technical & programmatic backstopping visits by Regional Advisers, Programme Specialists, external consultants, national counterparts and other technical/programme staff • Field monitoring visits by CO staff • CO Audit	• Technical & programmatic backstopping visits by Regional Advisers, Programme Specialists, external consultants, national counterparts and other technical/programme staff • Field monitoring visits by CO staff • CO Audit

		Year 1 (2009)	Year 2 (2010)	Year 3 (2011)	Year 4 (2012)	Year 5 (2013)
Planning references[2]	**UNDAF final evaluation milestones**	• UNDAF Annual Review [UNCT, Government]	• UNDAF Annual Review [UNCT, Government]	• UNDAF Annual Review [UNCT, Government]	• UNDAF Annual Review [UNCT, Government] • Midterm Review of Capacity Development Impact [UNCT, Government]	• UNDAF Evaluation (Development Results/ Impact) [UNCT, Government]
	M&E capacity- building	• M&E manual for CP [UNFPA M&E team] • M&E training for programme managers at all levels [UNFPA M&E team, Government & IPs]	• M&E manual for CP [UNFPA M&E team] • Refresher M&E training [UNFPA M&E team, Government & IPs]	• M&E manual for CP [UNFPA M&E team] • Refresher M&E training [UNFPA M&E team, Government & IPs]	• M&E manual for CP [UNFPA M&E team] • Refresher M&E training [UNFPA M&E team, Government & IPs]	• M&E manual for CP [UNFPA M&E team] • Refresher M&E training [UNFPA M&E team, Government & IPs]
	Use of information	• Relevant national or international conferences • ICPD@15/MDG Reporting • Preparation of AWPs	• Relevant national or international conferences • ICPD@15/MDG Reporting • Preparation of AWPs	• Relevant national or international conferences • MDG/ICPD reporting • Preparation of AWPs	• Relevant national or international conferences • MDG/ICPD reporting • Preparation of AWPs • Preparation of the CPA • Preparation of the CCA/UNDAF	• Relevant national or international conferences • MDG/ICPD reporting • Preparation of AWPs • Preparation of the UNFPA CP/CPAP
	Partner activities				• Multiple Indicator Cluster Survey (MICS) [MoH, UNICEF, NSD]	

[1] For each activity listed, it is suggested that the following data be included in the calendar: short name of M&E activity; focus vis-à-vis UNDAF/CP outcomes; agencies/partners responsible; timing.

[2] This section of the calendar includes a range of activities, events or milestones that UNFPA considers significant for its monitoring and evaluation activities.

*UNFPA CP monitoring tools:

- Field Monitoring Visit Checklists & Reports
- AWP Monitoring Tool (AWPMT)
- CPAP Planning & Tracking Tool
- CPAP M&E Calendar
- CPAP Results & Resources Framework (RRF)
- Standard Progress Report (SPR)
- Country Office Annual Report (COAR)

**UNDAF monitoring tools:

- UNDAF Results Matrix
- UNDAF M&E Framework
- RC report

***Frequency and timing of CO Audit (if any) to be negotiated with HQ/APRO