Partnership for Human Development Timor-Leste Health Program Review

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Strategic input on health to the Australian Government

Specialist Health Service

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Executive Summary

Introduction

The focus of this Review is the Partnership for Human Development (PHD) Health Program which is managed by the PHD Facility contracted by DFAT to Abt Global (previously known as Abt Associates). This is an AUD 70.5 million investment over two Phases (2016 – 2026). The Review aims to assess whether the program is 'on the right track' to make progress towards its outcomes and focuses primarily on the second Phase of implementation. Findings, analysis and recommendations will inform implementation during the final 18 months of the program, the End of Facility evaluation in 2026 and the design of Australia's next health partnership to take place in early 2025.

PHD Health supports the Government of Timor-Leste to deliver higher quality and inclusive primary health care with a focus on the essential service package. Phase 2 was designed to gradually move away from service delivery (with the exception of sexual and reproductive health and mental health) and improving clinical expertise towards a more holistic health systems strengthening approach focused on three Municipal and Regional Health Services, facilities and at national level. The focus of support is on maternal and child health, family planning / sexual and reproductive health, mental health, nutrition and some gender and disability issues including gender-based violence.

The program is complex with its new systems strengthening focus being blended with service delivery, health sector supports, and ongoing institutionalisation of legacy investments inherited from DFAT at the start of the program. As per the Phase 2 design and the DFAT PHD Guiding Strategy, the program takes a system strengthening approach to delivering services. It works in a careful and planned way to build MoH capacity to enable the transition of its direct service delivery programs to GoTL.

There are six Implementing Partners and enhanced in-house technical capacity. This complexity, the overall level of ambition and delays in the approval of the Phase 2 design has proved to be a challenge, including for a clear Theory of Change and effective monitoring, evaluation and learning (MEL).

In addition, the swearing-in of the Ninth Constitutional Government on 1 July 2023 led to a widespread restructuring within the Government, including sector ministries. The very high level of staff replacement at all levels in the health system has undermined government ownership and disrupted program governance arrangements, while limiting the ability of the program to gain momentum, due to the replacement of previously trained health staff.

Findings

MEL has been amongst the most significant challenges PHD Health has faced. The Theory of Change is complex with 39 Immediate Outcomes, and the outcomes that the Implementing Partners are reporting are not consistent. Gender, disability and nutrition are cross cutting, meaning they have separate Monitoring, Evaluation and Learning Frameworks (MELFs). The PHD Health and cross cutting MELFs have a total of 77 indicators. Telling a coherent story against outcomes with this level of complexity has been difficult. There is an opportunity to enhance reporting, including in relation to qualitative performance indicators.

Encouraging progress has been made in streamlining and improving the MEL system. A milestone-based approach aims to clarify what PHD Health is aiming to achieve, how success is linked to outcomes and how the program is tracking progress. Although the number of milestones has been reduced, they remain over ambitious and need further review and streamlining. The focus for the remaining period of PHD Health needs to be on consolidation and being clear and realistic on what

success means by 2026. This includes more definition around what the Phased facility approach is aiming to achieve.

The Review supports the overall strategic approach of Phase 2. However, health system strengthening is a long-term endeavour, especially in contexts where fragility remains a challenge. Sustainable change is only possible when support is calibrated to the pace of change that can be absorbed by government. Given that the implementation of Phase 2 is still in its early stages, it is premature to expect the program to have made significant progress in addressing system bottlenecks. Progress hasn't been made at the pace envisaged in the design and the 2023 Strategic Plan. However, there is ample evidence and plenty of examples that the program is moving towards its three Intermediate Outcomes and contributing to resolving health system bottlenecks. Phased Community Health Centres Comoro, Gleno, Passabe and Atsabe have all increased their scores in facility readiness to deliver the ESP-PHC over the 2022 baseline assessment. A substantial amount of foundational work is being established for the Ministry of Health (MoH) to build upon in the future. PHD Health's contributions are widely recognised and the program is regarded as a reliable and trusted partner.

PHD Health has made significant headway in supporting MoH and MoF to identify and address bottlenecks related to **financial management and planning**. Various training sessions facilitated by PHD, Ministry of Finance and MoH delivered to Ermera, Dili and REAOA have led to improvements in implementation of the quarterly budgets and the linking of budgeting and planning. Management, planning, and budgeting challenges are amongst the most significant impediments to the delivery of primary health care. The lack of accurate budgeting and accounting practices, poor financial management skills and integrated evidence-based planning are deep seated root causes of many systemic issues. PHD Health has demonstrated that gains can be made by improving knowledge and skills at local levels and building the confidence of municipal actors to better use the system and advocate for more funding. This provides a strong basis to build on.

A key achievement was PHD Health's effective support for the development of the MoH Partnership Manual in 2022 to guide coordination of health sector stakeholders. PHD Health has supported the MoH to roll out the Coordination Committees in the three municipalities and the Phased Community Health Centres as **quarterly review and coordination meetings**. Those interviewed reported how these meetings support the review of health performance data and progress against plans, identification of problems and solutions impacting on service delivery, priority setting, and coordination with partners. The review meetings identify training needs and as such have provided an entry point for the PHD team to support the Maternal and Child Health District Public Health Officers and Gender Based Violence focal points to prioritise trainings.

Community Health Centres spoke of the significant advantages of being able to engage community leaders in data analysis and decision making which raised awareness of maternal and child health issues. As such, PHD support has started to see improved health governance and accountability for facility readiness at the local levels.

PHD Health's Roving Team is using the **nutrition database** as an entry point to build skills in health information management at the municipal and facility levels, including quality data entry, data analysis, reporting and use of data and monitoring and evaluation (M&E) skills. The Review found as reported in PHD Health's 2023/24 Annual report that 'the database is improving the accuracy of registration and data collection, reducing data duplication, and enabling more effective monitoring and treatment of children with malnutrition' in certain facilities. Community Health Centre Becora is using the database to understand and track the levels of malnutrition in the community having registered 6200 children under 5 years since its introduction in 2023. The number of children attending follow up visits has increased from 1000 to 2800.

A number of activities are at a foundational stage where it's too early to assess impact on health system functioning and service delivery. These include the Family Medicine Post Graduate Diploma. By placing family medicine doctors in rural areas, the diploma is a critical input for the realisation of the model of care in the essential services package. Bringing services closer to communities should both impact positively on health outcomes and lead to a reduction of more costly referrals to higher levels of the system. Maluk Timor's support to the Timor Leste National Public Health Institute for Continuous Professional Development training, alongside their support to institutional development, is foundational. The critical role of both clinical and non-clinical training was consistently raised in consultations, especially the importance of leadership and management training. In addition, the work of the M&E Adviser in support of the national level Policy, Planning and Monitoring & Evaluation Department is providing a strong basis to build on but it's early days. This has the potential to support change both in health information and governance at all levels of the health system through strengthening the MoH's M&E systems and processes and supporting the use of data for performance improvement, budgeting and planning.

A key strength of PHD Health is its commitment to locally led development including through working with local actors, supporting local priorities and consistently using government systems and tools. The national team, many of whom formerly held senior government positions, is highly connected, understands the context and has lived experience of the health system. The approach to embed advisers in government offices has proved to be effective with the day-to-day awareness of the need to focus on building capacity rather than undertaking work that is the responsibility of government. The benefits of a Director who has been in the position since the first Phase are evident, including the deep knowledge of the program and strong connections. At the same time the program doesn't assume that local leadership excludes a role for non-local actors.

PHD Health is notable for embedding a commitment to 'inclusive' primary health care at the highest level of the program, and to explicitly being concerned with 'women, girls, people with disabilities and the poor' as an end of program outcome. Commendably, PHD Health's approach to gender equality and disability inclusion has evolved over the course of Phase 2, in its thematic and policy focus, as well as its resourcing, partnerships and outputs – with a strong team in place at this stage. This reflects the team's responsiveness to Government and MoH priorities, and to the PHD Mid Term Review findings. It is notable that the program has approached gender and disability efforts as distinctive tracks, rather than taking a composite 'GEDSI' lens. This is well rationalised and has enabled the program to generate valuable resources and contributions. However, the gender and disability work is undermined by two elements: the lack of a 'clear line of sight' or consistency in activities and measures from the Gender Equality and Disability Equity Strategies through to the MEL and annual workplans; and also from the lack of a foundational mapping or analysis of gender and disability entry points against the health system strengthening building blocks. This detracts from the cohesiveness of the gender and disability choices and efforts.

In discussions, PHD Health highlighted a priority for the municipal team to develop a more coordinated and structured approach to working between the Municipal Coordinators, the Roving Teams and the Implementing Partners. Despite challenges gaining traction, PHD Heath is encouraged to continue to pursue opportunities to strengthen their partnership working with Implementing Partners.

Recommendations

Setting Priorities

1. Within the context and the political economy dynamic, DFAT and PHD Health to work together to establish clearer parameters and boundaries around being responsive, including

being clearer on difference between being flexible versus being reactive and what that means practically for the program.

Ways of Working

2. Political Economy and the PIMA Improvement Cycle: PHD Health to conduct formal PEA orientation and applied training for all the program team supported by ongoing advice/mentoring from PHD and Abt. This was planned for in the PHD Health 2023 Strategic Plan but never eventuated. This should reflect the changes in the political economy, ensure the team are provided with methods and techniques to assist them think and work politically in their everyday work and enable a more structured approach to operationalising and integrating PMIA and PEA throughout implementation.
3. Balance of Time Between National and Municipal Levels: PHD's Health Municipal team to maximise time spent in municipalities whilst ensuring all efforts are utilised effectively and strategically. This will enhance opportunities to provide technical support to the MHS, facilities and to the Municipal Coordinators and maximise progress towards outcomes.
4. Working through Implementing Partners: PHD Health to review its ways of working and identify opportunities to foster stronger partnerships with the Implementing Partners and consider how it can better facilitate their relationships with MoH at national and municipal level as appropriate.
5. Maluk Timor and INSP-TL: PHD Health, DFAT and Maluk Timor to have an open and honest discussion to identify the root causes of the lack of progress, discuss the prevailing political economy and work as partners to strategically consider innovative solutions and entry points to 'nudge' forward.

Collaboration with Development Partners and DFAT's Other Bilateral Investment

6. DFAT and PHD Health to strengthen formal links with PARTISIPA, PROSIVU and Nabilan to share knowledge, build on each other's strengths and forge closer connections with a view to driving efficiency, aligning efforts and identifying opportunities for synergy.

Monitoring, Evaluation and Learning

7. PHD Health to be supported to continue to progress with plans to report progress against outcomes and milestones using both qualitative and quantitative indicators linked to the MELF and continue to simplify tools and ensure that clear documentation is available for the 2026 evaluation.
8. PHD MEL and Abt to provide MEL support to the PHD Health team and Implementing Partners as needed to support plans to further strengthen MEL. This will include ensuring that the team has a base level of understanding, including MELs role, and skills in data collection, analysis and use.
9. PHD MEL and PHD Health (supported by Abt) to reconsider the indicators at EOPO level across the health-related MELFs with a view to selecting a few of the existing indicators as key proxy indicators. Capturing a range of data for context monitoring can be done outside of the MELF.

Suitability of Strategic Approaches and Activities

10. Strategic Intent: PHD Health to undertake an evaluative study to consider the lessons and effectiveness of supported interventions to overcome demand side barriers to inform the new design.
11. Phased Facilities: PHD Health to more clearly articulate the strategic objectives of the Phased facilities, including what success will look like and a systematic approach to tracking progress. Work with MHS and the Phased facilities to capture what's working, lessons learned and constraints against the strategic intention. This will support replication and serve as an input to the evaluation.
12. Milestones: PHD Health to focus on consolidation rather than expansion. This will include reinforcing progress to date against outcomes including the foundational health system strengthening work for the new health design to build on.
13. Milestones: PHD Health, supported by PHD MEL and Abt Global, to review the 2024 / 2025 workplan through whole team strategic discussion to simplify and prioritise the milestones, review their level of ambition given the current context and be clear and realistic on what success means for the program by 2026. Focus on what can reasonably be expected to be absorbed by the MoH, ensure that activities are aligned to the revised milestones and there is a balance of focus between national, municipal and facility levels.

Additional Recommendations to Inform the 2026 Evaluation

14. The evaluation team to be provided with a comprehensive overview of the program (Phase 1 and Phase 2), including team and implementing partner roles and responsibilities, receive one package of priority documentation, and adequate time is allowed for consultation given program complexity.
15. PHD Health to work alongside the MoH in 2025 as planned to track and document progress against the 2022 baseline assessment and actions from the participatory diagnostic workshops. This will include a full FRA across the three municipalities in conjunction with MoH quarterly supervision visits. It will be an essential input for the 2026 PHD Evaluation to assess progress against the 2022 assessment.

GEDSI

1. Gender and disability: Review of the Management and Leadership Modules: There is a window of opportunity now to offer gender and disability review of the Management and Leadership Modules being led by Maluk Timor with INSP-TL. Offering to provide specialist gender and disability input or review would be timely.
2. Refine workplan for 2025: In collaboration with the Abt Global Senior Gender Specialist (and ideally coinciding with an in-country visit), discuss the recommendations of her review paper and agree on the activities that have the most promise of positive GEDSI outcomes by the end of the program.
3. Convene partner meetings: Nabilan is keen to discuss with PHD Health's the MoH's position on PRADET and consider joint talking points on the risks of the parallel DHS and VAW prevalence studies in 2025. Also convene a workshop of all PHD Health implementing partners to distil the collective experience of gender and disability entry points across the HSS building blocks, and MoH's receptivity.

4. Priority to visit CHC safe spaces: Visit the CHCs which have introduced a 'safe space' for survivors of GBV to confirm whether and how they have implemented the facility guidance, and to understand why clients are not presenting or being referred
5. Inclusive health and NAP GBV indicators: If the MoH remains receptive, after the significant turnover in personnel, it is recommended that PHD Health concentrate on supporting the MoH's implementation of the 15 inclusive health indicators and the NAP GBV that have been endorsed for the PHC M&E Framework.

Recommendations for the new Health Design

1. To support government-led strengthening of the health systems needed for the delivery of quality and inclusive decentralised primary health services.
2. To continue to work at all levels of the health system recognising that many of the health system constraints identified at municipal and facility levels need national level solutions.
3. To adopt a clear strategic approach, with a realistic level of ambition, for expanding to other municipalities, responsiveness and sustainability.
4. Build on previous successes and past investment including the foundational work under Phase 2 of PHD Health.
5. To consider with the MoH whether the leadership and management (ISDP) training needs to extend to the national level.
6. To be informed by a landscape analysis of other development partners health investments and identify possibilities for connection and joint working with DFAT's other bilateral programs.
7. To integrate climate change and consider including climate and health focused interventions.
8. To consider enhanced focus on politically and contextually informed problem-solving approaches to unblock service delivery constraints.
9. To include separate gender and disability expertise in the design team.
10. To revisit the gender and disability strategy recommendations.
11. To explore the potential for addressing demand side factors.
12. To analyse political economy and government relations in relation to GEDSI with MoH and MSSI.
13. To scope the potential for addressing GEDSI-related demand, norms and leadership aspects.
14. To develop a ToC and MELF that integrates gender and disability, replacing the stand alone ToCs and MELFs.

Contents

Acronyms

Acronym	Description
ADTL	*Asosiasaun Defisiénsia Timor-Leste*
AWP	Annual Work Plan
BEmONC	Basic Emergency Obstetric and Newborn Care
CPD	Continuous Professional Development
CHC	Community Health Centre
DISTanCE	Digitizing in-service Training for non-clinical and Clinical Excellence
DG	Director General
DHS	Demographic and Health Survey
DPHO	District Public Health Officer
EMONC	Emergency obstetric and neonatal care
EOPO	End-of-Program-Outcome
ESP-PHC	Essential Services Package – Primary Health Care
FMP	Family Medicine Program
FP	Family Planning
FRA	Facility Readiness Assessment
FY	Financial Year
GEDSI	Gender equality, disability and social inclusion
GBV	Gender based violence
GoTL	Government of Timor-Leste
HR	Human Resources
HSS	Health Systems Strengthening
INPFM	National Institute of Pharmacy and Medical Products
INSPTL	National Institute of Public Health – Timor-Leste
IPHC	Integrated Primary Health Care Program
ISDP	Integrated Suite of Professional Development Program
KPI	Key Performance Indicator
LTA	Long Term Adviser
MCH	Maternal and Child Health
MEL	Monitoring, Evaluation and Learning
MELF	Monitoring, Evaluation and Learning Framework
MoU	Memorandum of Understanding
MoH	Ministry of Health
MoF	Ministry of Finance
MoSA	Ministry of State Administration
MHMT	Municipal Health Management Team
MHS	Municipal Health Service
MNHC	Maternal and Newborn Health Care

Acronym	Description
MSITL	Marie Stopes International Timor-Leste
MTR	Mid-Term Review
NAP-GBV	National Action Plan on Gender-Based Violence
NHSSP	National Health Sector Strategic Plan II (NHSSP II) 2020-2030
OD	Organisational Development
OPD	Organisation of People with Disability
PHC	Primary Health Care
PHD	Partnership for Human Development
PEA	Political Economy Analysis
PFM	Public Financial Management
PGD-FM	Postgraduate Diploma – Family Medicine
PIMA	Plan/Implement/ Monitor/Adapt improvement cycle
PMT	Program Management Team
RAEOA	Special Administrative Region of Oe-cusse Ambeno
RHTO	*Ra'es Hadomi Timor Oan*
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SC	Steering Committee
STA	Short Term Adviser
SRH	Sexual and Reproductive Health
TLHIS	Timor-Leste Health Information System
TA	Technical Assistance
ToC	Theory of Change
ToR	Terms of Reference
UHC	Universal Health Coverage
VAW	Violence Against Women

1. Background

1.1. Introduction

The Government of Australia has commissioned, through the Specialist Health Service, a review of Australia's program of bilateral support to the Timor-Leste health sector. The Partnership for Human Development Health Program (PHD Health) is managed by the Partnership for Human Development Facility (PHD) contracted by DFAT to Abt Global (previously known as Abt Associates). PHD Health has been in operation since 2016 across two Phases. This Review focuses on the second Phase which shifted focus to a more health systems strengthening approach. The purpose of this Review is to identify lessons and determine whether the program is 'on the right track' to make progress towards the Intermediate Outcomes. Findings, analysis and recommendations will inform implementation during the final 18 months of the PHD Health Program, the final independent evaluation in 2026 and the design of Australia's next health partnership with Timor-Leste to take place in early 2025.

Health system strengthening (HSS), including the building of capability at individual and organisational levels, is a long-term endeavour, especially in contexts where fragility remains a challenge. Given that the implementation of Phase 2 is still in its early stages, it is premature to expect the program to have made significant progress in addressing system bottlenecks. However, there is evidence that PHD has contributed to resolving system bottlenecks and improving functioning of the health system or is in the process of doing so. A substantial amount of foundational work is also being established for the Ministry of Health (MoH) to build upon in the future, which the Review sought to identify for the new design.

1.2. Health Context

On the back of the strengthening Timorese health system, health outcomes have improved significantly over the past 20 years. Maternal and newborn health has improved since independence in 2002. The maternal mortality ratio has declined from 668 per 100,000 live births in 2002 to 195 per 100,000 live births in 2016. Facility births have more than doubled since 2009-10[1]. The infant mortality rate has halved since 2002. The under-five mortality rate has also declined from 97 per 1,000 live births in 2002 to 44 per 1,000 births in 2019. One of the big successes in the history of the country is the massive reduction of malaria incidence.

However, challenges remain and much remains to be done to reduce the continuing high rates of maternal and newborn mortality. Only 49 per cent of children aged 12-23 months had received all basic vaccinations[2]. The nutritional status of both children and adults remains significantly below acceptable world standards. Forty-seven per cent of children under five years are stunted[3].

A key message from the World Bank's Timor-Leste Human Capital Review 2023 is that there is no direct need for higher public expenditure on human capital, but for better public expenditure. The trend in government budget allocation to the health sector as part of the General State Budget shows a steady emphasis on health, with an increase to 6.2 per cent[4] for the 2025 budget over the 3.4 per cent[5] allocated for 2024.

[1] National Health Sector Strategic Plan II (NHSSP II) 2020-2030
[2] Investment Design Document, PHD Health Program Phase 2
[3] National Health Sector Strategic Plan II (NHSSP II) 2020-2030
[4] See: https://www.laohamutuk.org/econ/OGE25/graphics/2410OJE2025sectorEn.png
[5] See: https://www.laohamutuk.org/econ/OGE24/graphics/231211OJE2024sectorPrelimEn.png

Recent years have seen more Community Health Centres (CHCs) and Health Posts being built, health care infrastructure improved and availability of equipment enhanced, but much more needs to be done. Many health facilities still lack basic amenities and are unevenly distributed across the country, contributing to underutilisation. Increased investments in health supports are held back by health system issues. Sustainable Primary Health Care (PHC) service delivery requires attention to the wider health system, since all elements of the health system (stewardship, management including financial, health workforce, health information and medical supplies) affect health services.

Despite significant increases in recent years, the number of health workers is still relatively low and unequally distributed. Efficiency gains can be captured by improving the quality and distribution of health workers and increasing patient utilisation of PHC[6]. Rural and poor households receive poorer quality care. Increasing the use of primary care has the potential to drastically improve population health outcomes and increase the efficiency of health spending.

1.3. Overview of PHD Timor-Leste Health Program

Through PHD, Australia supports the Government of Timor-Leste (GoTL) to deliver higher quality and inclusive services in PHC, basic education, and social protection. The total planned value of PHD Health is AUD 70.5 million over 10 years (2016 to 2026). Actual expenditure as of 30 June 2024 was AUD 56.7 million. Phase 1 (2016 to 2021) was focused on parallel service delivery and substitution. The modality of delivery was primarily through subcontracts with partner organisations.

The focus of the Phase 1 grants included aspects of: Infrastructure (Health Transport); Health Workforce (Sexual and Reproductive Health / SRH, Learning Labs and ATLASS II); and Service Delivery (SRH and Liga Inan). There was a strong focus on improving clinical expertise for RMNCH (Reproductive, Maternal, Neonatal and Child Health). In addition, some Technical Assistance (TA) was provided to the MoH to strengthen the health monitoring and evaluation system and improve public financial management (PFM) competences of finance managers[7]. See Annex 3 for more details.

Following a 2019 Investment Concept Note, the joint MoH and DFAT design of Phase 2 was initiated in 2020 and received its final approvals from both governments by January 2022. Up until 2023 when the PHD Health Strategic Plan was finalised the focus was on establishing the foundations for the new HSS program approach, including the selection of municipalities. This delay in finalising the design was due in part by the need to prioritise supporting the GoTL with the response to the COVID-19 pandemic. This served to further cement trusted relationships with the MoH which reinforced the foundations for Phase 2. See Annex 2 for a PHD Health timeline.

The Governments of Timor-Leste and Australia jointly decided during the design process that the program would shift to a more health systems strengthening approach focusing intensively on systems that facilitate implementation of Essential Service Package for Primary Health Care (ESP-PHC). Efforts would be focused at national, municipality and facility levels. Three Municipal and Regional Health Services were selected and approved by MoH on 21 February 2022. These are Dili and Ermera Municipalities and the Special Administrative Region of Oe-cusse Ambeno (RAEOA). Simultaneously, Phase 2 was designed to strengthen key systems at a national level. Four ‘Phased’ facilities receive enhanced support across the three municipalities. These are the CHC Gleno and Atsabe in Emera, CHC Comoro in Dili and CHC Passabe in RAEOA.

Work includes working side by side with relevant directorates and autonomous agencies at the MoH to strengthen PFM, monitoring and evaluation (M&E) and the use of health information, medical supply chain management and human resource training at all levels of the health system. At

[6] Timor-Leste Human Capital Review, World Bank, 2023
[7] Australia Timor-Leste Health Review, 2017

municipality and Phased facility level there is also a focus on governance and coordination, leadership / management training and community engagement. Phase 2 reflects the ongoing decentralisation process which is gradually shifting authority and responsibility for delivery of PHC to Municipal and Regional Health Services.

Within this overall PHC approach, Phase 2 was designed to improve outcomes in Gender equality and disability and social inclusion (GEDSI), nutrition, maternal and child health, family planning (FP) / SRH and mental health. In implementation, gender, disability and nutrition have been approached as facility wide issues cross cutting across the sector programs including health. As such, they are resourced separately and have their own workplans and Monitoring, Evaluation and Learning Framework (MELF).

Phase 2's End of Program Outcome (EOPO) is 'Government of Timor-Leste delivers quality and inclusive primary health care". The Program Logic includes three Intermediate Outcomes to support achievement of the EOPO. These are:

1. National government policies, systems and decisions enable higher quality and inclusive delivery of PHC
2. Municipal health services facilitate improved delivery of the ESP
3. Health facilities have the leadership, resources and workforce to deliver higher quality and inclusive PHC services to the catchment population

This shift to a HSS focus was reconfirmed through the recommendations made by the 2022 PHD Mid Term Review (MTR). It also responds to the findings of the 2017 Australia Timor-Leste Health Review. The 2017 Review found that Phase 1 gave a disproportionate focus on health workforce to improve RMNCH clinical skills and competencies, despite the risk that these may not be effective or even lost due to a lack of health facility readiness. It noted that all elements of the health system (including stewardship, management, infrastructure, health workforce and service delivery) have the potential to undermine service delivery. The Review recommended an improvement in the balance of investments to:

- Reduce direct provision of services and do more to support GoTL to deliver
- Give more emphasis to overall health facility readiness for RMNCH services
- Do more to promote and support systemic/institutional reforms and to help the health system adapt to decentralisation.

Similar to Phase 1, Phase 2 provides grants to Implementing Partners, but the emphasis has shifted to working through grantees to strengthen the health system. In addition, PHD Health has more in house technical capacity to provide enhanced technical support directly to the MoH at all levels. This includes team members embedded in the MoH at national level and, to a more limited extent, municipal levels. Simultaneously PHD Health continues to focus on the transition of Phase 1 investments to GoTL ownership (notably Liga Inan and health transport). There is no direct budget support provided to the MoH under PHD Health.

In line with the DFAT PHD Guiding Strategy, there is also some direct service delivery through MSITL (Marie Stopes International Timor-Leste). During the Phase 2 design process the MoH requested DFAT to continue funding the provision and uptake of FP services. However, at the same time, MSITL is working to support MoH facilities to deliver FP and SRH services themselves. The grant to MSITL is around 50 per cent of the PHD Health expenditure in the 2023/24 financial year (FY) and as such, represents a significant part of the health budget administered through PHD.

A full list of Phase 2 Implementing Partners and their activities can be found in Annex 3. In summary:

- **AUD 2.76 million (2021-2024) to UNFPA** across four contracts covering access to quality Maternal and Newborn Health Care (MNHC) during the Covid-19 pandemic in regional and

referral hospitals, strengthening the health system to deliver integrated MNHC in selected CHCs, scaling up Electronic Logistic Information Management System and support for the implementation of mSupply.

- **AUD 10.74 million (2021- 2026) to MSITL** to support government-ownership of quality, Equitable Sexual and Reproductive Health Services in Timor-Leste (SUPPORT) program.
- **AUD 1.03 million (2021-2024) to Catalpa International** for 'Liga Inan', which uses mobile phones to facilitate communication between health workers and mothers.
- **AUD 4.37 million (2022 -2026) to Maluk Timor** across three contracts covering support to mSupply, healthcare facility improvements, strengthening vaccine services and digitizing in-service training for non-clinical and clinical excellence (DISTanCE). DISTANCE includes the support for clinical and non-clinical training, Timor-Leste National Public Health Institute's (INSPTL) capability including the Training Management Information System.
- **AUD 1.77 million (2018-2025) to PRADET** for support to mental health services including training of health care workers and provision of psychosocial support.
- **AUD 2.2 million (2022-2025) to UNICEF** to support implementation of DFAT's Vaccine Access and Health Security initiative, including strengthening cold chain and supply chain management capacity at all levels.

2. Approach and Methodology

2.1. Data Collection and Analysis

For the desk review, documents were sourced primarily through SHS and DFAT Post. The Review identified additional documents during the work which were sourced from Development Partners, DFAT Canberra and PHD. Documents reviewed are listed in Annex 8. The desk review helped map the policy environment and PHD activities in health, although this was challenged by the complexity of the program.

The Review Team conducted wide ranging key informant interviews and group discussions with over 90 individuals. The Review team undertook a two-day field visit to RAEOA. A full consultation list by category is in Annex 8. Semi-structured interview guides were used for the key informant interviews.

Evidence from the interviews and document review, and the Review Team's observations and interpretation, was captured in an 'evidence matrix' mapping evidence, findings and recommendations against the questions in the Review plan. This was used as a framework to guide analysis and synthesis of evidence to support identification of emerging themes. The national consultant on the team played an important role in helping to interpret data through their in-depth knowledge of the health system and political economy. At the end of the in-country mission, a wrap up session was held with DFAT Post to discuss initial findings of the Review.

2.2. Limitations

- The Review was initially intended to be a high-level assessment but evolved into being more comprehensive than envisaged due to the program's complexity. It proved challenging to gain a clear picture of the activities, requiring significant time to develop an overview due to numerous moving parts and multiple stakeholders involved. The Review was not adequately resourced for this, both input and the time available for consultations being limited.
- Lack of availability of senior government officials at national level was a limitation on the information available to the Review Team. This meant it wasn't possible to have all the consultations required, nor triangulate all information to strengthen reliability. Only one Director General (DG) was available for interview. The team was not able to meet with

critical stakeholders including the DG for Primary Healthcare, the DG for Corporate Services nor the National Director of MCH.

- In some cases, it was challenging to have enough time to consult facility staff due to competing clinical priorities.
- The transition to the new government means that key personnel have been replaced. The Review Team was able to meet with some former senior officials who have knowledge and experience of PHD Health. The Former DG for Health Services Delivery was unavailable.
- At the time of the Review, PHD Health's MELF was not approved nor fully reported against. In the past, progress reporting has tended to be activity based. As such the Review was not in a position to consider progress against the MELF and outcomes. The Review was also not tasked with verifying the accuracy of quantitative and qualitative program-related data.

3. Findings

3.1. How Phase 2 Priorities are Determined

There was a comprehensive health sector situational analysis, including of the policies, strategies, achievements, gaps and development opportunities of the sector, completed in November 2019. This informed the Investment Concept Note for the next Phase of DFAT's support. Phase 2 was then designed so that all activities were aligned and supportive of the GoTL and MoH health policies, priorities and plans.

PHD's Implementing Partners are delivering against approved proposals or scope of services with agreed outcomes / outputs and workplans. Priorities are determined differently for the PHD Health in-house HSS activities. To inform MoH's municipal/regional and facility health systems strengthening activities a baseline assessment was completed in 2022 covering the three targeted municipalities. Facility surveys were conducted at 86 CHCs and health posts. This was undertaken jointly with the MoH using their Facility Readiness Assessment (FRA) data collection tool, assessing facility readiness against the standards laid out in the EHP-PHC. PHD worked closely with the MoH to develop additional supplementary tools to assess against standards for human resources (HR), drugs and services[8]. The FRA was analysed across seven health system areas including infrastructure.

This was a robust and comprehensive situational, gap and bottleneck analysis that found that significant health system issues need to be addressed before Timor-Leste will be able to reach effective coverage of the ESP-PHC services. The baseline assessment was used to support the MoH to lead participatory diagnostic workshops in each of the municipalities to explore the system constraints and bottlenecks identified. Participants where from MoH, municipal/regional administrations, Municipal and Regional Health Services, health facilities, and development partners[9]. A number of these had not traditionally been included in planning and budgeting processes[10].

Through these workshops PHD supported the Municipal and Regional Health Services to present the data and discuss the bottlenecks and facilitated discussion to drill down to the root causes and identify solutions. The output was Microplans and Annual Plans that for the first time integrated planning and budgeting for resources from both MoH and the Municipal / Regional Authorities. In this way PHD supported MoH to use findings from the baseline assessment to inform their planning and budgeting cycle for 2023. PHD then facilitated the review and update of these plans at

[8] PHD Health: Baseline Assessment Report 2022
[9] ibid
[10] PHD Six Month Progress Report July to December 2023

municipal and Phased CHC level using the quarterly review and coordination meeting process further discussed in Section 3.2.2.

The results of the Participatory Diagnostic Workshops, the review and coordination meetings, updated FRAs, joint supervision visits and 6-month review meetings in each municipality are all used by the municipal team to set priorities for workplans. In addition, these priorities inform the focus of activities at national level. On a more day to day basis, the Municipal Coordinators are the point of liaison with the Municipal Health Service (MHS). The role of the Coordinators is to ensure that PHD inputs are aligned with MHS priorities, using a demand driven approach. Requests for funding are passed up the line to PHD Health Manager Municipal HSS for consideration.

3.2. Examples of Progress towards System Strengthening and Improved Service Delivery

PHD Health is strongly committed to supporting MoH deliver on its vision of achieving Universal Health Coverage (UHC) through primary health care[11]. There is evidence of strong partnerships, including at the subnational levels. MoH sees PHD Health as a reliable and trusted partner and the program has cultivated strong relationships. PHD Health's contributions and collaborative approach with the MoH were widely recognised during the consultations.

The Review concludes that the program is moving towards all three Intermediate Outcomes. Evidence was found that activities under Phase 2 are starting to resolve system bottlenecks and improve the functioning of the health system. This section highlights some of those examples.

Annex 2a to the FY2023-24 Progress Report tracks the quantitative indicators against the MELF. Very few of these have baselines so it is not possible to get a sense of progress towards outcomes from this tracker. However, examples of progress from the tracker include the per cent of planned quarterly integrated supportive supervision visits completed. The baseline was 44 per cent for Dili and 0 per cent for both Emera municipality and RAEOA in 2023. With PHD Health's support for operational costs these figures are reported to have increased to 100 per cent for Dili and 20 per cent for RAEOA. Table 7 in the FY2023-24 Progress report shows Maternal and Child Health (MCH) indicators for Dili, Ermera and RAEOA from 2022 to June 2024 sourced from the Timor-Leste Health Information System (TLHIS). Overall, these demonstrate improvements, including for ante natal visits and deliveries at facilities.

Examples of Health Systems Strengthening

Public Financial Management

PHD Health has made significant headway in supporting MoH and Ministry of Finance (MoF) to identify and address bottlenecks related to financial management and planning. Examples reported include the training sessions facilitated by PHD, PROSIVU, MoF and MoH delivered to Ermera, Dili and RAEOA during the 2023/24 FY which have led to improvements in implementation of the quarterly budgets for MHS in Ermera and Dili. For example, there was no budget transfer from MoH to MHS of Dili and Ermera in Q1-2023. However, as the result of the training and technical support, in 2024 both MHS Dili and Ermera has received Q1 budget ($40,931.95 and $41,779.75) respectively. With PHD's support, the expenditure of this budget has also accelerated, and delays in budget releases to MHS in Ermera and Dili are no longer a significant issue in 2024. Participants in the training sessions report enhanced understanding of their budgets and how funds available from MoH and municipality budgets can be accessed along with new skills in linking budgeting to planning.

Significant barriers to delivery of quality inclusive PHC are related to PFM. PHD's headway provides a strong basis to build on. Management, planning, and budgeting challenges are amongst the most

[11] National Health Sector Strategic Plan II (NHSSP II) 2020-2030

significant impediments to the delivery of quality inclusive PHC needed to expand UHC. The lack of accurate budgeting and accounting practices, poor financial management skills and integrated evidence-based planning are deep seated root causes of many systemic issues. PHD Health has demonstrated that gains can be made by improving financial management and planning skills at the local level and building the confidence of municipal actors to better use the system and advocate for more funding.

Review and Coordination Meetings

A key achievement was PHD Health's effective support for the development of the MoH Partnership Manual in 2022 to guide coordination of health sector stakeholders in formalising their engagement with MoH. Key structures include quarterly Coordination Committee at all levels of the health system. Municipal level Committees coordinate implementation of activities by the MHS and all partners and support the development of Annual Action Plans. PHD Health has supported the MoH to roll out these Committees in the three municipalities and the Phased CHCs as 'quarterly review and coordination meetings'.

All those interviewed at both municipality and facility levels provided these meetings as an example of where PHD facilitation support has led to change in the functioning of the health system. There were many references to these meetings supporting the review and utilisation of health performance data, progress against plans, identification of problems and solutions impacting on service delivery, priority setting, budget planning, coordination with partners and better use of available resources. CHCs spoke of the significant advantages of being able to engage community leaders in data analysis and decision making which raised awareness of MCH issues such as the importance of immunisation and skilled birth attendance. As such, PHD Health support has started to see improved health governance and accountability for facility readiness at the local levels and raised some awareness of the significance of budget allocations being aligned to health data.

The review meetings identify training needs and as such have provided an entry point for the PHD team to support the MCH District Public Health Officer (DPHO) and Gender Based Violence (GBV) focal points at Municipal and Regional Health Services to prioritise training, such as in Essential Newborn Care. The PHD Health team then plays a facilitative role to support the DPHOs' communication with INSPTL to develop training proposals and if needed support implementation in Dili, Ermera and RAEOA. The challenge is, as mentioned by one health facility, for these meetings to be sustained without PHD Health support. This requires competent leadership and capability in data analysis and data use for planning. Nevertheless, this substantial progress is a strong basis on which to build.

Nutrition Database

The excel based nutrition database is a further example of PHD Health's support impacting on the functioning of the health system. PHD Health's municipal Roving Team is using the nutrition database as an entry point to build skills in health information management at the municipal and facility levels, including quality data entry, data analysis, reporting and use of data and M&E skills. The Review found, as reported in the FY2023-24 Progress Report, that 'the database is improving the accuracy of registration and data collection, reducing data duplication, and enabling more effective monitoring and treatment of children with malnutrition' in certain facilities.

CHC Becora is the most advanced user, where the database has fully replaced paper records. The CHC is using the database to understand and track the levels of malnutrition in the community having registered 6200 children under 5 years since its introduction in 2023. No longer relying on paper records has facilitated regular growth monitoring including tracking those that need follow up. The support of community leaders is enlisted who then mobilise their community members to take their children for monthly monitoring. Work is underway to confirm the number of children in the

catchment area so the target of registering 100 per cent of children can be confirmed, but to date the number of children attending follow up visits has increased from 1000 to 2800. In RAEOA, the DPHO Nutrition reported that the database has resulted in an increase in growth monitoring from 23 per cent in 2018 to 80 per cent in 2024 although the officer noted uncertainty around the previous coverage rate. In addition, the DFAT funded Social Protection Program would have served as an incentive for attendance. CHC Becora, Nutrition DPHO in RAEOA and the National Director of Nutrition all raised the issue of the denominator in use still being based on the 2026 Demographic Health Survey DHS). This presents difficulties in tracking progress.

Emergency obstetric and neonatal care (EmONC) and Basic Emergency Obstetric and Newborn Care (BEmONC)

The work of UNFPA under the program 'Strengthening the health system to deliver a high-quality integration of Maternal and Newborn Health Care in Ermera, and RAEOA' has impacted on access to quality obstetric and neonatal care services. A number of those interviewed at both municipal and facility level referred to this support. Examples were provided of decrease in maternal mortality since the provision of EmONC training and increase in facility-based deliveries.

In 2022 UNFPA conducted the last batch of EmONC training making a total of 155 providers trained since 2018 from 36 facilities in the three target municipalities. The PHD FY2023-24 Progress Report showed that 80 per cent of CHCs in Dili, 43 per cent in Emera and 60 per cent in RAEOA had at least one health provider competent in EmONC. During Phase 2 PHD Health support has enable the MoH with UNFPA to launch the fourth and fifth BEmONC centres in Gleno in Emera and Atauro in Dili. These centers are equipped with trained health providers and the required essential infrastructure including medical equipment to handle complications during pregnancy and childbirth. Additional associated work included orientation training on ante natal and post-natal care standard guidelines and protocols were conducted in Ermera and RAEOA. This system strengthening for EmONC services provides a strong foundation for the new health design to build on.

Other Examples

Other examples of systems improvements achieved with PHD support cited by those consulted include:

- UNICEF spoke about their support to INSPTL to train 26 biomedical technicians in 2022 at municipality and facility levels. Towards the end of 2023 these technicians had repaired and maintained 101 fridges securing the cold chain, including for the HPV (Human Papillomavirus) vaccination campaign and installed 98 solar powered refrigerators.
- Passabe CHC reported that the satisfaction box for patient feedback has led to improvement in health workers attitudes towards patients and encouraged health seeking behaviour.
- Other interviewees referred to how PHD Health's (MSITL) support to develop a new form to register family planning clients means that one form is now used across facilities with a unique patient identifier, expiry date and batch numbers. The has resulted in improved patient care and reduced stock outs.

3.2.1. Changes in Facility Readiness

PHD Health is supporting the MoH to conduct FRAs which are scheduled every quarter. PHD Health has worked with the MoH to undertake training of Municipal and Regional Health Services to conduct the assessments and to use the data. This includes comparing the data against the baseline and using it for planning including during the review and coordination meetings. There have been challenges, including those linked to staff changes, overall lack of capability and lack of resources for the needed supervisory visits. However there has been some success in supporting the MoH and Emera, Dili and RAEOA Health Services to conduct FRAs with the latest scores available from the second Quarter in 2024 making it possible to assess changes in facility readiness to deliver the ESP-

PHC. The results of the Phased facilities assessment against the minimum standards can be seen in Table 1. Significant change is evident for Passabe and Atsabe.

Table 1: Phased Facility Readiness Assessment

Number	CHC	Overall Score Baseline (2022)	Overall Score Latest Score (Q2 2024)	Minimum Criteria Baseline (2022)	Minimum Criteria Latest Score (Q2 2024)
1	Comoro	81%	80%	No	Yes
2	Passabe	66%	88%	No	Yes
3	Gleno	83%	86%	Yes	Yes
4	Atsabe	69%	78%	No	Yes

PHD Health are planning to repeat the 2022 Baseline in 2025 working alongside the MoH. This will be useful information for the MoH at all levels to systematically check progress against the baseline, identify gaps, plan and direct resources. It will also be an essential input for the 2026 PHD End of Facility Evaluation.

3.2.2. Foundational Activities

A number of activities are at a foundational stage but it's too early to assess impact on health system functioning and service delivery.

- Key amongst these is the Post Graduate Diploma in Family Medicine (PGD-FM) which is a critical input for realisation of the model of care in the ESP-PHC. The 2022 Baseline Assessment report identified only Dili as having enough general doctors to meet the minimum staffing standards. The first Family Medicine Program (FMP) cohort is planned to commence the 2-year diploma in 2025. Once cohorts graduate and move to rural areas there is significant potential for the diploma to have an impact on service delivery through supporting the decentralisation of health services to community level and hopefully, a reduction in the number of referrals to higher levels of the system. Significant foundational progress has been made including:
  - Setting up clear governance structures, terms of reference and the Memorandum of Understanding (MoU) providing an anchor-point for decision-making and progress.
  - Establishment of a cadre of national specialist clinical teachers committed to supporting better care in the municipalities, reducing unnecessary referrals and responding to public health needs of communities.
  - Development of Timorese clinical teaching competencies for the PGD-FM to drive quality and professional development.

  PHD Health reports that the consultation and engagement needed for the development of the PGD-FM curriculum has facilitated widescale dissemination and discussion of the ESP-PHC and the National Health Sector Strategic Plan (NHSSP), which has led awareness and familiarity with these documents that might not have occurred otherwise.
- The clinical and non-clinical Continuing Professional Development (CPD) training that Maluk Timor is supporting INSPTL to undertake (DISTanCE), together with the institutional development work, is foundational for the next Phase of Australian support. What came out strongly from consultations across all levels of the health system was the importance of clinical and non-clinical CPD. The importance of leadership and management training, including its role in attitude change and motivation, was frequently referred to.

DISTanCE training packages remain under development with training to commence in 2025 with Maluk Timor's contract coming to an end in March 2026. This timeframe may prove to be too short to evaluate and demonstrate impact (application of learning and its targeted results) of the training but it's value as a foundation for the next program to build on is fully recognised. In the meantime, INSPTL reports that this work is strengthening their capacity as Maluk Timor is working side by side with them to co-design curriculum.

- In addition, the work of the M&E Adviser in support of the national level Policy, Planning and Monitoring & Evaluation Department provides a strong basis to build on, but it's early days. This has the potential to support change both in health information and governance at all levels of the health system through strengthening the MoH's M&E systems and processes and supporting the use of data for performance improvement, budgeting and planning. PHD Health has used a participatory approach to support the development of the Health Sector M&E Strategic Plan and a M&E Framework for PHC which brings together the indicators across all the various public health strategic plans. Both documents were finalised in May 2024.

  Work is ongoing to support the integration of indicators into TLHIS, build the capacity of the new department head and officers, and prepare the M&E Department for socialisation of the Guideline and Framework at municipal / regional level including tools. Once socialised and integrated into TLHIS, PHD Health can work with other development partners in this space to support the municipalities and facilities to collect and use data for decision making and ensure data quality. All this will take time, and results will be hard won, especially given the level of staff changes in the Department. Change can only happen at the pace that the MoH can absorb.

  However, once municipalities have capability, including a good understanding of the data, they can advocate for budget based on their needs and plan accordingly. Access to quality PHC data can also strengthen MoH national level accountability, including their reporting to the MoF and ultimately the Prime Minister's office. The MoH was keen to stress during consultations the critical role of PHD's M&E support and that work is 'just starting' with the aim being to have opportunity 'to achieve all goals in M&E strategic plan'.

3.3. Issues Impacting on Progress

3.3.1. Government Ownership and Program Governance

A key finding of the Review is the degree to which momentum has been undermined by the extraordinarily extensive personnel changes at all levels of the health system. As the second Phase of the program was underway, the change of government in July 2023 significantly shifted the political economy landscape that PHD Health operates in.

Phase 2 was co-designed with the GoTL, under the previous administration, and had strong government ownership. Former senior MoH officials are well able to articulate its vision and rationale. However, the extensive personnel changes since the election have impacted significantly on government ownership and understanding of the program. The national level governance arrangements established under the previous government are no longer functioning. Governance arrangements expected in the Phase 2 design include the Biannual Steering Committee (SC) meetings to be co-chaired by the Australian Ambassador and the Minister of Health. The SC was designed to be a strategic joint decision-making forum. In addition, the more technical Program Management Team (PMT) meetings overseeing program implementation (including representatives from DFAT, PHD and MoH) has also not met since before the new government's inauguration. Both the SC and the PMT are central fora for policy dialogue and for PHD Health to bring municipal and facility bottlenecks up to the national level to 'nudge' progress on needed system reform.

DFAT, the leadership team in PHD Health and those former Directors who are still working in the MoH at national level are socialising the program to build ownership amongst the new central MoH senior team, including through informal and opportunistic channels. The success is reportedly slow. PHD Health needs to ensure it is still delivering against the vision of the new administration and the strategic technical approach has senior official support. For any new administration it takes time to get across portfolios and a vision to be developed. With DFAT support, PHD Health is continuing to support the core tasks (such as the FMP, municipal level work, PFM and M&E support) whilst taking all opportunities to socialise the program and engage with MoH for decision making at national level outside of the program's governance arrangements.

The Review found ownership and strong engagement amongst health leaders at municipal / regional level and within those central partner institutions and agencies that PHD Health is working with, such as INSPTL and Medical and Pharmaceutical Supply Agency (INPFM). Examples of PHD Health actively encouraging engagement include INSP-TL being fully involved in the task scoping, terms of reference development and selection process of Maluk Timor. In addition, PHD Health reports that the Vice Minister is actively involved in strategic advice for the FMP.

3.3.2. Program Assumptions and the Extent of Staff Changes

The Phase 2 design assumptions are high level 'IF, THEN' assumptions in the narrative of the Theory of Change (ToC) linking the objective to the goal and the EOPOs to the objective. The PHD Health Strategic Plan includes a set of more operational assumptions that need to hold true for the program to achieve its outcomes. There is also an updated risk register annexed to Annual Workplans which recognises the risks related to government re-structuring leading to the loss of key positions driving program implementation and the importance of staff retention for facility readiness.

Key assumptions in the Strategic Plan that haven't held true include key MoH and Municipal Health Management Team (MHMT) stakeholders involved in collaboration with PHD stay in their current positions' and 'trained/mentored staff are retained at MHS health facilities'. The level of staff changes and the need for ongoing socialisation, has impacted on the pace to which the program can support improvements in the health system and service delivery. For example, all DGs at national level except one, are new, plus many heads of departments including Policy, Planning and M&E and Director of Budget and Finance Management. The current HR Director at MoH is the third one within 12 months. The Regional Health Secretary RAEOA took up his position following the 2023 election and the Director of Health Services, Dili has been in post since March 2024. This level of senior staff turnover has resulted in loss of continuity, including support and understanding of the ESP-PHC and the related M&E.

The 2022 baseline found that only 6 per cent of the 86 health facilities surveyed met the ESP-PHC minimum staffing recommendation, resulting in poor delivery of services. In addition, it revealed that "staff are not allocated appropriately, unclear about their responsibilities, have low motivation and poor attitude: there is insufficient staff capacity"[12]. The Review found that the extent of staff changes linked to the new government has served to compound these issues. Examples at Phased facilities include 42 new staff out of 190 staff in Comoro CHC and the health posts that fall under the CHC's jurisdiction. At Passabe CHC in RAEOA, 11 of the 23 staff were changed following the election. Staff turnover was frequently mentioned to the Review as one of the most significant challenges to service delivery at facility level. To compound the problem further, these CHCs reported all the new staff to be new graduates.

It could be assumed that replaced staff have not been lost to the public system, but this won't be the case in every instance. This level of turnover significantly impacts the effectiveness of facility level

[12] PHD Health Strategic Plan, 2023

training (including in mSupply, FP, SRH, MCH, GBV and nutrition services). Poor facility readiness (including due to staff retention) compromising comprehensive and quality PHC services delivery is a high risk in the PHD Health risk matrix even after treatments. However, this level of staff replacement which happens every five years was not a clear assumption in the design underpinning the ToC and the risk treatments in the risk register have only been partially effective or not effective when related to staff retention. See related discussion on program ambition in section 3.7.2.

3.3.3. Impact of Responsiveness on Program Outcomes

DFAT expects the PHD Facility to have a certain degree of flexibility and the ability of the program to be responsive was often mentioned by respondents as a strength. PHD Health has for example, provided 'just in time' support to the MoH to respond to health threats such as rabies and dengue. Other resource intensive activities undertaken that are not in the annual plan include the grant to UNICEF for COVID-19 support (with residual funds applied to the HPV vaccine campaign at MoH request) and activities associated with the Pope's visit. Such support responds to government priorities, reinforces DFAT as a partner of choice and raises the profile of PHD Health strengthening relationships with government officials. It is important for PHD Health to be visible and responsive, especially at this time when there are many new stakeholders within government offices.

PHD Health has also strategically used some of these opportunities to learn more about health system weaknesses and health system support for public health emergencies will, in some instances, have strengthened the health system more broadly as envisaged in the Phase 2 design. This will have proven useful in making progress against program outcomes. However, building health system resilience to respond to health threats including public health emergencies is not in the ToC and is not a program outcome. This might well be something that the new design should consider including ensuring that there are resources allocated for this work. There remains the risk that the amount of staff time devoted to addressing health threats and other unplanned activities may outweigh their contribution towards program outcomes. However, supporting the government's response to the COVID-19 pandemic was a critical and necessary priority for the program.

Other ongoing or previous activities that are not within the scope of the program as defined by the outcomes include the work on secondary and tertiary care. The program has embarked on supporting the development of a national strategic plan for hospital services as requested by the Vice Minister. In addition, the FY2024/25 Annual Workplan (AWP) includes the activity 'support the development and finalisation of the health sector M&E framework and progress card for secondary and tertiary care …'. These additional activities related to secondary and tertiary care are diverting resources away from the PHC and HSS focus of the design.

Some interviewed weren't confident in responding to questions related to what the program was seeking to achieve and others raised issues related to the visibility of results. It is suggested that these additional activities risk diluting the program's strategic focus and risk impacting progress against outcomes. The program needs to be adaptable and responsive in a planned way without being reactive.

Recommendation: Priority Setting

1. Within the context and the political economy dynamic, DFAT and PHD Health to work together to establish clearer parameters and boundaries around being responsive, including being clearer on the difference between being flexible versus being reactive and what that means practically for the program.

3.4. Ways of Working

3.4.1. Overview

A key strength of PHD Health is its commitment to localisation in line with DFAT's Guidance on Locally Led Development[13]. As designed PHD Health Phase 2 is taking a locally led approach to implementation through working with local actors, structures and institutions, supporting local processes and priorities and consistently using government systems and tools rather than introducing parallel structures or processes. Examples include the FRA and Microplanning processes and formats at municipal level. The program fully recognises that using government systems serves to strengthen them.

The program's locally led approach is also evident through the team, the direct funding of local civil society organisations such as PRADET, and the Monitoring, Evaluation and Learning (MEL) system being framed around using local data and alignment with MoH M&E frameworks wherever possible. Given the evolving nature of the Locally Led Development approach and the number of new team members, there might be benefits in PHD Health, with Abt's support, holding some team discussion around what it is and what it means for the program to ensure a consistent understanding.

3.4.2. Political Economy and the PIMA Improvement Cycle

The Phase 2 design sensibly built on the context and political economy analysis already being used by PHD program teams. There was a PESTLE (Political, Economic, Social, Technological, Legal, Environmental) analysis done in 2020 as a strategic review of program progress, risks, and opportunities. Abt Global also facilitated Political Economy Analysis (PEA) introduction for the whole PHD team in 2021 and further training has since been completed by senior staff. Since then, the PHD Health team has expanded and there have been staff changes.

In 2022 PHD Health usefully developed a framework outlining the approach to political economy analysis. It innovatively recommended an applied and practical political economy approach based on 'Thinking and Working Politically' and 'Everyday Political Analysis' tools and methods. This was to avoid substantial analysis at the start of Phase 2 which would quickly go out of date. PHD Health has embraced this approach building context monitoring and political analysis into regular working, program management and strategic decision making.

The framework included an initial workshop to test political economy constraints and opportunities to feed into a short Institutional Analysis as a practical update to the PEA done as part of the Phase 2 design. In 2022 the proposed roundtable was conducted with MoH stakeholders and identified key drivers and constraints to PHC HSS and highlighted entry points for PHD Health. The further Analysis envisaged in the framework didn't eventuate. It was to result in a set of briefing notes on the key political economy issues/findings to feed into a formal orientation and applied training program for all the PHD Health team. The training was to include methods and techniques to assist staff think and work politically in their everyday work. The intention then was for staff from PHD and Abt to be available to provide ongoing advice/mentoring to program implementors in applying these skills. The team hasn't received training beyond the initial introduction in 2021.

Training and support are still needed for team members at national and municipal levels to strengthen the systematic integration of applied political economy analysis into everyday work. This includes knowing how to identify the stakeholders, their incentives for change, how decisions are made and understanding how change may happen. Thinking and working politically is an essential skill for the team, including advisers, especially as they seek to facilitate locally led change as a key delivery principle.

[13] DFAT Guidance Note Locally Led Development, 2024

The Strategic Plan and the PEA framework both outline a facilitative problem-solving delivery approach to support municipalities and facilities to identify and effect improvements in health systems. This involves working politically with key health actors to identify health system constraints that are most effecting service delivery, explore the root causes of these blockages and to plan and assess improvement actions. For example, why aren't supervision visits happening? The Strategic Plan refers to this as the Plan/Implement/ Monitor/Adapt (PIMA) improvement cycle. Many of these challenges obstructing reform are fundamentally political and working in this way can identify entry points for reform and PHD's facilitation support.

PHD Health is drawing on this methodology including for quarterly review and coordination meetings and six-monthly evaluations. In August 2024 the National Directorate for Maternal and Child Health requested financial operational support for their six monthly MCH evaluation. PHD used this as an entry point to also offer technical and facilitation support which created an entry point to facilitate better analysis and use of data, discussion of issues/challenges and proposed solution.

However, there is scope to integrate this approach further into program delivery. The team would benefit from orientation and support in this way of working drawing on PHD Health's experience to date, including success factors and lessons learned. For example, the Municipal Coordinators were not recruited to play a more facilitative technical role. The positions are more coordination and logistics focused. Providing them with skills and support to proactively facilitate discussion around challenges and local solutions could lead the program to have more influence over priorities to balance the current demand driven approach. Looking at the role and skill set of any similar roles could be something for the design of the next investment to consider.

Recommendation: Political Economy and the PIMA Improvement Cycle

2.PHD Health to conduct formal PEA orientation and applied training for all the program team supported by ongoing advice/mentoring from PHD and Abt. This was planned for in the Health Strategic Plan but never eventuated. This should reflect the changes in the political economy, ensure the team are provided with methods and techniques to assist them think and work politically in their everyday work and enable a more structured approach to operationalising and integrating PMIA and PEA throughout implementation.

3.4.3. The PHD Health Team

The team is primarily made up of local staff, many of whom formerly held senior government positions. The team is therefore highly connected, understands the context and has lived experience of the health system. They are able to build trust-based relationships and guide program implementation in a culturally appropriate way both formally and informally through drawing on their existing relationships and networks. There are several new recruits who are at various stages of settling into their roles. The RAEOA Municipal Coordinator at the time of the field visit had only been in position for three months and the review identified a need for ongoing support recognising the difficulties of not being based with the rest of the team.

The team is supported by a national Director, national Health Sector Lead and international advisers. These nationals in leadership and decision-making roles bring local knowledge and political-economy expertise. The benefits of continuity of a Director who has been in a senior position since the first Phase are evident, including their deep knowledge of the program and strong connections. Many of those interviewed spoke of their strong relationship with the PHD team, including good communication.

The team is large and working across a complex program. The leadership team is aware of the risks of siloed working and is actively working to mitigate, including through weekly stand-up all team meetings where senior managers talk about their priorities and areas of work where support or more coordination within the team is needed. Also, senior managers meet on a monthly basis to

discuss progress against the work plan and challenges/risks that require solutions. However, the Review observed a lack of opportunities for comprehensive team discussions on technical and strategic matters, limiting the ability of junior team members and advisers to contribute to program strategy and share their perspectives.

The Review found lots of examples of joint teamwork. For instance, the Organisational Development (OD) and Municipality teams and the M&E Adviser are working synergistically together to push work forward. Examples of joint working cited include working through the OD Manager to liaise with INSP-TL on M&E CPD modules. If the MoH has issues with the quality of TLHIS data from facility level the M&E Adviser can ask the Roving Team to identify what the issues are so the adviser can highlight the issues with the TLHIS MoH team. This is a good example of the 'bottom up' approach of the PHD Health team acting as a conduit for bringing issues 'up the chain' for resolution. The organogram Annexed to the Phase 2 design had the Manager Organisational Development and Short-Term Adviser (STA) Medical HR and Training reporting into the Manager Municipal HSS. This makes logical sense, given the OD team's work is focused on improving service delivery at facility level. There was no doubt a good reason for the change in approach but given this change PHD Health should continue to ensure that all opportunities for synergies are maximised. For example, between the OD team and the Roving Team around the Integrated Primary Health Care and the Integrated Suite of Development Program training modules.

In discussions PHD Health highlighted a priority for the team over the next 18 months is to develop a more coordinated and structured approach to working between the Municipal Coordinators, the Roving Teams and the Implementing Partners. The Review supports this. Stronger collaboration would support progress towards outcomes. This includes more opportunities for ongoing technical discussions between PHD Health and the Implementing Partners alongside better coordination at local levels. For example, the RAEOA Municipal Coordinator is not aware of MSITL and UNFPA visits to the region. The monthly meetings with the Implementing Partners run by PHD's Health Transition and Grants Manager are more focused on contractual issues.

3.4.4. Balance of Time Between National and Municipal levels

The Review team was struck with the difference between the size of the team in the PHD Health Dili office compared to the two staff who greeted the team in Oe-cusse (the Coordinator and a driver). It is fully recognised that the Roving Team prioritised being in the Dili office to meet with the Review team and had planned their field visits around the Review mission. At the same time, the national level pull is strong given the number of national stakeholders, the complexity of the issues facing the national MoH and the level of requests, not all of which are within scope. The national level is important for the full functioning of the health system, but it has its complexities and progress can be challenging.

It is suggested that, given the limited time PHD Health has left to run, that the whole team (including at a senior level) remains conscious of the overall split of time between national and municipal levels. The municipal and facility levels hold the most potential for the biggest changes notwithstanding the importance of the national level PFM, Supply Chain Management, M&E advisory support and progressing the FMP. It is also recognised that national advisory support is supporting work at municipal levels and PHD Health is actively seeking opportunities to maximise this. For example, enhancing the planning and strategic focus of MCH and nutrition programs at the national level will positively impact progress at the facility level. Facilitating stronger connections between national, municipal, and health facility levels, with a focus on addressing PHC delivery challenges, such as coordinated supportive supervision, will also impact local progress.

The Review also found that the Roving Team is made up of committed experienced professionals who are dedicated to their roles and motivated to make a difference. It is challenging splitting time between three municipalities. Through consultations, it was evident how much the roles and

technical capacity is valued at municipal and facility levels. The Review heard that the team spends around 50 per cent of their time in the PHD Health office. Time spent in the Dili office is seen as an opportunity lost for the lower levels, who could benefit from any additional time expertise available. That said, it is fully understood that regrouping after fieldwork is an essential part of the process.

The Review recommends that the Roving Team, along with the Sector Lead and the Manager - Municipal HSS where feasible, maximises time spent at local levels whilst continuing to focus on making sure all time and activities are as strategically planned as possible to make progress towards outcomes. Continuing focus on the approach to visiting the municipalities will ensure all time spent is used well and remove the possibility of reacting to requests that are outside the microplans and Annual Plans.

This will optimise the value of the PHD Health team in the municipalities, be a more effective and efficient use of resources and reinforce the Municipal Coordinators in their role. Through being more present at municipal level the Municipal team can increase their mentoring of the Coordinators and further support their understanding of the issues and health system constraints and interactions with the MHMS. It would also enable PHD Health to be even more visible to the MHTs. There is a perception amongst some senior government officials at municipal / regional level that coordination between PHD's Dili office and the Municipal Coordinator could be stronger and there is potential for enhanced progress.

The Review also identified the option of moving the home base of the Roving Team from the PHD Dili office to municipal / regional health offices. This co-location could facilitate more visibility and more opportunities for providing technical support and building capacity, although the risks associated with co-location discussed in Section 3.4.5 would need to be managed. Thinking forward to the new design, one strategic approach that could be explored is building the capability of one or two stronger MHTs so that they can be a resource to other municipalities reinforced by PHD Health technical support. PHD Health has already initiated collaboration between the three municipalities by, for example, involving the Health Directors in each other's 6-monthly program review meetings. This strategy would depend on several things including MHT willingness and availability to fulfill such a role and more logistical issues like office space availability.

Recommendation: Balance of time Between National and Municipal Levels

3. PHD's Health Municipal team to maxmise time spent in municipalities whilst ensuring all efforts are utilised effectively and strategically. This will enhance opportunities to provide technical support to the MHS, facilities and to the Municipal Coordinators and maximise progress towards outcomes.

3.4.5. Technical Assistance

The Review found TA inputs to be aligned with the outcomes of the program and the milestones. PHD Health has a number of short-term and long-term national and international advisers. There are three advisers embedded full time in the MoH at national level (M&E, PFM and Supply Chain Management). The PFM and Supply Chain Management advisers and all members of the Roving Team all previously held senior positions in the MoH and as such have strong networks and knowledge of systems and processes. All these roles are widely supported by government partners. The Manager OD is co-located with INSPTL for 50 per cent of the time specifically to supplement capacity to drive the implementation of the FMP program.

Different roles that TA can play include: '**doers**' who substitute capacity and take responsibility for government functions (rather than supporting the work) and; **'partners'** in which TA supports government partners to perform their functions bringing specialised expertise and operational support as needed. This 'partner' role can include 'doing' but with clear primary focus on building local capacity. Benefits of 'doers' is that the approach provides results and ensures work is

undertaken in a technically sound manner, but the approach can undermine local responsibility and long-term self-reliance.

The Review found that the embedded advisers seek to be partners and focus on building capacity to both develop and use systems as well as maintain them. However, there is a risk that they move too far towards being 'doers' especially in response to urgent requests. The advisers are aware of this and are actively managing the balance on a day-to-day basis. For example, the M&E Adviser initial Terms of Reference (TOR) up to October 2023 was focused on producing deliverables whilst in the current role the adviser is developing capacity and supporting work for up to 40 per cent of the time, although this is still insufficient given needs. The Supply Chain Manager is working as a 'partner' by building capacity of INFPM to improve the inventory of medicines and consumables. The adviser is providing training and side-be-side mentoring of staff to improve data entry skills and facilitating partners to understand the links between data entry and data quality. PHD Health needs to continue to manage this to ensure that the advisers only work at a pace that can be absorbed by the MoH and don't end up doing work that is the responsibility of government.

In line with DFAT's Locally Led Development guidance PHD Health doesn't assume that local leadership excludes a role for non-local actors. One of the Long-Term Advisers (LTA) and several STA are internationals. Reporting to local managers, these short- and long-term international advisers play a supporting or complementary role to the local advisers, managers and technical professionals while building capability. They bring experience of other regional and international contexts and ways of doing things and contribute with perspectives, expertise, experience, networks and relationships.

Abt Global is a further source of international support. There is a perception from DFAT that additional technical support from the Abt team may have supported better structures for measuring and reporting progress against outcomes. Ongoing GEDSI support has recently been initiated. Other areas where the program could benefit include MEL, strategic health support and, as noted above, thinking and working politically and facilitation skills.

3.4.6. Working through Implementing Partners

The 2017 Review of Phase 1 found that 'the program does not seem to be well integrated; despite the clear thematic relationships within it, it remains essentially a collection of loosely linked projects'[14]. PHD Health has brought greater unity to Phase 2 through the HSS focus. Implementing Partners are committed to the systems strengthening vision and the importance of strengthening health workers skills, rather than delivering services on behalf of government.

PHD Health is a grant manager of 'grantees' whilst working with the same organistations as 'Implementing Partners' to deliver program outcomes. The partnership way of working is somewhat a departure from Phase 1 which was more focused on managing grants. PHD Health is more familiar with the grant manager role and has strong expertise in contract management. Equally, to varying degrees the Implementing Partners are more used to being grantees contracted to deliver agreed activities under their own organisational mandate and vision.

As a result, it is the partnership aspect of the relationships which the Review found to be more challenging on both sides. PHD and DFAT tend to use 'grantee' language when referring to the sub-contracted partner organisations. The Review found there can be some confusion amongst Implementing Partners as to which 'hat' PHD is wearing in which forum and that the relationships could benefit from PHD Health being clearer about this in meetings or other interactions.

[14] Australia Timor-Leste Health Review, 2017

The Implementing Partners tend not to see themselves as part of the PHD Health program and their visibility across all program activities varies. PHD Health has been proactive in creating opportunities for collaboration and synergy for example through establishment of the quarterly partners meeting and the development of plans for joint working. These efforts have had mixed success. Despite challenges gaining traction, PHD Heath should continue to pursue opportunities to strengthen the partnerships. There is room on both sides for more collaborative relationships. The overall program would be more effective and integrated if partnership working is strengthened.

For example:

- Proactively strengthening relationships between the Implementing Partners and across the PHD Team (including the advisers and the Roving Team) beyond the Grant Manager and leadership team. This approach might lead to better cohesion between the work of the in-house PHD Health team and the Implementing Partners, including identifying where more value-add linkages can be made at national, municipal and facility levels. One example provided was of MSITL's input not being sought to input to the CPD Emergency Management module, although there are plans to involve them in the FP CPD module drawing on their history of working with INPH-TL to review the FP curriculum.
- Continuing to ensure relevant Implementing Partners are invited and attend quarterly municipal and Phased facility review and coordination meetings.
- Finding ways to involve Implementing Partners in PHD technical and strategic discussions, around priority setting, milestone development and the MELF.
- Including Implementing Partners in PHD team training, as appropriate, including any MEL and PEA training.
- Involving the Implementing Partners in reflections with DFAT's other relevant bilateral programs including PARTISIPA, including to discuss bottlenecks and potential for closer working.
- Finding ways to be more effective at managing / facilitating the Implementing Partners relationship with MoH at both national and municipal levels, including related to strategic agendas. The Review confirmed the 2017 finding that 'each implementing partner seems to have its own relationship with MoH'[15]. A rationale for parallel relationships is that the Implementing Partners are organisations with their own identity / mandate and DFAT/PHD can be one amongst several funders. However, there is a sense that PHD and Implementing Partners are on occasion competing for profile and a seat at the table with the same government officials. This needs innovative solutions, but a small example could be for PHD Health to reflect on its approach at the MHS led 6-monthly program reviews attended by MSITL, UNFPA, PRADET and Maluk Timor. Currently PHD Health presents on behalf of the partners but some partners feel their contributions are not being fully acknowledged or accurately represented.

Recommendation: Working through Implementing Partners

4. PHD Health to review its ways of working and identify opportunities to foster stronger partnerships with the Implementing Partners and consider how it can better facilitate their relationships with MoH at national and municipal level as appropriate.

3.4.7. INSPTL and Maluk Timor

Maluk Timor was awarded the DISTaNCE contract in April 2024. The agreement covered working with INSPTL to develop and deliver the CPD in Integrated Primary Health Care (IPHC) and the

[15] ibid

Integrated Suite of Professional Development Program (ISDP) as well as systems development capacity building and organisational development. Maluk Timor has an established track record of supporting the PHC system in Timor-Leste including through a HSS approach.

INSPTL was created with decree law 84/2022 on 23rd November 2022 as a successor to the National Institute of Health, with renewed legal basis and new senior position appointments. It is a nascent institution which is still establishing itself with many positions yet to be filled and a strategic plan yet to be developed. The Director or Training is without the support of many Department Chiefs and as such is lacking the human resources to fulfill the Training Department's mandate. This is impacting on the ability of the Department to engage with Maluk Timor. At the time of visiting in October 2024 the Director noted that she was yet to review the draft modules supplied three months prior due to lack of capacity.

DFAT and PHD Health selected to contracted out the support to INSPTL rather than use a technical advisory modality. This approach came with a number of risks, especially for the OD work which has proven to be particularly challenging. Leadership matters in any change management scenario. International experience tells us that if senior managers are not supportive of a change in approach, reform or programs of capacity development, outcomes will not be achieved. Without engagement of key stakeholders technical solutions will flounder. As Maluk Timor wrote in their proposal, 'Organisational development requires INSP-TL's leadership buy-in' and 'INSP-TL leadership must buy-in and facilitate change management'[16].

The relationships with the INSPTL leadership are held by the senior team in PHD Health and DFAT. Introducing a fourth party (Maluk Timor) into this partnership has impacted on the local political dynamics, especially as Maluk Timor is a contractor with a grant and as such has struggled to build a trust-based relationship with INSP-TL and engage outside of formal meetings.

Maluk Timor was selected despite lacking capability in this type of institutional development work and not having a strong track record of success. As a result they have needed capacity building and related support that would not have been required if the support had been provided in-house using TA with the necessary skills and experience. Building the capacity of local organisations is not a program outcome and not tracked through the MELF. Allocating PHD resources to build Implementing Partner capabilities has a ripple effect, reducing the availability of program resources for advancing activities tied to outcomes. It could be argued that the need for some level of support and capacity building should have been anticipated by PHD and Abt Global on contract award.

Maluk Timor has struggled to engage with INSPTL leadership outside of the formal meetings with DFAT and PHD Health. Little progress has been made especially with the organisational development work. It is evident that Maluk Timor, DFAT and PHD Health are all frustrated. All parties are very committed to making this work and DFAT and PHD Health have provided a significant amount of assistance, including through monthly meeting between INSPTL, Maluk Timor, PHD Health and DFAT to review progress.

Recommendation: INSP-TL and Maluk Timor

5. PHD Health, DFAT and Maluk Timor to have an open and honest discussion to identify the root causes of the lack of progress, discuss the prevailing political economy and work as partners to strategically consider innovative solutions and entry points to 'nudge' forward. There may be opportunities for PHD Health to build ownership and buy-in through the Health Lead's position on the INHP-TL board or the Manager, Organisational Development who is embedded in INSPTL.

[16] DISTanCE Technical Proposal, Maluk Timor, March 2023

3.5. Collaboration with Development Partners and other DFAT funded bilateral programs

3.5.1. DFAT's other bilateral investments

DFAT's investments alongside the PHD Facility include two other facilities. PROVISU (2022- 2026) focuses on advancing reforms in three key areas: Public Administration, Economic Development, and Public Finance Management. PARTISIPA (2021 - 2031) supports the government to improve access to, and the quality of, basic services and infrastructure at the subnational level. The Australian Government also funds the Nabilan Program, implemented by The Asia Foundation, which seeks to address and prevent violence against women and children while fostering gender equality in communities, institutions, and policies. PROSIVU, PARTISIPA and Nabilan all intersect with the health sector.

PHD's annual reports included examples of PHD Health collaboration with these programs. For example, PARTISPA has involved PHD in its 2022 support for the development of municipal Annual Action Plans which included health and PHD Health has invited PARTISPA to present on decentralisation. PHD Health has also collaborated with PROSIVU this year. For example, in the provision of PFM training and capacity building across the three focus municipalities. In April 2024, joint trainings were held on planning and budgeting linked to the government's systems together with a separate training on treasury management focussing on economic classification and utilisation of the Government Resource Planning system.

There was a regular formal monthly PFM lunch between PARTISIPA, PROVISU and PHD. This forum allowed for discussion of government priorities and constraints, entry points and how the programs could best work together across sectors including health to address bottlenecks to further the delivery of services at decentralised levels. However, the lunch forum has not taken place since October 2023, and PARTISPA and Nabilan have not met formally with PHD Health since before the election. Communication is currently informal and ad hoc, including at municipal levels.

There are many areas of intersection between PHD Health and these programs. Although informal mechanisms do have a role, stronger formal linkages are important. There is much to be gained from the programs working regularly in partnership to capitalise knowledge in the different programs, identify areas for joint working and ensure there is no duplication of efforts. Leverage from existing DFAT supported programs related to health was a core design principle of Phase 2.

Recommendation: Collaboration with DFAT's other bilateral investments

6. DFAT and PHD Health to strengthen formal links with PARTISIPA, PROSIVU and Nabilan to share knowledge, build on each other's strengths and forge closer connections with a view to driving efficiency, aligning efforts and identifying opportunities for synergy.

3.5.2. Collaboration with other Development Partners

There is an irregular national development partners coordination meeting that is co-chaired by WHO. DFAT has recently handed the co-chair role to USAID. PHD has attended on DFAT's request to support in sharing Australia's work or depending on the agenda. However, the development partner landscape is fragmented. MoH's coordination at national level is challenged, including due a mixture of capacity and the turnover of officials, although it works better during times of crisis (COVID-19). It is important that PHD continues to support DFAT in its lead coordination role and continues to work to harmonise activities.

Partners are needing to respond to the priorities of the new government and the landscape of development partner support is shifting. The World Bank's IDA credit operations are not being continued for Human Development, including in health. The World Bank funded 'Healthcare Action Through Rapid Infrastructure Improvements Project' faced significant challenges and was not approved by the new Timorese administration. This initiative, with its focus on maternal and child

health, aimed to enhance health service delivery in rural and remote areas through additional regional infrastructure (referral hospitals). However, there are a series of World Bank analytical products supported by the DFAT funded Advance UHC program, that are to be completed by early 2025 and will be useful in informing DFAT's new health investment. These include reports on quality of health service delivery, Public Financial Management challenges and opportunities and public health expenditure efficiency.

USAID has recently transitioned away from solely supporting the strengthening of the healthcare system. The new Integrated Health System Activity remains committed to supporting the health system, including governance, financial sustainability and workforce management, with a new focus on MCH, nutrition and FP at national and municipal levels. The Asia Development Bank is currently designing a health facility infrastructure project focused on municipal hospitals, with core hospital standards focusing on infrastructure, medical equipment, health workforce and a clinical services plan.

PHD Health coordinates with development partners at national level, including sharing insights to support designs as well as coordinating to ensure synergistic support thematically. Examples include the proactive engagement with USAID and WHO HMIS advisers including around the establishment of a Health Information and M&E Think Tank, and PHD Health collaboration through attending MoH Technical Working Meetings alongside other partners.

However, there are examples of where coordination could be stronger on the side of PHD Health and the partner in question. For example, PHD's was not able to share its desk-based analysis of MoH's 2023 budget to inform its planning and budgeting for 2024 with MoH and municipal health services as MoH conducted its own municipal budget analysis with support from WHO[17].

3.5.3. DFAT's regional health programs

Australia's health aid to Timor-Leste is very fragmented given the number of funding sources across global, regional and bilateral funding sources. The difficulties for DFAT posts in coordinating across these different programs is well documented[18]. DFAT Canberra is currently funding 29 regional or multi country health investments that include Timor Leste. These include multi-country projects funded through Partnerships for a Healthy Region. These were designed without involvement of country governments and, as such, these organisations are coming in country often with limited existing relationships. They are tending to lean on the PHD Health team as a resource and a source of guidance. DFAT Post is actively managing this, but it is potentially diverting resources away from program outcomes.

3.6. Contribution of PHD Health's Monitoring, Evaluation and Learning

3.6.1. Phase 2's Complexity

PHD Health is a complex program with lots of moving parts and the Review found it challenging to get a clear overview of the program and what it's aiming to achieve. PHD Health used the development of the Health Strategic Plan in 2023 as an opportunity to revise the Phase 2 ToC in the design. Although the design covered all elements of the health system at national, municipal/regional and facility levels there was greater attention to governance, health financing, health information, health workforce and service delivery support. The original ToC in the design had 9 Intermediate outcomes against 3 EOPOs and an objective.

[17] PHD Annual Report 2023-24

[18] Evaluation of Australia's Support to Strengthen Pacific Health Systems 2008 – 2027, Office of Development Effectiveness, 2019

Changes were made during the development of the Strategic Plan. Support for medical supplies, medical equipment, and minor infrastructure were added to the five health system focus areas. The three EOPOs were reframed as Intermediate Outcomes and the design objective was reframed as the EOPO. The 9 IDD Intermediate Outcome were revised to become 36 Immediate Outcomes organised around seven health system areas. The final version of the ToC added 3 more Immediate Outcomes so the final number was 39. The final ToC also differed from the original by being presented by health system level (national, municipal, facility) and by the seven areas of the health system. This makes a total of 21 intervention areas, several of which have more than one Immediate Outcome. Making any revisions to the ToC to reduce complexity would be too much of a distraction given the time left for implementation. The final ToC for Phase 2 is shown in Annex 1.

3.6.2. Other Challenges

Challenges for PHD Health MEL have included:

- The complexity of ToC resulting in the need to track progress against 39 Immediate Outcomes.
- The cross-cutting nature of gender, disability and nutrition meaning that they are not integrated into the overall Health MELF, rather they have separate MELFs adding to the complexity of telling a coherent story.
- A high turnover of staff supporting PHD Health's MEL function leading to a lack of continuity and consistency.
- A change of approach from having resources specifically dedicated to health MEL to using the Facility MEL resources to support sectors. This means there is potential for cross-sector learning but among the disadvantages are the team needing to continually manage competing priorities.
- Not enough oversight of MEL from Abt Global, including providing additional specialist support when needed.
- The outcomes that the Implementing Partners are reporting against can be different from the outcomes in the PHD Health ToC.
- Long delays in the finalisation of the MELF. A key recommendation from the 2022 PHD MTR was that sector level MEL Frameworks and workplans should be finalised. However, the health MELF is yet to be approved by DFAT despite several rounds of revisions and feedback.
- The high number of indicators making the MELF unwieldy. The current draft health MELF has 38 indicators at the EOPO and IO level. This increases to 77 indicators when the gender, disability and nutrition 'mainstreaming in health' MELFs are also considered. Within these the Health EOPO has 21 indicators.
- The MELFs don't appear to track all Immediate Outcomes. The health MELF (including gender, disability and nutrition mainstreaming) doesn't reference Immediate Outcomes 1.1, 1.2., 1.3, 1.4, 1.8, 2.5. and 2.6.
- The FY 2023/24 AWP narrative included milestones against Intermediate Outcomes but the KPIs did not directly map onto the indicators in the MELF. Annex 2 (the detailed health workplan) was activity based linked to outcome statements which differed from the 24 milestone statements in the narrative. Furthermore, planning was against health system area, but reporting was against the national, municipal and facility Intermediate Outcomes, making it very difficult to get a sense of progress.
- Previous lack of tools and team capability for systematic data collection against qualitative indicators.
- MEL is not being to capture key political and contextual challenges facing implementation nor to use progress against milestones to inform management decision making

3.6.3. Progress Made

It is fair to say that MEL has been amongst the most significant challenges PHD Health has faced, despite having a dedicated PHD-wide MEL team. The MEL system has been running to catch up with the continually evolving MELF and planning formats. New tools and approaches are still needing to be developed to track progress against outcomes. Although there is need to work within the restrictions of an overly complex TOC, encouraging progress has been made in streamlining and improving the system.

The use of milestones, introduced in the FY2023/2024 Annual Workplan (AWP), has been developed further in the 2024/2025 workplan. In the most recent workplan activities are linked to both intermediate and immediate outcomes and milestones with KPIs reflecting both quantitative and qualitative indictors in the MELF. There is now a direct line of sight between the outcomes, the milestones, their related activities and the MELF. The summary for 2024/2025 health workplan produced by the MEL team simplifies the AWP by just focusing on the current year and introduces evidence (or means of verification) and lead reporter (PHD team member responsible).

Given the level of complexity the Review supports the milestone-based approach as a sensible step towards prioritisation. Equal progress is not required against all Immediate Outcomes. The approach adds clarity to what PHD Health is aiming to achieve over the remaining life of the program, how success is linked to outcomes and how the program will track progress. The current PHD MEL team supporting the health program recognises the importance of telling a robust story of progress against outcomes, including how PHD has contributed to health system change against milestones, evidenced through qualitative and quantitative performance indicators. This includes, tracking progress compared to the 2022 baseline including the FRA and actions from the participatory diagnostic workshops. This will be important for both for annual reports and the final Evaluation.

To address the need for qualitative alongside quantitative data, in 2023 the PHD MEL team introduced several qualitative tools as part of the Digital Monitoring, Evaluation and Learning system. Insight logs (capturing contributions towards HSS at the national level), Evidence Snapshots (covering the municipality and facility levels) and an Institutionalisation tracker now supplement the existing use of Spotlight Stories (case studies) annexed to progress reports. Since introduction a commendable total of 71 Evidence Snapshots and 81 Insight Logs have been completed by the team. The Review found the Snapshots and the Logs to be overly long and complex. The Insight Log format requires the identification of the relevant Immediate Outcomes but is not linked to milestones and indicators. The current format of the Evidence Snapshot does not link the information to Immediate Outcome, milestone or indicators. Based on the sample reviewed, further work is needed to make them more effective for progress reporting. This qualitative data source is yet to be drawn upon for reporting. This was a missed opportunity. It is very late in the day but the PHD MEL team is simplifying the tools, translating them into Tetum and revising the questions to capture progress against milestones.

In addition, there is work to be done in bringing the Implementing Partners along. PRADET does not have the capability yet to track the extent to which their support has impacted the health system and service delivery, although technical support is being provided. The PHD MEL team is planning to provide MEL training for partners (including Organisations of People with Disabilities or OPDs) on what is required from them at which points in time, and for which milestone / specific indicators data is needed. A new questionnaire is being developed to be completed with partners to capture qualitative data on milestones. Again, this is commendable but it's late in the day to be addressing the capacity needs of local organisations and inducting them on the milestones given that the program only has 18 months to run.

3.6.4. Indicators

The indicators at EOPO level are not within the control of the program but rather reflect the entire health sector. If they were within the program's control PHD Health would be fully accountable for

demonstrating impact on the volume, inclusivity and quality of all PHC services in three municipalities. The indicators do have value as 'context setting' data and are useful for monitoring the context. In addition, the high number of indicators at this level doesn't comply with DFAT's MEL Standards for programs to track progress using a small number of key indicators.

The indicators at Intermediate and Immediate Outcome level are in general appropriate in what they are tracking. The issues are more about the (1) number of indicators not aligning with DFAT's MEL Standards and its focus on a small number of key indicators (2) the number of indicators adding complexity to an already complex program logic and to the difficulty of getting an overall picture of what the program is aiming to achieve and (3) the indicators representing the level of ambition of the program.

Efforts have been made to progressively streamline the milestone approach decreasing the number from 25 in 2023/2024 down to 19 this year. However, the FY2024/2025 AWP also includes 5 gender, 4 disability and 6 nutrition milestones mainstreamed in health, making a total of 34 although there is some overlap. In addition, Annex 2 of the FY2024/25 AWP lists over 60 indicators to track progress. This remains complex and, with the status quo, it will continue to be a challenge for PHD Health to clearly track and communicate progress.

See Section 3.7 for discussion on the program's level of ambition, simplification of the milestones and indicators and the need for greater clarity on what the program is aiming to achieve.

Recommendations: Monitoring, Evaluation and Learning

7. PHD Health be supported to continue to progress with plans to report progress against outcomes and milestones using both qualitative and quantitative indicators linked to the MELF and continue to simplify tools and ensure that clear documentation is available for the 2026 evaluation.

8. PHD MEL and Abt to provide MEL support to the PHD Health team and Implementing Partners as needed to support plans to further strengthen MEL. This will include ensuring that the team has a base level of understanding, including MEL's role, and skills in data collection, analysis and use.

9. PHD MEL and Health (supported by Abt) to reconsider the indicators at EOPO level across the health-related MELFs with a view to selecting a few of the existing indicators as key proxy indicators. Capturing a range of data for context monitoring can be done outside of the MELF.

3.7. Suitability of Strategic Approaches and Activities

3.7.1. Strategic Intent

The Review concluded that PHD Health's strategic approach is the most appropriate to have the biggest impact on health outcomes, and it is recommended that this approach be maintained in the design of DFAT's new health investment. The program's focus on PHC at all levels of the health system is an evidence backed approach that is the foundation for health care service delivery and Universal Health Care[19]. Improvement in PHC services supports reduced demands on tertiary services, improved population health outcomes, improved productivity and ultimately reduced health care costs. The NHSSP 2011-2030 prioritises PHC and the GoTL is committed to UHC at the

[19] WHO Fact sheet on UHC, Accessed 23rd November 2024, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

highest level[20]. The MoH's ESP-PHC serves as the policy document where the MoH outlines the statement of entitlement for the population to seek PHC services as a way to achieve UHC[21].

Strong health systems at all levels are needed to deliver comprehensive and integrated PHC services[22]. Components of the system are inter-dependent and action in one area impacts on others. The program's focus on the municipal / regional level aligns with the GoTL's decentralisation policy to bring services closer to communities. However, the MoH and PHD Health also recognise the role of the national level in addressing the causes of blockages to local service delivery and the importance of engaging simultaneously at this level to build momentum for change.

PHD Health has sensibly prioritised by focusing on the core interventions of SRH, FP, MCH, nutrition, mental health and GBV. These put significant demand on the health system and as such have the potential for significant health gains. Support to the functioning of the health system to affect improvements in the delivery of these services will also impact the broader services in the ESP-PHC.

It is widely accepted that an integrated approach to service delivery is less fragmented and more efficient. The Phase 2 design and implementation reflect this with a strong focus on integration, including through support to INSPTL's coordination function of CPD training. Those interviewed did cite examples of where training could be further integrated although it is recognised that PHD Health expects Implementing Partners to coordinate. The FP Focal Point in RAEOA referred to PHD Health funded GBV training being provided separately from MSITL's FP and emergency response training. On the converse, respondents in RAEOA referred to MSI and PRADET coordinating well at the regional level. The Review is mindful that the model of Implementing Partners providing training separately can imply vertical approaches. Mental health support is provided mainly as a vertical program through PRADET. Within PHD Health support to nutrition is a small program that is mainstreamed rather than integrated with the overall health program.

On balance PHD Health (including Implementing Partners) focuses on supply factors. There is also some support to the demand side barriers to access, including through: the inclusion of community leaders in CHC partnership and coordination meetings; activities related to health providers attitudes and skills such as the suggestion box; outreach services (SISca) addressing lack of information and; Liga Inan. When asked about the biggest challenges they faced all health facilities referred to behaviour change and the need for innovative approaches to encourage community members to seek services. The new design should consider the balance of support between supply and demand side barriers to access building on PHD's successes to date (see Section 4.2).

Recommendation: Strategic Intent

10. PHD Health to undertake an evaluative study to consider the lessons and effectiveness of supported interventions to overcome demand side barriers to inform the new design.

3.7.2. Level of Ambition

Phase 2 was designed as a six-year program (May 2021 to December 2026). However, once approved in 2022 Phase 2 had just over four years to be implemented before the end of the PHD head contract in May 2026. The Strategic Plan to guide the implementation, finalised in March 2023, noted that the focus for the first fifteen months was mainly on establishing the foundations for the

[20] National Health Strategic Plan, MoH 2011

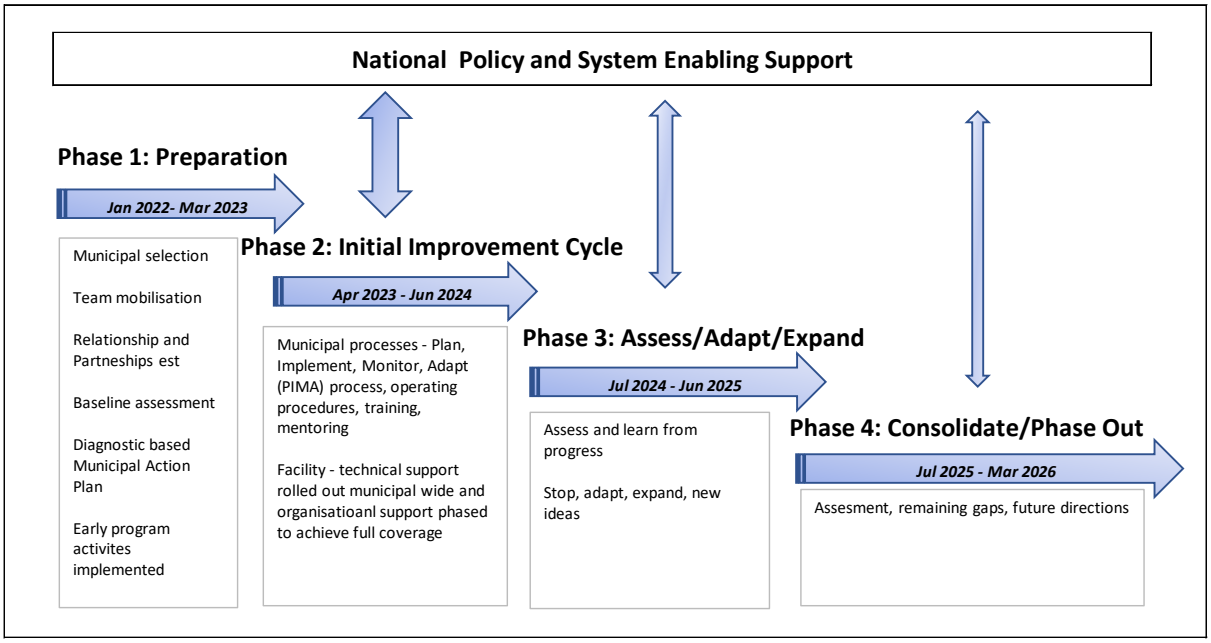
[21] A number of those interviewed referred to the package as aspirational. Reportedly some attempts have been made to cost it and the sentiment is that the final cost would be much higher than the available resources. This will be a factor in the sustainability of PHD Health's support to implementation.

[22] Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020, 9789240017832-eng.pdf

new HSS program approach[23]. With the advent of the Strategic Plan there was three years left to implement (April 2023 to May 2026). The disruption of COVID-19 and the shift from purely service delivery to a more HSS focused program added challenges for both PHD Health and its Implementing Partners. A timeline can be found in Annex 2.

It's the Review's opinion that the design was already ambitious even prior to this shifting timeline, especially given the long-term nature of health systems strengthening, the fragile context and other risks, including the high turnover of staff with every new government. Sustainable change is only possible when support is linked to the pace of change that can be absorbed by the government. The delays added another layer of complexity.

Figure 1: Phased Program of Support for each Municipality. Source: PHD Health Strategic Plan, 2023



The 2023 Strategic plan envisaged 4 Phases as depicted in Figure 1:

- Phase 1: Preparation (January 2022 – March 2023)
- Phase 2: Initial Improvement Cycle (April 2023- June 2024)
- Phase 3: Assess/Adapt/Expand (July 2024 - June 2025)
- Phase 4: Consolidate and Phasing Out (July 2025-March 2026)

Progress hasn't been made at the pace envisaged. The program is still in Phase 2 and has little prospect of reaching Phase 4 in the time remaining for implementation. Under Phase 3 the Plan anticipated the joint analysis of what is and is not working to inform possible next actions and expansion together with the slow withdrawal of national level support. Given the issues with securing government ownership this hasn't happened although it could be argued that this Review is a small part of that.

3.7.3. Phased Facilities

PHD Health has already sensibly reduced the level of ambition by decreasing the number of Phased facilities from seventeen to five. The concept of a Phased approach working more intensively in a small number of facilities makes good sense. Tackling the 'whole system' can be overwhelming and just too complex; smaller is manageable and can provide valuable lessons. PHD Health facilitative

[23] Health Strategic Plan, PHD, 2023

support can provide support to untangle the treads of blockage to a better functioning health system and service delivery.

However, the Review found it difficult to determine exactly what the strategic intent of the Phased facility approach is including what PHD Health is specifically aiming to achieve beyond improving facility readiness. The Strategic Plan does not go down to that level of detail and an analysis of the ToC, the MELF and the FY2024/25 AWP didn't provide needed clarity (see Annex 5). Those interviewed variously described the Phased facilities as pilots, centres of excellence, models, sequencing of effort or trying activities in some facilities. Those Phased CHCs consulted knew they were receiving additional support from PHD citing examples such as the suggestion box and the quarterly partnership and coordination meeting. However, they weren't entirely clear on what the end goal was.

PHD Health needs to more clearly articulate what the Phased facility approach is aiming to achieve, what will be demonstrated, what success would look like and how MEL will be used to monitor and measure progress with a view to ensuring sustainability and replication. In addition, PHD Heath is encouraged to further consider how they will work with the MHS and CHCs to capture the lessons learnt, what has and hasn't worked, barriers and what needs to be place for success such as MoH commitment. This will support the expansion of the Phased facility approach either during the remainder of PHD Health or in the next health program if there is agreement to continue with the approach. It will also support the end of facility evaluation.

Recommendation: Phased Facilities

11. PHD Health to more clearly articulate the strategic objectives of the Phased facilities, including what success will look like and a systematic approach to tracking progress. Work with MHS and the Phased facilities to capture what is working, lessons learned and constraints against the strategic intention. This will support replication and serve as an input to the evaluation.

3.7.4. Milestones

The Review found that overall, the milestones for FY2024/25 and FY2025/26 are complex and have a high level of ambition that is, in some cases, unlikely to be realised given current progress and the prevailing context. A number of those consulted expressed desire for the number of supported municipalities be expanded. It is the Review's opinion that the strategy for this needs to be considered with the MoH as part of the new design of Australia's next health investment. Given the level of ambition of the program, now is not the time to expand at the municipal and facility level and decrease national level support.

The focus for the remaining period of PHD Health needs to be on consolidation and what can realistically be achieved before the end of the program building on progress to date and the current political context. Given limited resources and time constraints, concentrating efforts on priority areas offers the greatest potential for impact in alignment with the ToC.

Recommendation: Milestones

12. PHD Health to focus on consolidation rather than expansion. This will include reinforcing progress to date against outcomes including the foundational health system strengthening work for the new health design to build on.

As well as being ambitious, the milestones also vary in their complexity. There are some which are at the output level, for example HM.12 with its reference to the number of clinical educators starting to deliver FMP training for the FY2024/25. Others are broad and lack specificity in their intent. Examples include HM 13 under workforce or HM18 under Service Delivery. Both milestones are related to Immediate Outcome 3.9 (facilities healthcare workers have strengthened PHC clinical and SBCC capacity) and refer to capacity to deliver SRH/FP, mental health, MCH, nutrition and disability-

inclusive health services. Both HM13 and HM18 have a significant number (nine) performance indicators each, cover a range of different technical areas and have several Implementing Partners (including UNFPA, MSITL and PRADET). The Review found them to be unspecific.

Other milestones for FY 2024/25 and FY 2025/26 are too ambitious given the prevailing context. For example,

- HM07 - Health Information milestones linked to HIO1.5 are too ambitious and not achievable given the number of new staff, including at a senior level, in the MoH's M&E and TLHIS Departments. The priorities of the PHD Health M&E adviser should be to consolidate previous achievements and upskill the new team including to socialise the PHC M&E Framework. As recognised by the PHD team, there is a need to lower expectations and the timeline for deliverables.
- HM10 - Health workforce milestones linked to HIO 1.12. For the INSPTL to be resourcing and implementing the training strategy by the end of the program is unlikely to be achieved given the minimal progress with the strategy to date and the need for INSPTL to strengthen its institutional capability and governance mechanisms.

Recommendation: Milestones

13. PHD Health, supported by PHD MEL (and Abt) to review the 2024 / 2025 workplan through whole team strategic discussion to simplify and prioritise the milestones, review their level of ambition given the current context and be clear and realistic on what success means for the program by 2026. Focus on what can reasonably be expected to be absorbed by the MoH, ensure that activities are aligned to the revised milestones and there is a balance of focus between national, municipal and facility levels.

Suggestions related to the milestones include:

- Health Information. Shift focus from secondary and tertiary care back to the PHC M&E Framework, its integration into the TLHIS and embedding its use at national, municipal and facility levels. Priorities to include socialisation of the M&E PHC framework, TLHIS forms updated with new indicators and in use, quality of data improved, MoH's M&E and TLHIS teams working better together and PHD support harmonised with the support provided from other development partners.
- Health Financing. Build on successes to date supporting Dili, Ermera and RAEOA to improve and use knowledge and skills to develop and resource their annual workplans, linking planning to budgeting and accessing all available resources from a variety of sources.
- Health Governance. Build on success to date with the quarterly review and coordination meetings in Dili, Emera and RAEOA, including at Phased CHC levels. Priorities include working with the enabling environment so that they are independently organized and sustainable, and MHMTs use the forum to facilitate solutions to heath system issues effecting PHC service delivery.
- Medical Supplies and Equipment. Continue to focus on the functionality of mSupply so it is operational and being used for quantification and forecasting. Objectives could include X% of health facilities using the system and routinely entering data so that the MoH has sight of consumption data to forecast and inform their allocation of funds for procurement of essential medicines and consumables.
- Service delivery. Separate out FP/SRH, MCH, nutrition, mental health and disability in the current milestones. Focus on what is achievable under each element, recognising that nutrition is a small investment.
- Health Workforce. Continue to prioritise the FMP and the clinical and non-clinical in-service (CPD-IPHC and ISDP) training as key foundational activities for Australia's future health

support. Clarity around who will be targeted for the leadership and management training (MHMT, DPHO, facility staff etc) to ensure maximum impact.

3.8. GEDSI

Achieving UHC - so that all people have access to the health services they need, when and where they need them - fundamentally means addressing inequalities and the social barriers that shape people's health status and influence their access to healthcare. With DFAT's long standing policy commitment to supporting gender equality and disability equity and rights, women and girls and people with disabilities are priority populations and their interactions with the health system are important to understand.

Health systems are said to 'often fail people with disabilities',[24] and in different ways given the diversity of disabilities. Some barriers that are commonly faced, irrespective of impairment, include:

- Discriminatory attitudes among healthcare workers which hinder service provision
- Inadequate knowledge among providers to meet general and specialist care needs
- Lack of awareness or respect for autonomy and consent
- Lack of outreach to adults and children with disabilities who are more likely to be at home
- Limited availability of essential services that people with disabilities need such as rehabilitation and assistive technologies

In the case of women, girls and people of diverse gender identity, a range of social dynamics are also formative on their health outcomes. These include patriarchal gender norms and differentials in gender power relations - such as reduced bodily autonomy especially in relation to SRH and FP, and to the prioritisation of ANC and maternity health care seeking - shape susceptibility to illness, health risks, and access to appropriate and affordable health care.[25] The health system is not gender-neutral by design, even if it takes scrutiny to reveal it.

Across the HSS building blocks, the explicit prioritisation and championing of gender equality and disability equity and rights is therefore needed to address these barriers and influences. PHD Health's ambition, approach to and resourcing gender equality and disability inclusion has varied over the course of Phase 2. The strengths and challenges identified at this point in time are discussed in the section below, with recommendations for the remainder of Phase 2 and for the new design provided separately.

Strengths:

Gender equality and disability inclusion have strong endorsement as priorities for action under Phase 2 of PHD Health. They are explicitly integrated into the following foundational documents:

- In the Phase 2 Heath design EOPO1 includes reference to 'inclusive' primary health care as a national level outcome, and EOPO3 is geared to the delivery of 'quality and inclusive Essential Service Package to catchment populations, including women and girls, people with disability and the poor'[26]. The design also provides for the recruitment of a Coordinator – Gender and Disability Inclusion to support MoH on gender and disability activities in the PHD Health design.
- Gender equality and disability equity are 1 of 4 Key Cross-cutting Priorities of PHD Health.

[24] Kuper, H, Azizatunnisa, L. et al. Building disability-inclusive health systems, The Lancet, May 2024, 9(5), E316-E325.
[25] Achrekar, A. Akelsro, S, Clark H. et al. Delivering health for all: the critical role of gender-responsive health systems, The Lancet, May 2024, 12(5), E733-E734
[26] PHD Health Investment Design Document (2021)

- Gender equality is a significant objective of PHD, and gender equality and disability equity markers have been used against milestones in the annual workplans for PHD Health.

A strength of the PHD Health approach to gender and disability is recognition of the distinctive health experiences, priorities, and networks representing women and girls as compared with people with disabilities - as highlighted above - and programming them as separate streams, rather than an integrated 'GEDSI' approach (where a gender focus tends to dominate).

PHD Health is an instructive example of the benefits of dedicated resourcing for disability equity. The IDD specified that PHD Health should access funds from the 3 per cent of the annual overall PHD budget allocated to disability resourcing (AUD900,000 over 5 years, or AUD180,000 annually). The summary budget for Financial Year 2025 highlights the continued facility-level prioritisation of disability, with 5 per cent allocated to it (AUD 1.04 million) as compared with 1 per cent allocated to gender (AUD 185,223). This has enabled PHD Health to have more and more senior disability-designated roles within the program as compared with the staffing for gender, and it has had formal, funded partnerships with three Timorese OPDs (including *Ra'es Hadomi Timor Oan* (RHTO) and *Asosiasaun Defisiénsia Timor-Leste* (ADTL)). Local women's organisations are not direct partners in PHD Health delivery, despite provision for this in the design.

It is clear from the history of PHD facility-level Investment Monitoring Report ratings for gender and disability, averaging a score of 4 and 5 out of 6, respectively, and from PHD's self-assessments that disability efforts have generated stronger outcomes. [This has been up until the end of 2023, when the relationship with the Ministry of Social Solidarity and Inclusion ceased after the cancellation of the Social Protection program. This will pose challenges for future work on disability equity and rights, as addressed below.]

In terms of gender equality under PHD Health, there are important aspects to commend. Foremost is the significant and continued funding to MCH health services that only women and girls need, alongside support to women-centred GBV and SRH/FP service provision. This has endured since Phase 1. With Timor-Leste's globally high lifetime prevalence rates of physical, sexual and psychological violence (35 per cent), lower levels of women's access to modern contraception methods met (46.9 per cent), high maternal mortality ratio (142 per 100,000 live births) and adolescent birth rates (42 per cent)[27], these priorities are entirely defensible for a PHC program in Timor-Leste. UNFPA and MSITL are strongly of the view that the MoH is not yet ready to assume management of these services - and this view predated the recent restructuring and staffing changes within the MoH. It is also notable that PHD Health accepted this advice rather than discontinuing funding or compromising these programs in a premature handover to government.

PHD Health has also demonstrated responsiveness to the government own priorities by supporting the implementation of MoH's obligations under the National Action Plan on Gender-Based Violence (NAP GBV) 2022-32 and the Convention on the Rights of Persons with Disabilities.

A final strength of PHD Health's gender and disability efforts is that its activities cover each of the six HSS building blocks, as is shown in Table 2. This has been mapped by the Review team based on information provided by the PHD Health team and program documents.

Gender and disability activities against the six HSS building blocks

Leadership and Governance

- Direct engagement by PHD with MoH to support implementation of its commitments under the NAP GBV and DNAP.

[27] Timor-Leste Health Sustainable Development Goal: Factsheet. World Health Organization. Undated.

- Support to MoH's quarterly gender working group through UNFPA, with MSITL, PRADET and Nabilan focused on improved service delivery across the 3 focus municipalities.
- Collaboration with CBM Australia to support MoH to map its sector obligations under the Convention on the Rights of Persons with Disabilities.

Service Delivery

- Support for facility readiness improvements at 5 CHCs via disability accessibility audits and minor infrastructure modifications such as ramps, handrails, accessible doors, and toilets (including Gleno CHC, and 3 CHCs in Dili).
- Refurbishment of 'safe spaces' for discrete and confidential GBV-related service provision (Vera Cruz CHC supported by Maluk Timor).
- Support to accessibility and GBV safe spaces in 7 CHCs and upgrading of 20 existing maternity clinics through UNFPA.
- Support the development of a Standard Operational Procedure for mental health case referral, and the training of related case management among providers in 13 municipalities.

Health System Financing

- Dialogue with MoH (and MoE) to increase the sectoral budget allocation for NAP GBV implementation, with USD17,195 being allocated in 2024 to safe spaces in health facilities.
- Facilitated discussion between MoH, SEI and MoF to create a dedicated budget code for GBV service delivery in health within the state budget.
- Worked with MoH PFM advisers on budget execution for GBV service provision at the facility-level in all 3 sites.
- Support to INSPTL budget execution of the USD24,000 allocated for disability inclusive health training with RHTO (74 health providers across Manatuto and Oecusse).

Health Workforce

- Support to RHTO to forge and now renew an MoU with the MoH.
- Engagement of OPD RHTO to develop and conduct training of INSP-TL on disability inclusive health. Four trainers are still active.
- Engaged RHTO to partner within INSPTL to train 625 health providers across 9 municipalities in disability inclusive health.
- Training of midwives and doctors on SRH/FP by MSI-TL.
- EmONC training of municipal and facility-level health providers which includes content on respectful maternal care and GBV service provision, by UNFPA.
- Family planning training of health providers which includes content on male engagement in women accessing care by MSITL. This totals 80 providers across 45 facilities in 9 municipalities, funded by PHD.
- Incorporation of GBV in Operational Guideline for Integrated SRH Services in PHC, implemented in 7 CHCs, by UNFPA.

Medical Products, Vaccines and Technologies

- Clinical equipment and non-clinical commodities for SRH/FP service provision by MSITL.

Health Information Systems

- Support to the integration of 15 disability inclusion indicators and NAP GBV indicators into the national PHC M&E Framework. These are yet to be rolled out in the MoH Annual Action Plan.

- Commissioned study on barriers and drivers to accessing MCH, SRH and GBV services (Dili, RAEOA) by UNFPA in 2024, and study on Disability Inclusive Health Services Evaluation Report by Alinea in 2024.
- Translation of the Washington Group disability identification screening questions into Tetum.
- Support MoH in the adoption of the child disability screening tool developed for the now-cancelled Bolsa da Mae Jerasaun Foun (BdM JSF) program, supported by PHD Social Protection Pillar.
- Conducted a gender analysis of 86 healthcare facilities across the 3 municipalities as part of PHD Health's baseline assessment, with 9 recommendations for action.
- Establish a health information and communication board to promote healthcare facilities to people with speech and hearing impairments.

Challenges:

Despite the efforts and results described above, this Review has surfaced several GEDSI-related questions and challenges for PHD Health.

Foremost is that the Review ultimately found it challenging to assess the extent of progress against gender equality and disability inclusion at the *outcome-level*, and to draw conclusions about the contribution of partner and PHD staff efforts on gender and disability to *'inclusive' HSS*. Several stakeholders consulted for the Review expressed a similar sentiment, with one noting, 'I think there is a lot of good GEDSI work going on, but the program cannot tell a coherent story.' Whether this is a result of lagging progress or lagging reporting is not entirely clear. However, this comment links to a range of Review findings including onstrategic direction setting, leadership and expert resourcing, and the MELF supporting the gender and disability efforts, which are discussed below.

- **Strategic direction setting broad and late in the program:** The facility-level Gender Equality Strategy 2022-2026 and the Disability Equity Strategy 2023-2026, with coverage of the health program, are appraised by this Review as excellent quality context, policy analysis and guidance on principles and approaches. The goal of the Gender Strategy is to 'mainstream gender equality in PHD's institutionalisation of service delivery improvements'. It emphasises strengthening the supply of appropriate and accessible services and addressing constraints to access. It also highlights the need to address violence against women as 'a foundational barrier to inclusive services', as well as elevating attention to women's leadership and decision making. Intersecting identity factors such as gender identity and sexuality, age and rural residence are also highlighted as compounding gender-based barriers. The Disability Equity Strategic has mirror image goal and objective statements, focused on disability inclusiveness. However, it foregrounds a twin track approach with both targeted and mainstreaming efforts, as well as an emphasis on partnership with OPDs, data, do no harm standards, and policy dialogue and advocacy. The strategy is aligned with implementation of the CRPD and the Disability National Action Plan (DNAP).

  However, both strategies were released in 2023 – more than a year after commencement after which many funding decisions had already been made. Furthermore, these strategies are pitched at the facility-level and so require conversion to an action plan tailored to PHD Health. The overall PHD team have noted finding these strategies 'quite broad' and so need honing in order to support implementation. This adaptation usually requires experienced, specialist gender and disability skills and it is not clear if the Dili-based GEDSI team has had the time or specialist background to do so. This is likely to be one reason why there are questions about the coherence of the GEDSI approach, and limitations in being able to link activities to Intermediate Outcomes and EOPOs.

- **PHD facility model has had implications for GEDSI progress on health:** The choice of facility modality has also arguably made it harder for PHD Health to achieve and/or report on GEDSI

outcomes. A feature of the facility model is that flexibility is built in at the design stage, and that program elements such as the MELF are developed and refined throughout implementation. This has resulted in different sequencing in the development of the MELF versus the strategy documents for gender and disability equity and rights. They are not integrally linked. This has resulted in a lack of coherence and connection between the PHD Health MELF 'milestones' relating to gender and disability, and the outcomes articulated in the strategies. Furthermore, the MELF does not disaggregate data by gender or disability, making progress for women and girls and people with disabilities under EOPOs 1 and 3 virtually impossible to measure and be accountable for.

- **Lack of a foundational analysis of gender and disability HSS entry points:** GEDSI review of PHD Health has been challenging because there of the need to mine a considerable range of documents to piece together what has been implemented and achieved. There is no consolidated, current overview of the GEDSI work. PHD Health has produced quality analysis and studies on gender and disability in Phase 2 (listed in Table 2), but what is missing is a foundational mapping of gender and disability entry points against the six HSS building blocks with links to achieving the Intermediate Outcomes and EOPO. If undertaken now, it could build upon the content of Table 2 and serve as both a stocktake and planning tool for the remaining period. It would be useful for team reflection on the political will and receptiveness of the MoH to the activities implemented to date, on which activities have the greatest potential for beneficiary impact and achievements against the Intermediate Outcomes and EOPO.
- **Fragmentation of strategies, ToCs, MELF plans, and workplans:** Review of the 'guiding' GEDSI documents – namely, the gender and disability strategies, separate MELF and annual workplans – highlights the following key issues:

    1) The lack of a clear thread or coherence in the gender and disability objectives, indicators and milestones between these guiding documents
    2) The separate MEL frameworks for disability and gender have complicated milestones, are not well integrated with the overarching MELF, and include indicators that do not relate to the activities being implemented such as supporting women's leadership in the health sector.

    An example of the lack of coherence follows from the gender documentation:

- **Gender Strategy Indicator relating to GBV:** Services contribute to gender equality and the prevention and response to VAWC, including use of referral pathways.
- **Related objective in the Gender ToC:** Services contribute to gender equality and the prevention and response to VAWC, including use of referral pathways (GE-03)
- **Related milestone in the overarching Health MELF:** 3.14 Facilities provide gender-sensitive health services (There is no GBV-related indicator).
- **Related milestone in the Gender MELF:** We will see PHD supporting MoH and MoE in their in coordination with SEI for implementation of the NAP-GBV through budget analysis and brokering dialogue (KCP2.1). Instances of MoH and MoE coordinating with SEI on NAP-GBV implementation.
  (KCP2.2)

The example above highlights the differences between the objectives, indicators and milestones relating to GBV (as well as ending violence against women *and children* (VAWC)). It is also not well linked with the activities being implemented such as the establishment of safe spaces in CHCs, and integration of GBV in workforce training and service guidelines.

Some milestones are also multi-faceted and complex to interpret, such as 'We will see evidence on past program performance on advancing gender equality inform design of PHD activities and advocacy agendas (KCP2.2)'. Reducing the number and streamlining the formulation of milestones is recommended for the final year. With the separate gender and disability MEL frameworks, there is currently limited mainstreaming in the health MELF itself. An integrated MELF is recommended for the new design and would be a stronger tool for driving mainstreaming, disaggregated data collection, and consolidated reporting on program outcomes.

- **Flux in GEDSI management and specialist staffing:** As with many programs, PHD Health has changed its staffing profile on gender and disability over time. However, at the facility-level, it is notable that there has been GEDSI staffing flux, including departures in two key roles (Gender Manager and Disability Focal Point), a long-term vacancy in a senior Performance and GEDSI Lead position, and the relatively late formal engagement of the Abt Global Senior Gender Specialist in 2024 at the facility-level. With the cancellation of the Social Protection program, PHD's Social Protection Lead was redeployed as the GEDSI Lead (an assessment of their GEDSI advisory background was not made). However, there has been limited internal GEDSI training for the team, as envisaged by the Gender Equality and Disability Equity Strategies. CBM International was funded by DFAT Canberra and was involved in data collection and advisory inputs such as review of the Maluk Timor modules across Phases 1 and 2, although this contract has concluded. This variable access to GEDSI expertise within PHD Health - especially on gender and at senior levels - has had implications for the strategic direction and coherence of the work. It is arguable that this is the reason why many of the excellent programmatic and internal capacity building activities proposed in the Gender Equality Strategy (see its Annex 2) have not been implemented, with missed opportunities including support to women's leadership in the healthcare workforce and improving workplace policies for women in the MoH.

  Right now, the team in place for PHD Health includes 0.5 FTE for a gender mainstreaming adviser and 1.0 FTE for a Senior Coordinator for Disability. There is some access to the PHD GEDSI Lead and to the Abt Senior Gender Specialist who has been engaged for 60 days of STA, with 20 days for in-country visits. It would be valuable to confirm inputs from the Senior Gender Specialist early in 2025 to help the program focus its last 12+ month GEDSI workplan.
- **Coordination with DFAT and bilateral programs:** Coordination efforts are worth reviving for the remainder of the program. Since the change of government in 2023, the quarterly forum with the MoH which involved PHD and Nabilan has lapsed. Meetings between the two programs have been occasional since 2023, and their overlapping work on GBV with the MoH means it is important to schedule. This is especially in light of both programs funding PRADET's work on medical forensic examination (noting uncertainty around this NGO's ongoing permission to work with the MoH). The quarterly Kalibur network meetings whereby DFAT convenes the GEDSI focal points of all bilateral programs is useful for updates, but not sufficient for joint approaches and advocacy.

  A forthcoming issue where it would be useful to speak with one voice to the MoH is on the parallel conduct of DHS with its GBV module and the second VAW prevalence survey slated for 2025. The DHS approach to measuring VAW prevalence typically results in a lower prevalence rate than the WHO-validated VAW methodology which Nabilan applies. (NB The last time these surveys were conducted in Timor-Leste, it was a disparity of 20 percentage points on the lifetime prevalence of physical and sexual violence, at 37 per cent versus 59 per cent, respectively). It would be valuable for PHD Health and Nabilan to be aligned on the explanation for this measurement disparity and how to support the MoH to interpret and respond to VAW.

With respect to DFAT, it is noted that management of PHD is distributed between three A-based First Secretaries. The structure means that there are limited opportunities for the DFAT PHD GEDSI focal point to be across the health and education components, and 'intervene for GEDSI' at formative points. Arrangements that foster more regular debriefing and planning would be valuable.

- **Engagement with grant partners on gender and disability:** The Review consultations elicited great support for the PHD Health team's work on NAP GBV and on bridging and supporting the engagement between MoH and RHTO. However, in terms of GEDSI mainstreaming, partners highlighted that GEDSI advisory interaction was limited. One partner suggested that it tended to be most intense at reporting time and focused on eliciting examples. Two partners affirmed that they would welcome working at a more strategic level with a PHD gender or disability advisor, with a preference for someone based in Dili and with Tetum language. Two partners also noted that there would be value in implementing partners meeting as a group with the PHD Health team, to contribute to overarching strategy and advocacy, rather than solely having a discrete, grantee connection.
- **Need for follow up and monitoring of quality:** PHD Health's work on building CHC support for and establishing safe spaces to receive, respond to and provide onward referral for women and children experiencing violence is to be credited. The Vera Cruz CHC is the most developed model and has data to show it is serving clients, however the Review team was not able to visit it due to staff being unavailable with clinical demands. The Review team encountered variation in the fit out and security of these safe spaces in three CHCs visited, and the allocation of health staff and their GBV training level. Two of the four CHCs reported no cases to date. (Please see the facilities checklist audit in Annex 4). With a view to the remainder of PHD Health and the new health design, municipality-level visits to follow up on the functioning and quality of PHD Health-supported initiatives such as these safe spaces is imperative.
- **Limited focus on intersectionality**: DFAT's guidance on gender equality and disability equity and rights encourages attention to 'intersecting' discrimination, and how subgroups such as women with disabilities or unmarried girls may face particular and compounding barriers. Notably, PHD Health undertook a Phase 1 study on women with disabilities and their access to SRH and FP services. However, there is limited reference to target populations in Phase 2. This is worth considering in the new health design, and as part of focusing efforts and resources.
- **Investment in indicators but data not collected yet:** It is notable that PHD Health has been successful in working with the MoH to develop 15 inclusive health indicators for the PHC M&E Framework. At this stage, the indicators have not been implemented. This does not detract from the achievement in eliciting MoH endorsement for these measures. However, the imperative remains for these indicators to be implemented. The MoH is yet to do so, and this would be a worthwhile focus of GEDSI effort for the remainder of Phase 2

3.9. Lessons Learned

Support across all levels of the health system. PHD Health's approach of embedding technical advisers at the national level while the HSS Roving Team provides technical support at the municipal level has facilitated system change. Through this structure PHD Health is able to use a bottom-up approach to resolving system bottlenecks. For example, when Ermera received less funds from central MoH than budgeted, the municipal team was able to work through the Municipal Budget and Financial Management Advisor P to determine the bottlenecks and facilitate dialogue between municipal and national levels that would not have taken place otherwise. PHD Health should

continue to focus on this bottom-up approach, recognising that not all health system issues can be solved at the local level.

Program Coherence. The 2017 Review found limited coherence within the portfolio of RMNCH investments. The HSS approach of the Phase 2 design sought to unify the investments and refocus the program. This has been successful to a certain extent, but the program remains complex with its new HSS focus being blended with service delivery, health sector supports, and ongoing institutionalisation of legacy investments inherited from DFAT at the start of the program. This has proved to be a challenge for a clear ToC and effective MEL.

Government Engagement. Although MoH jointly designed Phase 2 with DFAT, staff changes since July 2023, at all levels have been significant and are ongoing. These constant changes in personnel require ongoing briefing and re-education. Staff churn has significantly challenged all aspects of the program. The success of Liga Inan is partly because the platform had a broad base of support and Catalpa worked to build coalitions, reach the new staff through existing supporters and use both informal and formal communication channels.

Political Economy. Sustained change to underlying systemic issues takes time and requires close monitoring of the political economy dynamics. Developmental change is fundamentally political and linked to deeply entrenched power structures, bureaucratic norms and local political dynamics. Annex 5 of the Phase 2 Design records lessons learnt by the USAID REINFORCE program that aimed to build stronger health service capacity with Covalima as a 'model' municipality. The design highlights how the lessons from REINFORCE demonstrate the importance of high quality, politically and contextually informed problem-solving approaches to unblock service delivery constraints. This was the approach that PHD Health integrated into its 2023 Strategic Plan.

Sustainability and Government Ownership. Working at the pace of local stakeholders is crucial for achieving sustainable system change because it aligns efforts with the capacity, priorities, and institutional dynamics. This approach ensures that changes are both feasible within the existing system and owned by those responsible for long-term stewardship. Working in support of government processes takes time and considerable collaboration. A key challenge for PHD Health is to firmly establish practices that ensure initiatives and processes are sustainable, allowing PHD Health to gradually step back. These include having no fixed timeframe around initiatives to support health reform including organisational change and the provision of scaled technical and financial assistance during transition Phases to bridge capacity gaps.

Institutionalisation. The transition of services to GoTL management has been a significant area of work for PHD Health under Phase 2 at a time when the program is positioning itself to address constraints in the service delivery system. Capacity, financial commitment and policy alignment are all essential for any transition. Experience shows these elements are inextricably linked to the changing context. The allocation of sufficient resources in the budget is the best indicator of government commitment. Experience dictates that following questions: To what extent can a similar level of system functioning or service delivery be maintained following the transition, given the enabling environment? Does there need to be a readjustment of expectations?

Lessons Learned through the 2017 Review of Australia's Health program are in Annex 6.

4. Recommendations

4.1. Recommendations for PHD Health Phase 2

Setting Priorities

1. Within the context and the political economy dynamic, DFAT and PHD Health to work together to establish clearer parameters and boundaries around being responsive, including being clearer on difference between being flexible versus being reactive and what that means practically for the program.

Ways of Working

2. Political Economy and the PIMA Improvement Cycle: PHD Health to conduct formal PEA orientation and applied training for all the program team supported by ongoing advice/mentoring from PHD and Abt. This was planned for in the Health Strategic Plan but never eventuated. This should reflect the changes in the political economy, ensure the team are provided with methods and techniques to assist them think and work politically in their everyday work and enable a more structured approach to operationalising and integrating PMIA and PEA throughout implementation.
3. Balance of Time Between National and Municipal Levels: PHD's Health Municipal team to maxmise time spent in municipalities whilst ensuring all efforts are utilised effectively and strategically. This will enhance opportunities to provide technical support to the MHS, facilities and to the Municipal Coordinators and maximise progress towards outcomes.
4. Working through Implementing Partners: PHD Health to review its ways of working and identify opportunities to foster stronger partnerships with the Implementing Partners and consider how it can better facilitate their relationships with MoH at national and municipal level as appropriate.
5. Maluk Timor and INSP-TL: PHD Health PHD Health, DFAT and Maluk Timor to have an open and honest discussion to identify the root causes of the lack of progress, discuss the prevailing political economy and work as partners to strategically consider innovative solutions and entry points to 'nudge' forward. There may be opportunities for PHD Health to build ownership and buy-in through the Health Lead's position on the INHPTL board or the Manager, Organisational Development who is embedded in INSPTL.

Collaboration with Development Partners and DFAT's Other Bilateral Investment

6. DFAT and PHD Health to strengthen formal links with PARTISIPA, PROSIVU and Nabilan to share knowledge, build on each other's strengths and forge closer connections with a view to driving efficiency, aligning efforts and identifying opportunities for synergy.

Monitoring, Evaluation and Learning

7. PHD Health be supported to continue to progress with plans to report progress against outcomes and milestones using both qualitative and quantitative indicators linked to the MELF and continue to simplify tools and ensure that clear documentation is available for the 2026 evaluation.
8. PHD MEL and Abt to provide MEL support to the PHD Health team and Implementing Partners as needed to support plans to further strengthen MEL. This will include ensuring that the team has a base level of understanding, including MELs role, and skills in data collection, analysis and use.
9. PHD MEL and PHD Health (supported by Abt) to reconsider the indicators at EOPO level across the health-related MELFs with a view to selecting a few of the existing indicators as

key proxy indicators. Capturing a range of data for context monitoring can be done outside of the MELF.

Suitability of Strategic Approaches and Activities

10. Strategic Intent: PHD Health to undertake an evaluative study to consider the lessons and effectiveness of supported interventions to overcome demand side barriers to inform the new design.
11. Phased Facilities: PHD Health to more clearly articulate the strategic objectives of the Phased facilities, including what success will look like and a systematic approach to tracking progress. Work with MHS and the Phased facilities to capture what's working, lessons learned and constraints against the strategic intention. This will support replication and serve as an input to the evaluation.
12. Milestones: PHD Health to focus on consolidation rather than expansion. This will include reinforcing progress to date against outcomes including the foundational health system strengthening work for the new health design to build on
13. Milestones: PHD Health, supported by PHD MEL and Abt Global, to review the 2024 / 2025 workplan through whole team strategic discussion to simplify and prioritise the milestones, review their level of ambition given the current context and be clear and realistic on what success means for the program by 2026. Focus on what can reasonably be expected to be absorbed by the MoH, ensure that activities are aligned to the revised milestones and there is a balance of focus between national, municipal and facility levels.

Additional Recommendations to Inform the 2026 Evaluation

14. The evaluation team to be provided with a comprehensive overview of the program (Phase 1 and Phase 2), including team and implementing partner roles and responsibilities, receive one package of priority documentation, and adequate time is allowed for consultation given program complexity.
15. PHD Health to work alongside the MoH in 2025 as planned to track and document progress against the 2022 baseline assessment and actions from the participatory diagnostic workshops. This will include a full FRA across the three municipalities in conjunction with MoH quarterly supervision visits. It will be an essential input for the 2026 PHD Evaluation to assess progress against the 2022 assessment.

4.2. Recommendations for the next Phase of Australia's bilateral health investment

Recommendations for the new Health Design: Discussion

1. **To support government-led strengthening of the health systems needed for the delivery of quality and inclusive decentralised primary health services**

   Timor-Leste's Constitution provides for an administrative decentralised system of government. Parliament approved Law No. 23/2021 on Local Power and Decentralisation in November 2021[28]. Authority and responsibility for delivery of PHC is gradually being shifted to Municipal and Regional Health. The new health investment should support this process

[28] https://www.mj.gov.tl/jornal/public/docs/2021/serie_1/SERIE_I_NO_45.pdf

and work with decentralised health and administrative structures to address the challenges for the decentralisation of health services with a focus of PHC. There will be opportunities, for example, to support PFM bottlenecks through the PFM decentralisation process.

2. **To continue to work at all levels of the health system recognising that many of the health system constraints identified at municipal and facility levels need national level solutions**

   The new investment has the potential to facilitate bottom-up pressures on central ministries to deliver better support and improve municipal-national coordination to help address health sector institutional constraints, for example in health financing, technical support and supervision. In this way local level constraints should inform national level technical support.

3. **To adopt a clear strategic approach, with a realistic level of ambition, for expanding to other municipalities, responsiveness and sustainability**

   Any phasing and sustainability plans need to be based on lessons learned and an understanding of the risks, especially the critical issue of high staff turnover and the long-term economic outlook noting that the 2027 election will coincide the start of the new program. The design should include a clear strategy for transitioning of support to MoH management or indicate that this will be an early activity during inception. Criteria for scale up beyond Dili, Emera and RAEOA should be developed with the MoH during design, or early in implementation. In addition, the design should include a strategic approach to responding to MoH priorities so that any responsiveness is planned and not reactive. This may involve consideration of including an outcome related to health security and health threats.

4. **Build on previous successes and past investment including the foundational work under Phase 2 of PHD Health**

   It is crucial for the design to build upon the substantial groundwork laid during PHD Health Phase 2, ensuring continuity and maximising the potential for further progress. This includes the structured support to the MHMTs, the lessons generated through the Phased facilities, the substantial capacity building of health workers and managers (including through the Implementing Partners, the clinical and non-clinical in-service training CPD-IPHC & ISDP), FMP, PFM, supply chain management, monitoring and health information management. PHD Health's support has also generated a significantly enhanced understanding of the blockages to improvements in health service delivery at local levels, with experience of working with both the supply side factors and the demand side barriers.

5. **To consider with the MoH whether the leadership and management CPD training needs to extend to the national level**

   The review heard considerable support for the leadership and management training at municipal and facility levels with references to clinicians needing these skills, including on supportive supervision, for better management of infrastructure, equipment and supplies, using information, planning and delivering services and coordinating resources for implementation. A number of those interviewed also referred to the need to strengthen governance, leadership and accountability at the national level.

6. **To be informed by a landscape analysis of other development partners health investments and identify possibilities for connection and joint working with DFAT's other bilateral programs**

It is important that any new investment works closely in partnership with other investments, harmonises and creates synergies wherever possible. This includes development partners current and planned programs and DFAT's bilateral programs such as PROSIVU, PARTISPA and Nabilan. PARTISIPA is a key partner for DFAT's new health investment given their critical role in supporting the decentralisation of service delivery. Partnerships should be formalised through the Scope of Services for new head contracts and Memorandum of Understanding between programs with workplans that identify points of intersection, synergies and mutually agreed areas of joint action. The bilateral programs should regularly review progress against the joint workplans and participate in each other's planning and reflection exercises.

7. **To integrate climate change and consider including climate and health focused interventions**

   The design should build on and leverage some of the ongoing work in the sector, led by WHO, and ensure that the strategic approach is informed by the Health National Adaptation Plan for Preventing Health Risks and Diseases from Climate Change (2020-2024). WHO has also supported the GoTL to develop a Climate Resilient and Environmentally Sustainable Health Care Facilities Policy and is in the process of undertaking Climate Vulnerability and Environmental Sustainability Assessments of Target Health Care Facilities

8. **To consider enhanced focus on politically and contextually informed problem-solving approaches to unblock service delivery constraints**

   Constraints are more straightforward where solutions are known, the challenges are simpler and where inputs and outputs can be defined. Complex persistent problems with multiple stakeholders lend themselves to a problem-based approach facilitating MoH to identify and solve problems. A facilitated 'action-process' can build capacity and confidence at municipal and facility levels by supporting service planning and delivery and learning.

4.3. Recommendations related to Gender and Disability

Recommendations related to Gender and Disability: Phase 2

1. **Gender and disability: Review of the Management Leadership Modules**

There is a window of opportunity now to offer gender and disability review of the Management and Leadership Modules being led by Maluk Timor with INSP-TL. With the INSP-TL leadership expressing personal understanding of the barriers and issues faced by women in the health sector and discriminatory attitudes faced by groups in interactions with health services, offering to provide specialist gender and disability input or review would be timely. The link between HCW attitudes and healthcare seeking patterns and the gender-responsiveness and inclusiveness of the health system also makes it relevant.

2. **Refine workplan for 2025**

In collaboration with the Abt Global Senior Gender Specialist (and ideally coinciding with an in country visit), discuss the recommendations of her review paper and agree on the activities that have the most promise of positive GEDSI outcomes by the end of the program. (Also discuss emerging findings from the UNFPA demand side study, if available.) Also refine the corresponding milestone statements together.

3. **Convene partner meetings**

A priority bilateral discussion is meeting with Nabilan to discuss GBV and medical forensic examination. Nabilan is keen to discuss with PHD Health's the MoH's position on PRADET, due to Nabilan's concerns that the MoH is suggesting their medical examination role is not supported in future. Nabilan and PHD Health are also both engaging with MoH on medical forensic examination protocols and so there is a need to ensure alignment in standardised approaches and guidance to the MoH. Also consider joint talking points on the risks of the parallel DHS and VAW prevalence studies in 2025.

4. **Visit to CHC safe spaces**

As a priority, PHD Health should visit the CHCs which have introduced a 'safe space' for survivors of GBV to confirm whether and how they have implemented the facility guidance, and to understand why clients are not presenting or being referred. The Vera Cruz CHC could provide a benchmark for what can be achieved, and the staffing and costs entailed in receiving clients. This could be done in tandem with an accessibility audit, ideally with or by RHTO or other OPD, to observe the modifications at the facility-level and the impact on the number of clients with physical disabilities. Advice could also be provided on low-cost modifications that could be made at the facility level, and any detail on cost, to enhance service access and uptake by clients with other impairments.

5. **15 inclusive health and GBV indicators**

If the MoH remains receptive, after the significant turn over in personnel, it is recommended that PHD Health continue to support the MoH's implementation of the 15 inclusive health indicators and the NAP GBV health-related indicators that have been endorsed for the PHC M&E Framework. These indicators have been agreed, and so provide a firm basis for support. They will also be key in collecting the disaggregated data that is so needed to monitor the performance of the health system on inclusion.

Recommendations related to Gender and Disability: New Design

1. **Include separate gender and disability expertise in the design team**

   DFAT's new Disability Equity and Rights Strategy (November 2024) introduces a disability equity requirement for new designs, equivalent to the mandatory requirement for gender equality to be integrated at IO or EOPO level on new designs. This warrants the inclusion of separate gender and disability expertise on the new health design (whether through 2 team members, or a disability or gender team member with access to advisory expertise on the other thematic area).

2. **Revisit the gender and disability strategy recommendations**

   Revisit the health-related recommendations in both the Gender Equality and Disability Equity Strategies, as well as the review paper by the Abt Global Senior Gender Specialist. Consider which recommendations could be carried into the new design. Also review the health, equality and equity-related Concluding Recommendations to be issued by the committees on the CRPD and CEDAW in 2025.

3. **Explore the potential for addressing demand side factors**

PHD Health has supported enhancements at the facility level for GBV survivors and people with disabilities. However, it has not focused on client demand, uptake or disaggregation of health records. The PHD Health-funded UNFPA study on the barriers to SRH and GBV services will be a critical input for understanding demand and the gender-based and social factors affecting it. PHD Health with DFAT (and Nabilan or other interested grant partners) could convene a workshop to have in-depth discussion of recommendations and identify those activities which could be piloted or progressed in the new design.

4. **Analyse political economy and government relations**

   Consider an analysis of the political economy, government relations and interest to gender and disability. Alongside being prepared to 'nudge' and take initiative on GEDSI, explore where MoH has shown greatest interest and enquire into the status of DFAT's relationship with MSSI for progressing disability equity.

5. **Scope the potential for GEDSI-related social norms and leadership**

   Explicitly consider what the new design could and should address in relation to social norms affecting healthcare seeking – due to the low healthcare seeking for ANC, delivery and GBV. Also consider a more holistic program of HCW pre- and/or in-service training on gender equitable leadership, gender-equitable/inclusive and safe workplaces, and HCW attitudes.

6. **Integrated Theory of Change, and budget for adequate specialist FTE and activity.**

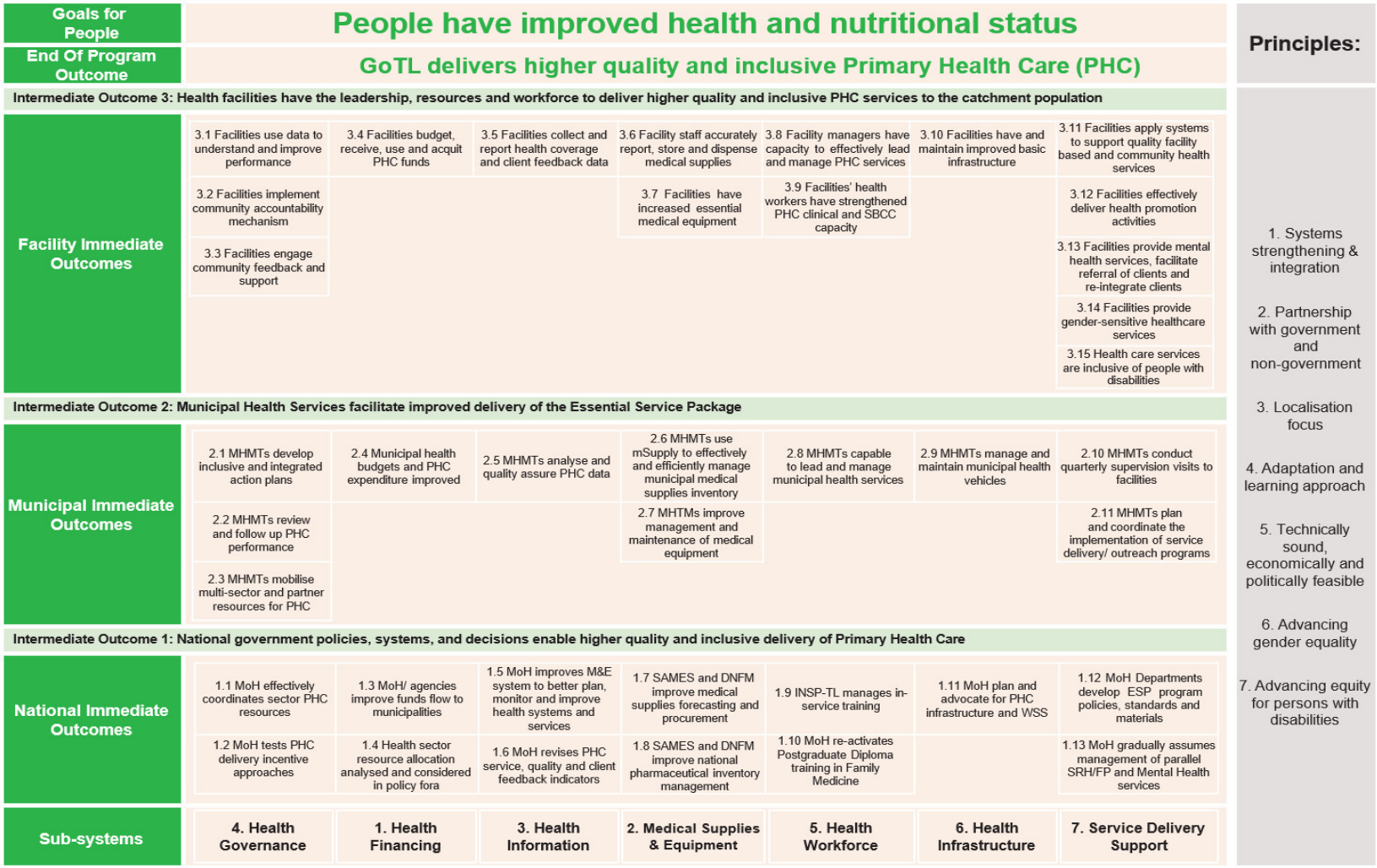
   Develop a ToC where gender and disability (and the key elements such as VAW or women's leadership) are integrated, and have clear, smart indicators. Also specify the FTE, seniority and specialist skills needed in the program.

7. **Integrated MELF**

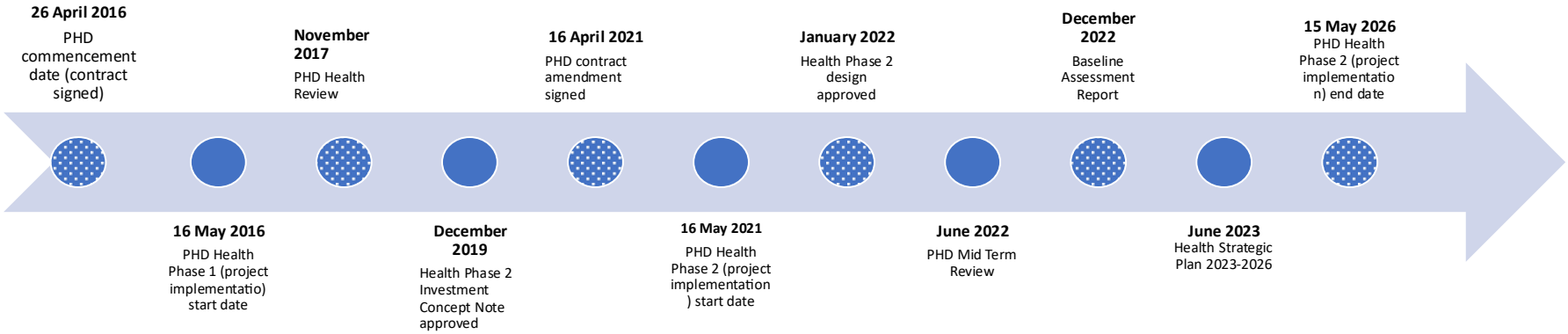
   Produce an integrated MELF (or guidance for an integrated MELF) which has gender and disability mainstreamed, rather than being stand alone. Also ensure thorough disaggregation of data by gender, disability and other relevant markers.

5. Annexes

5.1. PHD Health Phase 2 Theory of Change



5.2. Timeline of PHD Health Phase 1 and Phase 2



5.3. Phase 1 and Phase 2 Implementing Partners

See Attached Excel

5.4. Health Facility Check List – GEDSI Pointers

This document was developed to provide the review team with a shortlist of key things to observe or enquire when visiting the PHD community health facilities that have specifically made some infrastructural and service modifications to meet the needs of women and children survivors of violence, and of people with disabilities across a range of so-called impairments. The list was intended to support exploration of how PHD funding and support has or could improve the provision of care, services and infrastructure. Please note that the table includes the raw data from the data collection at the sites, to preserve the immediacy of CHC staff responses.

The Review team interviewed and visited 4 CHCs and Health Posts. 1 was in Dili and 3 were in Oecusse:

1. **CHC Comoro (Dili) – interviewed and visited**
2. **CHC Quiomanteko – interviewed and visited**
3. **CHC Passabe – interviewed**
4. **Health Post Banako - interviewed and visited**

NB CHC Vera Cruz was not able to be visited because staff were unavailable due to clinical demands.

1. **First line of questioning –** Has PHD Health supported any facility-level enhancements to receive and care for survivors of violence and people with disabilities?
2. **Observations of other support that PHD could provide**? See the list below.

GBV considerations:	**CHC Comoro** **(Dili)**	**CHC Quiomanteko** **(Oe-cusse)**	**CHC Passabe** **(Oe-cusse)**	**Heatlh Post Banako** **(Oe-cusse)**
○ Private, secure 'safe space' for counselling and waiting room for survivors ○ Is there discrete signage? - Is it locked and secure? - Is there security nearby? - Does it have any objects in the room for comfort, and	No, we do not have a separate room for counselling. Victims of GBV come to our CHC on regular basis. But we just mainly focus on injury treatment.	Yes, we have a room here. We have a table, and chairs, and a cabinet. That's all that we have inside the room. No toys. The room is locked and secure. But the room is very small. There is no designated place for the waiting room.	Yes, we dedicated a room for this case. This room as a door, can lock and one table and chairs. No other objects and we do not have toys inside this room.	We do not have a specific place. (Observation: only two multipurpose rooms that are interconnected and provide a range of services from immunisation to delivery). Health Post is much smaller than a CHC.

GBV considerations:	CHC Comoro (Dili)	CHC Quiomanteko (Oe-cusse)	CHC Passabe (Oe-cusse)	Heatlh Post Banako (Oe-cusse)
toys or books for young children?	When the victims come to our CHC, we will provide some medical treatment to treat their wounds, then we will refer to the Police. Most times, police will take them to our CHC for medical immediate treatment. However, we do not have a room for observation of the patients of GBV. So they need to leave as soon as we treat their injuries. This CHC does not have a dedicated area as waiting rooms for GVB. The victims will just wait outside the room with other people that come to the clinic for consultation/clinical treatments CHC has security to overlook the whole CHC. This CHC does not provide forensic examination.	So far we do not have any patients come to our CHC for GBV cases. We have security taking care of the whole CHC.		No specific place/room for GBV consideration. Yes, we have one security staff.
○ How is the safe space staffed?	3 doctors (M=2;F=1) 1 midwife (F) 2 nurses (F) 6 staffs (F=4; M: 2)	We have 4 staffs, but only two in charge of GBV cases. We have 1 mid-wive (female) that focus on this, and a male doctor.	We have 2 team members dedicated to attend the victims of GBV. 1 midwife (female) and one doctor (male), and one admin person to record the data.	1 nurse (the one that participated in the training and has direct responsibility to attend GBV cases). 1 midwife 1 pharmacist

GBV considerations:	CHC Comoro (Dili)	CHC Quiomanteko (Oe-cusse)	CHC Passabe (Oe-cusse)	Heatlh Post Banako (Oe-cusse)
○ What training have staff received?	- Gender based violence training - Mental health counselling	Yes, these two staff members have attended training facilitated by PHD. Maybe in May or July this year.	Yes, they attended the training on GBV facilitated by PHD.	In general, the staff in this health post have received the following trainings: basic life support, and GBV. GBV training was in July or August 2024.
○ Is there a protocol from screening to referral?	No, we did not really have it in place. Sometimes the VPU team will take the victims to our CHC, so that we can treat some wounds. But we do not really do referral. Sometimes the victims will come directly to our CHC for treatments.	Maybe we have. I am sure they know how to do it because both staff already attended the training facilitated by PHD.	Yes, we have it but never use it. So not sure about the process.	Yes, but we do not really apply it because community members do not come because of GBV. Sometimes we have heard about violence incidents happening in the community or at the household level, but people do not make it public or call police or come to the Health Post for their injuries. So, as a staff here, we cannot really go out there and tell them to come.
○ What care and services are offered to women and children in the safe space?	We will provide carer for their injuries. But if the wounds are severe, we will refer them to CHC Vera-Cruz as they have more medical equipment to provide care to the victims. We also sometimes refer the victims to the safe place in the Formosa CHC. They can stay there for 72 hours.	We have not done it yet because no cases so far.	No women report their cases to our CHC in Passabe.	No one comes to our Health Post so far. We have no cases, so sometimes we also forget about the training that we have already received.

GBV considerations:	**CHC Comoro** **(Dili)**	**CHC Quiomanteko** **(Oe-cusse)**	**CHC Passabe** **(Oe-cusse)**	**Heatlh Post Banako** **(Oe-cusse)**
○ Is there a process for referral to other services – including care of injuries, mental health, and forensic examination? Also, to legal, NGO support, financial services – as available?	Only for care for minor injuries. If it is severe injuries, we will refer to CHC Vera-Cruz, and to CHC Formosa	No cases so far. We have not done it yet.	Yes, but no cases so far.	We have no cases, so sometimes we also forget about the training that we have already received.
○ What data is collected, paper or electronic, and what is the process for reporting up the line?	Only collect manual data on paper. But no proper place to store the data. The room has no lock, and there is no proper cabinet to store client documents.	We do not know yet. We have not had any discussion about it because there have been no cases so far.	Both ways to collect the data, but now we do not have any data on GBV cases yet.	No data collected so far because no one comes to our clinic.
Disability accessibility considerations:	N/A	N/A	N/A	N/A

GBV considerations:	CHC Comoro (Dili)	CHC Quiomanteko (Oe-cusse)	CHC Passabe (Oe-cusse)	Heatlh Post Banako (Oe-cusse)
○ Is there an accessible entrance (eg ramp on a low slope, rails to hold onto, tessellated tiling to assist low vision or blind patients)?	Yes, the CHC is now in the process of building a ramp in the entrance. But this is work in progress. This is the only thing that is happening related to physical accessibility. Nothing else dedicated particular for people with different disabilities to access the clinic.	Yes, we have just built a ramp in the entrance. But no accessible toilers and no other supports provided specifically for people with disabilities.	No.	No, we do not have them.
○ Have staff received any training on how to screen and identify people with disabilities?	No specific training for the staff so far.	Yes, we have a male doctor, and a male midwife already attended the training on how to screen and identify people with disabilities. They attended this training a couple of years ago.	No, not yet.	Not yet.
○ Any broader training in relation to children and adults with disabilities? ○ Are there any subsidies or fee waivers for people with disabilities? ○ Are there any transport services for people with disabilities to reach the clinic? ○ Are there accessible toilets - wheelchair wide entrance to bathroom and to cubicles, and low set rails and toilet paper inside? ○ What services does the health facility offer – eye testing and glasses, hearing testing and hearing aids, assistive devices?	No subsidies and no transport services.	No, so far in the last 6 – 12 months, we have not had any training on disabilities. No, we do not have any subsidies for people with disabilities. We do not have accessible toilets yet. Also we do not really have toilets for patients in general. For pregnant mothers who deliver their babies here, they will also use the staff toilets.	No, not yet. No	Not yet. We do not provide any especific support to PwDs. No link with DPOs, and no link to support to people with sign language.

GBV considerations:	CHC Comoro (Dili)	CHC Quiomanteko (Oe-cusse)	CHC Passabe (Oe-cusse)	Heatlh Post Banako (Oe-cusse)
○ Does the facility have any link with people in the community who can provide sign language? ○ What referrals does the health facility provide – for orthotics and prosthetic referral, additional testing, mental health services? ○ What data is collected, paper or electronic, and what is the process for reporting up the line? ○ Does the clinic have links with OPDs in the area?	No, there is no accessible toilets. Nothing specific yet. No, we do not have any link that can support us to provide sign language. We just make referral letter to their general conditions. But if we have people with disabilities come to our clinic general medical treatment, we will make it our priority to attend them first. Collect general data only, not specific data for people with disabilities. We know about RHTO but we do not work or have link with them.	We do not have any eye testing and glasses, hearing testing and hearing aids, assistive devices. But the doctors will just do the examination manually, then he will refer the patients to the hospital. As far as we know, people with disabilities receive a subsidy from the government. The doctor will also provide a referral letter to the MSSI for them to access to the subsidy. However, it is all done manually. No, we do not have any link that can support us to provide sign language. Referral for MSSI subsidy, and refer the patients to have additional testing for mental health in the hospital.	No. No. No specific services. No. No.	

GBV considerations:	CHC Comoro (Dili)	CHC Quiomanteko (Oe-cusse)	CHC Passabe (Oe-cusse)	Heatlh Post Banako (Oe-cusse)
		We have an electronic and manual system. But we only collect general data, not specific for people with disabilities. No, we do not have any links with OPDs.	In paper, manual. But not specifically for people with disabilities. Yes, we have worked together with RHTO. They supported a wheelchair to our clinic. We also requested one more for the regional government, but we are not sure if they are going to provide the wheelchair.	

Extra notes:

- In Comoro CHC in Dili, they do have the cases of GBV but they do not record any data on GBV victims that come to their clinic. They mentioned that some of the victims will come to them directly for the injury treatments, but some will be taken by the police to their clinic. They do not have a specific waiting room, and just collect information on them as a general patient. They do not have someone trained to do the referral cases, or to follow the procedures when treating or responding to the cases of GBV. This is a lost opportunity, given that Nabilan (another DFAT-funded program) has a strong Referral Network for GBV. PHD Health/facilities could benefit from this.
- Of the 2 CHCs and 1 Health Post in Oecusse – no cases are being reported or brought to their facilities for treatment.
- Of all 4 facilities, 3 of them do not have contact with OPDs. CHC Comoro knew of RHTO but they do not have any relationship with them. As for CHC Passabe, they knew about RHTO because once RHTO donated a wheelchair to their clinic. So, when we talk about disability, people tend to only consider physical accessibility (eg ramps, wheelchair, accessible toilets) but not other impairments and not really around building partnerships with OPDs.

Sources: UN Women, UNFPA, WHO, UNDP & UNODC. (2015). Health Module – Essential Services Package for Women and Girls Subject to Violence

https://www.unfpa.org/resources/essential-services-package-women-and-girls-subject-violence-module-2 ; Disability-inclusive health services toolkit : a resource for health facilities in the Western Pacific Region. https://www.who.int/publications/i/item/9789290618928

5.5. Analysis of PHD Strategic Plan and Workplan: Phased Facilities

The 2023 Strategic Plan notes that immediate outcomes that are "primarily technical in nature … will be rolled out on a municipality wide basis". These cover the facility level immediate outcomes related to health financing, health information, medical supplies and equipment, health workforce, health infrastructure and service delivery support.

The Strategic Plan also notes that those immediate outcomes that "involve specific organisational change will be supported on a Phased basis". These cover the immediate outcomes under governance in the Program Logic (3.1 use of data for performance improvement, 3.3 community feedback and 3.2 accountability) and the service delivery immediate outcome 3.11 related to application of systems.

The Strategic plan also refers under the Sustainability Straegy section to a "Phased approach to facility capacity development" and "more intensive targeted support for facility specific diagnostic and improvement strategies".

The 2024/25 Annual Workplan doesn't separately plan activities for Phased facilities. Additionally, the milestones do not provide clarity on the improvement strategies or define what success looks like for the Phased facilities.

In the workplan there is a governance activity that that is relevant to the Phased facilities under municipal Intermediate Outcome HI02 and immediate outcome 2.1 (MHMTs mobilise multi-sector and partner resources for PHC) with related municipal level milestones although the indicators are partly related to facility level:

> "Support MoH's quarterly review and coordination meetings (with analysis and use of health performance data, ensure key stakeholders participation, facilitate meeting discussions, and support documentation and implementation of clear actions from the meetings) to discuss and address health sector performance and resourcing issues (with government funding, program funding, if necessary, and through mobilisation of other sectors and partners' support) in Dili, Ermera, and RAEOA (at municipal/regional and CHCs levels)."

There is another activity under health information in the workplan at municipal level that speaks to use of data by facilities for planning but it's under 2.5 with municipal level indicators / milestones:

> "Support MoH's implementation of the Health Sector M&E framework for PHC in Dili, Ermera, and RAEOA to facilitate health facilities' understanding of key indicators, timely entry, completeness and submission of data to municipal health services, and the use of data for continued services improvement and for annual planning and budgeting"

There are no activities related to community feedback nor accountability, and the governance related immediate outcomes (3.1, 3.2, 3.3) don't feature in the 2024/5 Annual Workplan although the Strategic Plan notes that these outcomes are covered under the organisational change focus of the Phased facilities.

Several of the milestones for FY 2024/25 refer to targeted facilities but it is unclear if these are the same as the Phased facilities.

5.6. Lessons from the 2017 Australia Timor-Leste Health Review

The Australia Timor-Leste Health Review identified several lessons learned as follows:

- **Health Systems Approach**. Timor Leste's health system is only as strong as its weakest link. Continuous monitoring of linkages and sequencing in the development of the entire health system could help to ensure that different elements improve in ways that support each other to achieve objectives (e.g. Health Facility readiness needs to improve to enable staff to practice new skills
- **Program Coherence**. There is limited coherence within the current portfolio of RMNCH investments, i.e. the component projects are not unified in a way that makes the whole greater than the sum of the parts. At the same time, there have been important changes in the context of the health sector during recent years. In view of this, and the fact that most of the current program contracts end in 2018, there is now both a need and an opportunity to redesign the program to ensure relevance to the evolving context and improve the mix of investments and modalities. Rights and equity (poor/rich and rural/urban as well as gender and disability) could also have more prominence.
- **MoH Ownership**. Although MOH was engaged in the development of the current DFAT/PHD program, an increasingly assertive sense of ownership by MOH calls for more emphasis on alignment and harmonization as per the forthcoming MOH manual, with all new proposals submitted to MOH at an early stage for comments and advice, and national priorities determining geographical focus of activities
- **Sustainability**. The program could focus more on building capacity to foster sustainability. A more strategic approach to management would increase program coherence. Sustainability of what is achieved through TA depends on: (i) turnover of people trained and (ii) the extent to which relevant institutions embed new procedures and change their cultures. 'Deep change' will require strong MOH leadership, not just good TA
- **Rigorous MEL**. The program needs a clear theory of change, together with a comprehensive and rigorous overall M&E framework within which component projects can be logically 'nested'. A Collective Impact approach to management of the program could involve planning, monitoring and reporting for the program overall rather than just for individual projects
- **Role of Political Economy monitoring**. With limited funds - and especially as other donors depart - it's important to focus on catalytic interventions with potential for transformation; these often involve the Information and Governance elements of the health system. Close monitoring of political economy dynamics is vital to identifying emerging opportunities (and threats) as they arise; ongoing policy and strategy dialogue is essential to this, and flexibility helps in capitalising on opportunities and managing emerging risks

5.7. Documents Reviewed

PHD Documents

- Health Review Report 2017
- PHD Guiding Strategy (2019)
- PHD Health Report on EmONC Progress Report 1 July – 31 October 2022
- PHD Gender Equality Strategy 2022 – 2026
- Health Sector Partnership and Coordination: Partnership Manual (2022)
- PHD Health: Baseline Assessment Report (2022)
- PHD Health Annual Report June 2023 – June 2024
- PHD Health Strategic Plan 2023 – 2026
- PHD Monitoring, Evaluation, and Learning Plan (2024)
- PHD Health Monitoring, Evaluation and Learning Framework (2023)
- PHD Health: Sector and Crosscutting MELFs
- PHD Insight Log-Health and Health Evidence Snapshot
- PHD Gender Analysis of Primary Health Care System (Dili, RAEOA and Ermera)
- Maluk Timor, DISTaNCE Narrative and Preliminary Data (2024)
- Maluk Timor, DISTanCE Technical Proposal (2023)
- PHD Health Progress Reporting: Six Month report, Period 1 January – 15 June 2024
- PHD Narrative Report: 1 January -30 June 2024
- Disability Inclusive Health Services Evaluation Report (2024)
- *Liga Inan* Transition Plan
- The mSupply Foundation: Summary of mSupply in Timor-Leste (2023)
- The mSupply Roadmap to Institutionalisation (2023)
- UNFPA: mSupply Monitoring Report (2023)
- Marie Stopes Timor-Leste Activity Plan 2021-2022
- MSITL-Support Report Period: Jan-June 2024
- PRADET-TL Six Monthly/Annual Report, Period 1 January – 30 June 2024
- PHD List of Phased Facilities
- PHD Micro plans in Ermera, Dili, RAEOA
- PHD Six Monthly Report July – December 2022
- PHD Budget for Financial Year 2023 – 2024
- PHD Program Journey: how the Australia Timor-Leste Partnership for Human Development (PHD) change scope and focus over the program's years of operation (2024)
- PHD Six Month Progress Report January – June 2022
- PHD Six Month Progress Report January – June 2023

- PHD Six Month Progress Report July to December 2023
- PHD Theory of Change (as of 1 January 2024)
- PHD Annual Work Plan Financial year 2023-2024
- PHD Annual Work Plan Financial year 2024-2025
- PHD Health and Nutrition Team Structure (revised in 2024)
- PHD Annual Report July 2023 – June 2024
- FRA Scores Q2 2024 Dili, Emera and RAEOA versus baseline 2022
- PHD Institutionalisation Tracker (2024)
- Political economy analysis in PHD health, a proposed approach – 2022
- PHD Roundtable Discussion – key drivers and constraints to PHC HSS (2022)

Government of Timor-Leste Documents

- Concept Note: Reducing Malnutrition Rate in RAEOA through Multisectoral Nutrition Intervention Program (2024)
- Essential Service Package for Primary Health Care for Timor-Leste 2022 (2022)
- Essential Service Package for Secondary and Tertiary Care for Timor-Leste. National Directorate of Support for Hospital Services (2022)
- General State Budget 2025
- General State Budget 2024
- General State Budget 2023
- General State Budget 2022
- The Health Transport and Ambulance Program (HTAP) Discussion Paper (2021)
- Module 2 Health Services: Essential Services Package for Women and Girl Subject to Violence: *Core Elements and Quality Guidelines.*
- National Health Sector Strategic Plan II: Toward a 'Healthy East Timorese People in a Healthy Timor-Leste' (2020 – 2023)
- National Action Plan on Gender Based Violence (NAB-GBV)
- Policy Brief: Reaching the Un-reach through INTERGRATED HEALTH PROGRAM (IHP)
- Strategic Plan 2023 – 2027: National Services for Ambulance and Medical Emergency, P.I Timor-Leste (2023)
- Timor-Leste Maternal Mortality Rate – Historical Data and Analysis (2024)
- Timor-Leste: Monitoring the Health SDG goal: Indicator of Overall progress (2020)
- Microplan for Dili, Emera and RAEOA

DFAT Documents

- Australia Timor-Leste Partnership for Human Development: Investment Design Document
- PHD Mid Term Review 2022
- Timor Leste Health Design Options Situational Analysis (2019)
- Annual Investment Monitoring Report, 1 January 2022 – 31 December 2022
- Annual Investment Monitoring Report (2023)

- Australia Timor-Leste Partnership for Human Development (PHD) theory of change (as at 1 January 2024)
- DFAT Investment Design Title: Partnership for Human Development (2023)
- Technical Cooperation Agreement between the Ministry of Health of RDTL and Abt Associates Pty representing the Australia Timor-Leste Partnership for Human Development Program
- DFAT Guidance Note Locally Led Development, 2024
- DFAT Design, Monitoring, Evaluation and Learning Standards, 2023

Other Documents

- Evaluation of Australia's Support to Strengthen Pacific Health Systems 2008 – 2027, Office of Development Effectiveness, (2019)
- GAVI, Timor-Leste Factsheet (2023)
- World Bank Human Capital Report (2023)
- Factsheet 2023: Expanded Program on Immunisation (EPI)
- Evidence Snapshot Health

5.8. Stakeholders Consulted

MOH – National Level

No	Name	Job title	Organisation
1	Dr. Terlinda Barros	Director General for Hospital Services	MoH
2	Dr. Rosye da Silva	National Director of Nutrition	MoH
3	Mr. Delfim Ferreira	National Director of DNFM (Direcção Nacional da Farmácia e Medicamentos or National Directorate of Pharmacy and Medicine)	DNFM
4	Ms. Rita Ataíde	Department Chief for Planning and Management of Procurement	DNFM
5	Mr. Alfredo da Costa	Procurement and Operation Director of Instituto Nacional de Farmácia e produtos Médicos or Medical and Pharmaceutical Supply Agency (INFPM)	INFPM
6	Mr. Crisanto Monteiro	Distribution Director	INFPM
7	Mr. Matias de Araújo	Quality Control Director	INFPM
8	Dr. Merita Monteira	President of INSPTL	INSPTL
9	Ms. Mery Estella Laot	Director of Training	INSPTL
10	Dr. Simplício Amaral de Deus	Director General SNAEM	SNEAM
11	Dr. Horacio S. da Costa	Staff/Former Director General SNEAM	SNEAM
12	Jose Celestino G. Pereira	Director of Finance	SNEAM
13	Belarmino da Silva	N/A	SNAEM
14	Marcelino Pereira	N/A	SNEAM

National Level Directors & Dili Municipality

No	Name	Job title	Organisation
15	Dr. Odete Freitas Belo	Former Minister for Health	N/A
16	Mr. Augosto Pinto	Former National Director for Human Resources	N/A
17	Mr. Marcelo Amaral	Former DG for Corporate Services	N/A
18	Ms. Maria Natalia	Former Head of Policy, Planning and Monitoring & Evaluation Current role as staff of M&E (same department)	N/A
19	Ms. Agustinha Segurado	Former Director of Dili Municipal Health Services Current role as Coordinator for Family Planning program (different directorate)	N/A

RAEOA (Oe-Cusse)

No	Name	Job title	Organisation
20	Mr. Luis de Jesus Neno	Regional Secretary of Health in RAEOA	MoH
21	Mr. António Firdaus Ximenes dos Santor Neno	Director of RAEOA Health Services	MoH
22	Ms. Liliana da Cunha	DPHO Nutrition	MoH
23	Mr. Marcus Nofa	Chief of Department for Finance (RAEOA Hospital)	MoH
24	Ms. Herminia Bulu Sedo	Family Planning Focal Point	MoH
25	Dra. Maria	Head of CHC Quiomanteko	MoH
26	Dra. Zelia da Cunha	Head of CHC Passabe	MoH
27	Edita de Sousa	Mid-wife, Health Post of Banoko	MoH
28	Ana	Nurse, Health Post of Banoko	MoH
29	Imelda Maria Corbafo	Nurse, Health Post Bimelo	MoH

Dili Municipal Health Services

No	Name	Job title	Organisation
30	Mr. Mateus Pinto	Director of Dili Municipality	Dili MHMT
31	Dr. Lola Hornay	Nutrition Coordinator	CHC Becora
32	Dr Marilia da Conceicao	Head of CHC Vera Cruz (inclusive health services)	MoH Dili
33	Ms. Emilia de Sousa	Head of CHC (mid-wife)	CHC Comoro
34	Dr. Odisia	Maternity and ANC	CHC Comoro
35	Linda Soares	Mid-wife	CHC Comoro
36	Renato da Cruz da Silva	Lab technician	CHC Comoro
37	Adelaide	EIS (data system)	CHC Comoro
38	Natalino Pereira	Administration	CHC Comoro
39	Julia Tavares	Finance	CHC Comoro

No	Name	Job title	Organisation
40	Bernardo	Nurse	CHC Comoro

Technical Implementing Partners

No	Name	Job title	Organisation
41	Dr. Natarajan Rajaraman	Executive Director	Maluk Timor
42	Mr. Manuel dos Santos	Executive Director	Pradet
43	Mr. Joaozito dos Santos	Director	RHTO
44	Ms. Floriana da Silva	Media Officer	RHTO
45	Ms. Silvia Soares	Training and Inclusion Manager	RHTO
46	Mr. Anders Hofstee	Co-director	Catalpa International
47	Dr. Domingas Bernardo	Assistant Representative	UNFPA
48	Dr. Triana do Rosario	Head of Maternal and Child Health Department	UNFPA
49	Dr. Domingas Sarmento	M Supply	UNFPA
50	Ms. Angelita Maria Gomes	Health Officer	UNICEF
51	Ms. Veronica Correia	Social Behavior Change Officer	UNICEF
52	Dr. Amelia Barreto	Country Director	MSITL
53	Mr. Arsenio		MSITL
54	Ms. Sandy	OPSS manager	MSITL
55	Ms. Brigita	HR manager	MSITL
56	Mr. Samuel	Outreach manager	MSITL
57	Mr. Emanuel	Evidence to action	MSITL

Other Organisations

No	Name	Job title	Organisation
58	Mr. Miguel Guterres	National Professional Officer for Health System Strengthening, WHO Timor-Leste	WHO
59	Aishath Thimna Latheff	Technical Officer (Climate Change and Health), WHO Timor-Leste	WHO
60	Tito de Aquino	Climate Change and Health	WHO
61	Emma Charlston	Program Manager, Timor-Leste	Menzies School of Health Research
62	Mr. Apolinario Araujo - his email signature says Abílio de Araújo	Municipalities Support Director	PARTISIPA

GEDSI

No	Name	Job title	Organisation
62	Felicity Errington	First Secretary, GEDSI	AHC
63	Xylia Ingham	Nabilan Team Leader	TAF
64	Annemarie Reerink	Abt GEDSI Adviser engaged with PHD Health	Abt
N/A	N/A	PHD's GEDSI team	PHD

DFAT

No	Name	Job title	Organisation
65	Caitlin Wilson	Ambassador	DFAT
67	Deidre Ballinger	First Secretary, health and nutrition	DFAT
68	Rebecca Dodd	Counsellor for human development	DFAT
69	Julia Magno	Senior officer – health	DFAT
70	Suzana	Senior officer – nutrition	DFAT

PHD Team

No	Name	Job title	Organisation
71	Armandina Gusmao	Sector Lead	PHD
72	Ismael Barreto	Heath Sector Lead	PHD

DFAT - Advisers

No	Name	Job title	Organisation
73	Andrew McNee	Strategic Health Mentor (STA)	PHD
74	Amrutha Gopalakrishnan	Adviser-Health M&E (embedded in MoH)	PHD
75	Patricia Schwerzel	PHC Adviser	PHD
76	Lyndal Trevena	Specialist Consultant Health/OD Team	PHD
77	Miguel Maria	PFM adviser (embedded in MoH)	PHD

DFAT - Managers

No	Name	Job title	Organisation
78	Ninivia Barreito	Manager – Nutrition	PHD
79	Maximiano Neno	Manager - OD (50% embedded in MoH)	PHD
80	Endang Soares da Silva	Manager - Supply Chain (100% embedded in INFPM and DNFM)	PHD
81	Tercisio Amaral	Manager – Municipal health system strengthening	PHD
82	Imaculada L. Belo Maia	Manager - Health Program transition & Grants	PHD

DFAT - Municipal Strengthening Team

No	Name	Job title	Organisation
83	Tarcisio Amaral	Manager – Municipal health system strengthening	PHD
84	Imaculada Lobo Belo Maia	Manager - Health Program transition & Grants	PHD
85	Antonito Cabral	Senior Officer - Health Monitoring, Evaluation & Learning (MEL)	PHD
86	Dr. Olinda dos Reis Albino	Technical Professional (HSS Roving Team)	PHD
87	Dr. Carla Madeira	Technical Professional (HSS Roving Team)	PHD
88	Ines Alves	Technical Professional (HSS Roving Team)	PHD
89	Herminio Lelan	RAEOA Municipal Coordinator (based in Oe-cusse)	PHD

DFAT - MEL

No	Name	Job title	Organisation
90	Tessa Koppert	Program Performance & Communications Director	PHD
91	Antonito Cabral	Senior Officer - Health Monitoring, Evaluation & Learning (MEL)	PHD
92	Detaviana Freitas	Manager - MEL	PHD
93	Cairo	MEL Coordinator	PHD

5.9. Alternative Text

Figure 2: Phased Program of Support for each Municipality. Source: PHD Health Strategic Plan, 2023

This figure provides an illustration of a phased approach to supporting Municipalities.

1. **Top row** – National Policy and System Enabling Support with double ended arrows to illustrate how this support and phases of support are mutually reinforcing.
2. **Phase 1: Preparation (January 2022 – March 2023)**
    - Municipal selection
    - Team mobilisation
    - Relationship and partnerships established
    - Diagnostic based Municipal Action Plan
    - Early program activities implemented
3. **Phase 2: Initial Improvement Cycle (April 2023 – June 2024)**

- Municipal processes – Plan, Implement, Monitor, Adapt (PIMA) process, operating procedures, training, mentoring
- Facility – technical support rolled out municipal wide and organizational support phased to achieve full coverage

4. **Phase 3: Assess/Adapt/Expand (July 2024 – June 2025)**

- Assess and learn from progress
- Stop, adapt, expand, new ideas

5. **Phase 4: Consolidate/Phase out (July 2025 – March 2026)**

- Assessment, remaining gaps, future direction

PHD Health Phase 2 Theory of Change

This diagram depicts the theory of change for PHD Health Phase 2.

- **Goal/Purpose**: people have improved health and nutritional status
- **End of Program Outcome**: GoTL delivers high quality and inclusive Primary Health Care (PHC)
- **Intermediate Outcome 3**: Health facilities have the leadership, resources and workforce to deliver high quality and inclusive PHC services to the catchment population
- **Facility Intermediate Outcomes:**

3.1. Facilities use data to understand and improve performance

3.2 Facilities implement community accountability mechanism

3.3 Facilities engage community feedback and support

3.4 Facilities budget, receive, use and acquit PHC funds

3.5. Facilities collect and report health coverage and client feedback data

3.6. Facility staff accurately report, store and dispense medical supplies

3.7. Facilities have increased essential medical equipment

3.8. Facility managers have capacity to effectively lead and manage PHC services

3.9. Facilities' health workers have strengthened PHC clinical and SCBB capacity

3.10. Facilities have and maintain improved basic infrastructure

3.11. Facilities apply systems to support quality facility based and community health services

3.12 Facilities effectively deliver health promotion activities

3.13 Facilities provide mental health services, facilitate referral of clients and re-integrate clients

3.14 Facilities provide gender-sensitive healthcare services

3.15 Health care services are inclusive of people with disabilities

- **Intermediate Outcome 2**: Municipal Health Services facilitate improved delivery of the Essential Service Package
- **Municipal Immediate Outcomes**

2.1 MHMTs develop inclusive and integrated action plans

2.2 MHMTs review and follow up PHC performance

2.3 MHMTs mobilise multi-sector and partner resources for PHC

2.4 Municipal health budgets and PHC expenditure improved

2.5 MHMTs analyse and quality assure PHC data

2.6 MHMTs use mSupply to effectively and efficiently manage municipal medical supplies inventory

2.7 MHMTs improve management and maintenance of medical equipment

2.8 MHMTs capable to lead and manage municipal health services

2.9 MHMTs manage and maintain municipal health vehicles

2.10 MHMTs conduct quarterly supervision visits to facilities

2.11 MHMTs plan and coordinate the implementation of service deliver/outreach programs

- **Intermediate Outcome 1: National government policies, systems and decisions enable higher quality and inclusive delivery of Primary Health Care**
- **National Immediate Outcomes**

1.1 MOH effectively coordinates sector PHC resources

1.2 MOH tests PHC delivery incentives approach

1.3 MOH/agencies improve funds flow to municipalities

1.4 Health sector resource allocation analysed and considered in policy for a

1.5 MOH improves M&E system to better plan, monitor and improve health systems and services

1.6 MOH revises PHC service, quality and client feedback indicators

1.7 SAMES and DNFM improve medical supplies forecasting and procurement

1.8 SAMES and DNFM improve national pharmaceutical inventory management

1.9 INSP-TL manages in-service training

1.10 MOH re-activates Postgraduate Diploma training in Family Medicine

1.11 MOH plan and advocate for PHC infrastructure and WSS

1.12 MOH Departments develop ESP program policies, standards and materials

1.13 MOH gradually assumes management of parallel SRH/FP and Mental health services

- **Sub-Systems: Health Financing, Medical Supplies & Equipment, Health Governance, Health Workforce, Health Infrastructure, Service Delivery Support**
- **Principles:**

1. Systems strengthening & integration
2. Partnership with government and non-government
3. Localisation focus
4. Adaptation and learning approach
5. Technically sound, economically and politically feasible
6. Advancing gender equality
7. Advancing equity for persons with disabilities