# Rapid Assessments of Bottleneck Inhibiting the Scale up of Family Planning, Task Sharing and SBCC Practice in Timor-Leste

FINAL DRFAT REPORT

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WITH THE TECHNICAL & FINACIAL ASSISTANCE FROM

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**CONTRIBUTORS AND ACKNOWLEDGMENTS**

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The United Nations Population Fund (UNFPA) has been a key donor and provider of both financial and technical assistance, making this assessment possible. Additionally, WHO has been part of the agency that provide technical assistance during the assessment including digitalize the questionnaires in the online version. Both UNFPA and WHO have provided support, encouragement, and practical advice throughout the project

The project would not have been possible without participation from the high level managers at the national level Ministry of Health (MoH), the District Public Health Officer-Maternal and Child Health (DPHO-MCH) and the Family Planning providers from Ainaro, Baucau, Bobonaro and Ermera, who shared their experiences and perspectives during interviews and focus group discussions. Their voices have been critical in highlighting the real-world challenges and opportunities for scaling up family planning, Task Sharing and Social Behavioral Change Communication (SBCC) programs.

Grateful thanks to the General Director of Primary Health Care Ministry of Health, Director of Maternal and Child Health, Director of Health Promotion and Education, Executive Directors of Regional Hospitals Baucau, Maubisse, Ainaro and Maliana, the Family Planning Coordinator and Officer, Marie Stopes International-Timor-Leste (MSI-TL), WHO, UNICEF, UNFPA, Timor-Leste Midwifery Association (APTL), Midwifery Department-National University of Timor-Leste (UNTL), Midwifery Department- Instituto Superior Cristal (ISC), Midwifery Department- Instituto Ciencia de Saúde (ICS) and Cooperativa Café Timor-Leste (CCT) for their collaboration and insights. Their knowledge of the health system, policies, and programmatic gaps provided the foundation for identifying bottlenecks and exploring actionable solutions.

Special thanks to H.E. Minister of Health dr. Élia A.A. dos Reis and the National Institute of Public Health Timor-Leste (INSP-TL) Unit of Ethics, Research and Development, for their approval and support of this assessment in Timor-Leste.

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**EXECUTIVE SUMMARY**

The bottleneck assessment is a key component of the WHO-FP Accelerator Plus project that aims to support countries in scaling up and sustaining the implementation of WHO recommended evidence-based practice (EBPS). The assessment objective is to understand the challenge to EBP implementation and scale-up within resource-constrained health system, so this assessment focuses on asking key stakeholders to identify and come to consensus on key challenge their health system faces in scaling-up and identifying solution to address it.

The analysis initiated through submission of a request letter of approval by the UNFPA Timor-Leste, with Ref. no. 944/GMS/DGCSP/VIII/2024 regarding the approval of HE Minister to Director General CSP through the National Directorate of Maternal and Child Health for WHO and UNFPA to conduct assessment bottlenecks of Family Planning. This is a collaborative effort between Ministry of Health, WHO and the UNFPA. The WHO is providing technical assistance, while UNFPA is providing Funding as well as technical assistance for this process.

Upon approval, initial process was conducting Desk Review Phase for identification of Gaps in coverage through; Data Review and analysis of indicators across family Planning themes PPFP/PAPP, Task sharing and SBCC, Policy and guideline Analysis for identifying gaps in Guidance and a thorough Examination of National policy guidance documents regarding PPFP/PAFP, Task sharing and SBCC. The second phase were the Bottleneck Identification which was done through; Case studies and Key Informant Interviews (KIIs). To respond to the questionnaires of the three case studies by involvement of key organizations working in Reproductive Health or Family Planning and identifying 1-2 case studies for each module including successful and less successful studies. In the final phase a national workshop was conducted which has brought together a total of 34 people of groups of stakeholders to reach an agreement on the most significant bottlenecks impeding the scale-up of post-pregnancy FP (PPFP) in Timor-Leste, as well as to identify solutions to address the challenges and barriers.

The finding results shows that, of the three modules on PPFP, Tasks sharing and SBCC, most respondents fully agree with the indicators in line with the health system building blocks on the enabling environment to support the implementation of FP programmes. However, the challenges faced for scaling up of the program as there are no specific policies, guidance and or tools to facilitate the health care providers in implementing the PPFP, task sharing and SBCC across the country. In addition, budget allocation was not specific to the program needs and no regular monitoring and supportive supervision from the national and municipality level to the sub district for the up scaling of the FP. Furthermore, accountability and mandatory reporting of private sector in support of the government in FP services needs strengthening including continuous collaboration between agencies, NGO or civil society in supporting the government.

It is hope that this bottleneck analysis can facilitate the country in assessing the scale of the problems and needs of family planning, justifying the scaling solutions, monitoring progress, and adapting the scaling process, communicating, and building political support and ensuring accountability and incentives. Furthermore, analyzing the gaps or bottleneck or barriers is a practical way to address important aspects of the scaling challenges.

**ABBREVIATIONS AND ACRONYMS**

| | |
|---|---|
| COC/POP | : Combined Oral Contraceptive /Progesterone Only Pil |
| CHWs | : Community Health Workers |
| KSP/ PHC | : Kuidadus Saúde Primáriu/ Primary Health Care |
| DPHO-MCH | : District Public Health Officer- Maternal and Child Health |
| EBPs | : Evidence Based Practices |
| ECP | : Emergency contraceptive pill |
| FP | : Family Planning |
| GSI | : Grupo Suporta Inan |
| HMIS | : Health Management Information System |
| HQ | : Head Quarter |
| IEC | : Information, Education and Communication |
| INSPTL | : Instituto Nasional Saúde Públiku Timor-Leste |
| IUD | : Intra Uteri Device |
| KII | : Key Informant Interview |
| MHS | : Mudansa Hahalok Sosial |
| MNCH | : Maternal Neonatal and Child Health |
| MNH | : Maternal Neonatal Health |
| MSI-TL | : Marry Stopes International-Timor-Leste |
| PAFP | : Post Abortion Family Planning |
| PPFP | : Post-Partum Family Planning |
| RH | : Reproductive Health |
| SBCC | : Social Behavior Chance Communication |
| SISCa | : Sistema Integradu Saúde Comunitária |
| SMI | : Saúde Materno Infantil |
| SOP | : Standard Operational Procedure |
| 2 DM | : Two Days Method |
| UNFPA | : United Nation Fund Population |
| WHO | : World Health Organization |

Table of Content

Contents

1.**The Bottleneck Assessment** (BNA)

The bottleneck assessment is a key component of the WHO-FP Accelerator Plus project that aims to support countries in scaling up and sustaining the implementation of WHO recommended evidence-based practice (EBPS). The assessment objective is to understand the challenge to EBP implementation and scale-up within resource-constrained health system, so this assessment focuses on asking key stakeholders to identify and come to consensus on key challenge their health system faces in scaling-up, and identifying solution to address it.

Based on submission letter for requesting approval by the UNFPA Timor-Leste, the letter issued with Ref.944/GMS/DGCSP/VIII/2024 regarding the approval of HE Minister to Director General CSP through the National Directorate of Maternal and Child Health, WHO and UNFPA to conduct assessment bottlenecks of Family Planning. This is a collaborative effort between Ministry of Health, WHO and the UNFPA. The WHO is providing technical assistance, while UNFPA is providing Funding and as well as technical assistance for this process.

2.**The Process of the bottleneck assessment**

1) Recruitment of consultants
2) Gathering of relevant tools and protocols
3) Review of WHO's generic BNA protocols by the consultants
4) Translate Key Informant Interview (KII) Tools from English to Tetun Language
5) Desk review of policy documents and case studies
6) Data collection through KII
7) Data Analysis and drafting the BNA reports Consensus Building workshop with key stakeholders
8) Presentation for and discussion with HQ team and other Country team
9) Finalizing the BNA report write up

**3. Situational Analysis in Timor-Leste**

By 2050, Timor-Leste's population is expected to have increased by 0.8 million, reaching 2,159,658 according to high variant forecasts. The population of the nation is expected to rise by 626,676 and 518,830, respectively, in 2050, according to the medium (the suggested) and low variant forecasts.

The current population based on the 2022 census wall chart can be seen in table 1.1 below:

| Municipality and Administrative post | Population in private household and Institutions | | | Population in private household | | | Urban Population (%) |
|---|---|---|---|---|---|---|---|
| | Total | Male | Female | Total | Male | Female | |
| Timor-Leste | 1,341,737 | 681,229 | 665,750 | 1,340,925 | 680,781 | 660,114 | 28.6 |
| Urban | 383,416 | 194,329 | 194,329 | 382,962 | 194,002 | 188,960 | 100.0 |
| Rural | 958,321 | 486,900 | 471,421 | 957,963 | 486,779 | 471,184 | 0.0 |

Data Source: Population and Census Housing 2022

## 4. Family Planning status in Timor-Leste

Article 57, (1) of the Timor-Leste Constitution ensures that all Timorese have free access to healthcare. This refers to having access to all medical treatments, including family planning and reproductive health services. In all significant policies and strategies, including the National Strategic Development Plan 2011–2030, the National Health Sector Strategic Plan 2011–2030, the Reproductive Health Policy, and the RMNCAH Strategy, family planning (FP) policy has been recognized as one of the essential elements of health services. The anticipated distribution and SDPs currently offering FP contraceptives items as per national guideline can be seen in tables 2 and 3 as follows:

**Table 2. The anticipated distribution of contraceptive products in accordance with national guidelines**

| Level of Facility | Male Condoms | Female Condom | Pills (COC/POP) | Injectable | ECP | IUD | Implant | Male sterilization | Female sterilization |
|---|---|---|---|---|---|---|---|---|---|
| HP | 190 | 0 | 188 | 189 | 0 | 18 | 22 | 0 | 0 |
| CHC | 72 | 2 | 71 | 72 | 3 | 72 | 72 | 0 | 0 |
| NH/RH | 6 | 5 | 6 | 6 | 3 | 6 | 6 | 0 | 0 |
| Total | **99% (268)** | **3% (7)** | **97%(265)** | **98% (267)** | **2% (6)** | **35%(96)** | **37% (100)** | **1% (2)** | **2% (6)** |

Data source: UNFPA Family Planning Audit report

**Table 3. SDPs currently offering FP contraceptives items as per national guidelines**

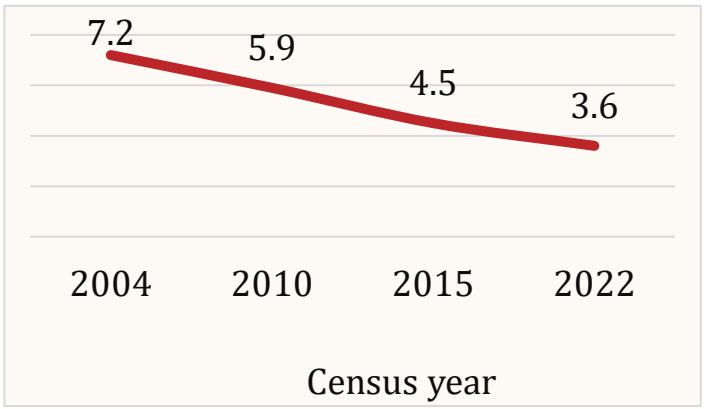
| Level of Facility | Male Condoms | Female Condom | Pills (COC/POP) | Injectable | ECP | IUD | Implant | Male sterilization | Female sterilization |
|---|---|---|---|---|---|---|---|---|---|
| HP | 74 | 1 | 144 | 143 | 0 | 22 | 32 | 0 | 0 |
| CHC | 52 | 0 | 58 | 62 | 3 | 53 | 54 | 0 | 0 |
| NH/RH | 3 | 2 | 3 | 3 | 1 | 3 | 4 | 2 | 6 |
| Total | **47%(129)** | **1%(3)** | **64%(175)** | **77%(208)** | **1%(4)** | **29%(78)** | **33%(90)** | **1%(2)** | **2%(6)** |

Data Source: UNFPA Family Planning Audit report 2022

## 5. The Unmet Need and Total Fertility Rates (TFR) in Timor-Leste

Over the past two decades the TFR in Timor-Leste has decline from 7.2 in Census 2004 to 3.6 in the census 2022. The decline of fertility is an encouraging sign that fertility patterns are changing, likely due to increased access to family planning methods, improved maternal health services, and changing socio-economic conditions. However, the fertility rate is still relatively high by global standards, particularly in comparison to other countries in Southeast Asia.

Despite this progress, the unmet need for family planning remains high at 25%, which indicates that a significant proportion of women who wish to avoid or delay pregnancy still lack access to or are unable to use family planning methods effectively, specially post pregnancy. This suggests that family planning services are either not reaching all women or there are barriers preventing them from accessing the services due to human right issue, the policy restrictions, lack of knowledge and attitude of providers as well as lack of awareness from the community. The adolescent birth rate of 4.9 is alarmingly high, reflecting both a lack of access to reproductive health services and the early onset of sexual activity and childbearing among young women. This is a critical public health issue, as early pregnancies are associated with a range of risks




**Source: Timor-Leste, Census & Housing Population 2022**

**Source: Timor-Leste, DHS 2016**

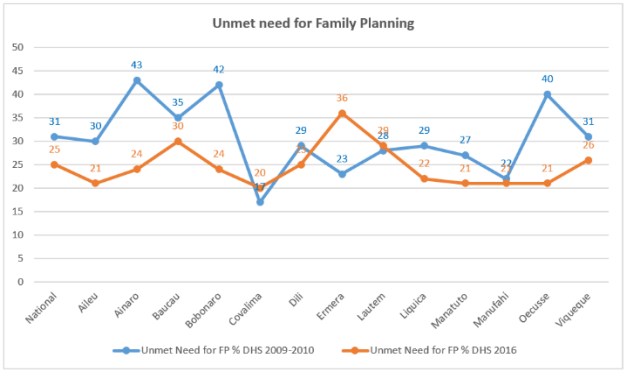
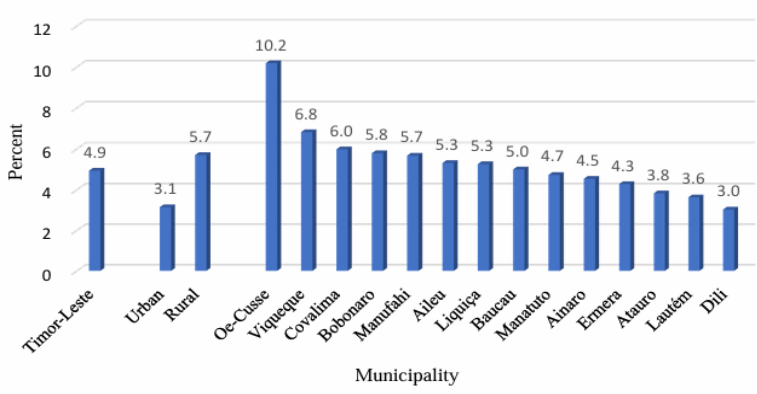



*Figure 3.11: Percentage of women age 15-19 who have started childbearing by place of residence and municipality,2022*




**Source: Timor-Leste, Census & Housing Population 2022 (Demographic Dividend)**

## 6. Aim of the Project

A comprehensive bottleneck analysis on factors influencing the expansion and sustainability of gender-responsive Post-Partum Family Planning (PPFP) and Post Abortion Family Planning (PAFP), FP Task-Sharing/ Shifting, and Social Behavior Change Communication (SBCC) Initiatives in Timor-Leste

### 6.1 Objectives

1. Desk review and policy analysis of status of FP Evidence Based Practices (EBPs)
2. Investigate stakeholders' perspectives on factors hindering the scale-up of FP EBPs
3. Facilitate stakeholder consensus on key bottlenecks to scale up BPs
4. Collaborate with stakeholders to develop targeted solutions for scaling up FP EBPs

### 6.2 Methodology

1. Desk Review Phase
    1) Desk review for identifying Gaps in coverage
        - Data Review and analysis of indicators across family Planning themes PPFP/PAPP, Task sharing and SBCC
        - Policy and guideline Analysis for identifying gaps in Guidance
    2) A thorough Examination of National policy guidance documents regarding PPFP/PAFP, Task sharing and SBCC
2. Bottleneck Identification
    1) Case studies
    2) Key Informant Interviews (KIIs)

3 Case Studies

1. Involvement of key organizations working in Reproductive Health or Family Planning
2. Identifying 1-2 case studies for each module including successful and less successful studies

### 6.3 Data Collection

1. A contextually adapted Likert Scale questionnaire was used, covering PPFP/PAFP components, task allocation, and SBC
2. Data collection was conducted through distributed KII questionnaires and digital forms for stakeholders at the national and municipal levels to capture the views of various stakeholders to identify barriers.

### 6.4 Geographical Scope

District selection criteria prioritize diversity, covering urban and rural settings and capital centers.

Dili, Ermera, Maliana, Manatuto, Baucau and Ainaro.

### 6.5 Study Population

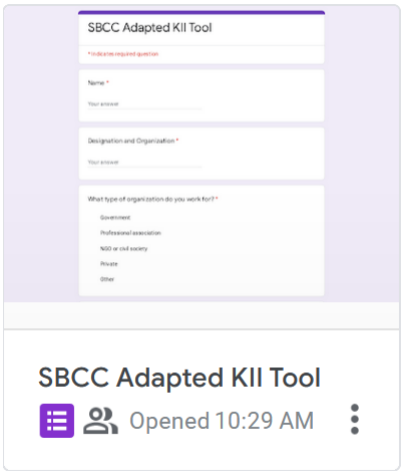
Our study population includes Policy and Manager level, health care providers and civil society

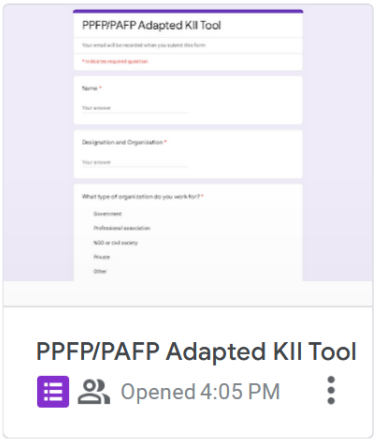
### 6.6 Data Collection Tool: Themes

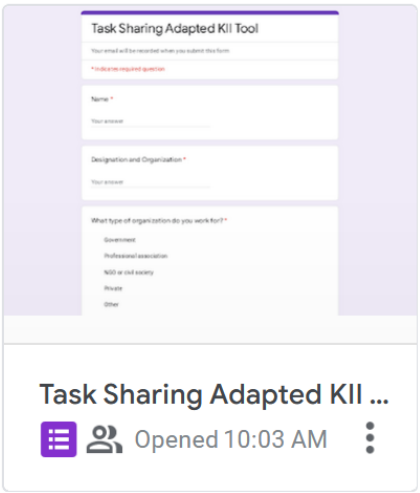
1. Implementation status
2. Governance (Leadership & commitment, Accountability, Regulation and Guidance Formulation)
3. Financing (Budgeting, Donors, Insurance, Spending allocation, Planning, Equity)
4. People (Knowledge & Awareness, Acceptability, Consultation, Coordination, Networks and Community engagement)
5. Information (Reporting, Data & HMIS, Guidelines & tools, Client IEC and Health promotion)
6. Medicines & technology (Infrastructures and Supplies)
7. Service delivery (Management, Supervision, Team work & coordination, Service organization & scheduling, Referral systems and Fees)
8. Human Resources (Training & education, Capacity, Roles, Skills & competencies and Motivation)

### 6.7 Data Collection Process

To collect data, a multifaceted strategy was used, which included using Google Forms tools and filling out the questionnaire. By sending the URL to respondents immediately, make easier for them to access.




### 6.8 Distributed Key informants interview questionario the respondents

Distributed Key informants interview questionnaires to respondents to filling out in the municipalities of Ermera, Maliana, Manatuto and Baucau can be seen as follows:

**Photos of events**

*Figure 1: The 3 respondents of Ermera municipality at the Ermera DPHO-MCH Office on August 2nd, 2024*

*Figure 2: The 2 Respondents of Maliana Municipality at Maliana DPHO-MCH Office on August 23rd 2024.*

*Figure 3: The 2 respondents of Manatuto Municipality at Manatuto DPHO-MCH office on August 26th, 2024.*

*Figure 4: The 2 respondents of Baucau Municipality at Baucau DPHO-MCH office on August 27th, 2024*

## 7. Findings of the Data Collection KII

Questionnaires tools for Post-Partum Family Planning (PPFP), Task Sharing and Social Behavior Change Communication (SBCC) are adapted for data collection. Questionnaires were distributed to the 25 respondents of PPFP/PAFP, the 26 respondents of the Task Sharing and the 27 respondents of the SBCC at the national and municipality level. Designation of respondents varies from policy decision maker up to the service delivery levels. Findings can be seen in the table 4 -10.

### 7.1 Demographic data of respondents

**Tabel 4. Distribution of respondents**

| No | Distribution of Respondents | PPFP | Task Sharing | SBCC |
|---|---|---|---|---|
| 1 | National Level | 14 | 15 | 16 |
| 2 | Municipality | 11 | 11 | 11 |
| **Total** | | **25** | **26** | **27** |

**Table 5. Designation of respondents**

| No | Respondents | PPFP | Task Sharing | SBCC |
|---|---|---|---|---|
| 1 | Policy workers | 3 | 3 | 4 |
| 2 | Program Manager | 5 | 5 | 5 |
| 3 | INSPTL | 2 | 2 | 2 |
| 3 | Clinician/providers | 8 | 8 | 8 |
| 4 | Civil Society Organization | 4 | 5 | 5 |
| 5 | UN Agency | 3 | 3 | 3 |
| **Total** | | **25** | **26** | **27** |

**Table 6. Demographic data of respondents on PPFP/SBCC/Task Sharing can be seen in the table below:**

| No | Variable/indicator | **PPFP n 25** | **SBCC n 27** | **Task Sharing n 26** |
|---|---|---|---|---|
| 1 | Designation and Organization | 14 MoH + INSPTL 2<br>9 (APTL 2, AETL 1, Academic 3, CCT:1, UN 3, Religion 1) | 15 MoH + INSPTL 2<br>10 (APTL 2, AETL 1, Academic 3, CCT:1, UN:3 Religion 1, AUSAID 1 | 14 MoH + INSPTL 2<br>9 (APTL 2, AETL 1, Academic 3, CCT:1, UN:3, Religion 1. |
| 2 | Municipality/District | 14 (60%) National<br>11 (44%) (Districts | 16 (60%) National<br>11 (44%) (Districts | 15 (60%) National<br>11 (44%) (Districts |
| 3 | What type of organization do you work for? | 21(80.8%) Government<br>4 (15.4%) Private<br>1 (3.8%) UN Agency | 22 (81.5 %) Government<br>4 (14.8 %) Private<br>1 (4%) UN Agency | 21(80.8%) Government<br>4 (15.4%) Private<br>1 (3.8%) other |
| 4 | What is your role in that organization? | 10 (40%) Program Management<br>10 (40%) Clinician or Health Workers<br>3 (12%) others<br>2 (8%) Policy | 9 (33.7%) Program Management<br>11 (40.7%) Clinician or Health Workers<br>3 (11,1%)/ Policy<br>3 (11,1%/ others<br>1 (3.7) Research/M&E | 11 (42.3%) Clinician or Health Workers<br>10 (38.5%) Program Management<br>2 (7.7%) Policy<br>2 (7.7%) others<br>1(3.8%) Research |
| 5 | At what level to you provide support to FP programmes? | 9(36%) District<br>6(24%) National<br>5 (20%) Community<br>4 (16%) Other<br>1 Sub-National or regional | 9(33,3%) District<br>8 (29.6%) National<br>5 (18.5%) Community<br>4 (14.8%) Others<br>1 (3.7% Sub-National or regional | 9 (34.6%) District<br>8 (30.8%) National<br>5 (19.2%) Community<br>3 (11.5%) Others<br>1 )3.8% ) Sub-National or regional |
| 6 | How long have you been working in or supporting FP programmes? | 13(52%) >10 years<br>5(20%) 1-3 Years<br>5(20%) 3-10 Years<br>2 (8%) < 1 Year | 12 (44.4%) >10 years<br>6 (22.2%) 1-3 Years<br>5 (18.5) 3-10 Years<br>4 (14.8%) < 1 Year | 10 (38.5%) >10 years<br>9 (34.6%)3-10 Years<br>4 (15.2%) 1-3 Years<br>3 (11.5%)< 1 Year |

**POST PREGNANCY FAMILY PLANNING**

Table 7. Respondents' opinion of the implementation of the Post-Partum and Post Abortion Family Planning Scale up in Timor-Leste can be seen in the following table:

| BNA Framework | Categories | Question | Respondents opinion of the BNA PPFP ( n: 25) |
|---|---|---|---|
| **Implementation Status** | | Postpartum and post-abortion family planning are adequately implemented and scaled-up nationally." | 18 (72 %) Fully Agree<br>3(12%) Somewhat agree<br>2 (8 %) Somewhat Disagree<br>1 (4%) Neutral<br>1 (4) missing |
| **Governance** | **Leadership and commitment,** | "There is adequate leadership and commitment to support scale-up of postpartum and post-abortion FP." | 17 (68%) Fully Agree<br>3 (12 %) Somewhat agree<br>2 (8 %) Neutral<br>1 (4 %) Somewhat Disagree<br>1 (3.7 %) Fully Disagree<br>1 (3.7 %) Don't Know |
| | **Accountability** | "There is adequate accountability for postpartum and post-abortion FP among policy makers and programme managers." | 16 (64%) Fully Agree<br>6 (24 %) Somewhat agree<br>2 (8 %) Neutral<br>1 (4 %) Fully Disagree |
| | **Regulation** | There is adequate regulation to ensure access to postpartum and post-abortion FP. | 13 (52 %) Fully Agree<br>6(24 %) Somewhat agree<br>4(16 %) Neutral<br>1 (4%) Fully Disagree<br>1 (4%) missing |
| | **Guidance Formulation** | Guidance (including policies, guidelines and tools) on postpartum and post-abortion FP is up-to-date and available to all district health teams, health facilities and education establishments. | 17(68 %) Fully Agree<br>5 (20%) Neutral<br>1 (4%) Somewhat agree<br>1 (4%) Somewhat Disagree<br>1 (4%) missing |
| **Financing** | **Budgeting** | There is adequate budget available at all levels to support postpartum and post-abortion FP scale up. | 14 (56%) Fully Agree<br>4 (16%) Somewhat agree<br>3 (12% Neutral<br>3 (12 %) Don't Know<br>1 (1.37 %) missing |
| | **Donors** | Donors adequately finance scale-up of postpartum and post-abortion FP | 15 (60 %) Fully Agree<br>4 (16%) Somewhat agree<br>3(11.1% Neutral<br>2 (8%) Somewhat Disagree<br>1 (4%) missing |
| | **Insurance** | National health insurance schemes cover access to contraceptives within post-partum and post-abortion care | 15 (60%) Fully Agree<br>3 (12%) Somewhat agree<br>3 (12%) Don't Know<br>2 (8%) Neutral<br>1 (4%) Somewhat Disagree<br>1 (4%) missing |

| BNA Framework | Categories | Question | Respondents opinion of the BNA PPFP ( n: 25) |
|---|---|---|---|
| | **Spending Allocation** | Government expenditure on PPFP matches the allocated budget | 13 (52 %) Fully Agree<br>4 (16%) Somewhat agree<br>3 (12%) Neutral<br>2 (8%) Don't Know<br>1(4%) Somewhat Disagree<br>1 (4%) Fully Disagree<br>1 (4%) missing |
| | **Planning** | There is a national plan for PPFP scale-up: | 17 (68 %) Fully Agree<br>3 (12%) Neutral<br>2 (8 %) Don't Know<br>1(4%) Somewhat agree<br>1(4%) Somewhat Disagree<br>1 (4 %) Fully Disagree |
| | **Equity** | There is equitable allocation of budget for implementation and scale-up of PPFP nationally according to population or other health and demographic criteria | 15 (60%) Fully Agree<br>4 (16%) Somewhat agree<br>2 (11.1%) Neutral<br>2 (11.1%) Don't Know<br>1 (4 %) Fully Disagree<br>1 (4%) missing |
| **People** | **Knowledge & Awareness** | There is adequate knowledge and awareness of recommended PPFP policies and practices | 16(64 %) Fully Agree<br>4 (16%) Somewhat agree<br>3 (12%) Neutral<br>1 (4 %) Somewhat Disagree<br>1 (4%) missing |
| | **Acceptability** | There is acceptance of recommended PPFP policies and practices at all levels of the health system. | 17 (68 %) Fully Agree<br>5 (20%) Somewhat agree<br>3 (12%) Neutral |
| | **Consultation** | Key stakeholders have been adequately consulted during the creation of PPFP policy and practice guidance. | 13 (52 %) Fully Agree<br>7 (28%) Somewhat agree<br>3 (12%) Neutral<br>2 (8%) Don't Know |
| | **Coordination** | There is adequate coordination between different stakeholders to ensure effective scale-up of PPFP | 16 (64 %) Fully Agree<br>4 (16%) Neutral<br>2 (8%) Somewhat agree<br>2 (8%) Don't Know<br>1 (4%) missing |
| | **Networks** | There are effective professional networks supporting scale-up of PPFP | 14 (56 %) Fully Agree<br>5 (20%) Somewhat agree<br>3 (12%) Neutral<br>2 (8%) Don't Know<br>1 (4%) missing |
| | **Community Engagements** | There is adequate community engagement to promote the benefits of postpartum FP and healthy birth-spacing | 17 (68 %) Fully Agree<br>3 (12%) Somewhat agree<br>3 (12 %) Don't Know<br>2 (8%) Neutral |
| **Information** | **Reporting, Data/HMIS, Guideline & Tools, Client IEC, Health Promotion** | There is adequate reporting on PPFP uptake and trends. | 15 (60 %) Fully Agree<br>3(12%) Somewhat agree<br>3(12%) Neutral<br>2 (8%) Somewhat Disagree<br>1 (4%) Don't Know<br>1 (4%) missing |

| BNA Framework | Categories | Question | Respondents opinion of the BNA PPFP ( n: 25) |
|---|---|---|---|
| | **Data/HMIS** | There is an effective HMIS to support data collection on PPFP, and data on PPFP is used regularly for performance management. | 15 (60 %) Fully Agree<br>6 (24%) Somewhat agree<br>3 (12%) Neutral<br>1 (4 %) Don't Know |
| | **Guideline & Tools** | Updated guidance on PPFP is available and used. | 17 (68 %) Fully Agree<br>4(16%) Neutral<br>1(4%) Somewhat agree<br>1(4%) Somewhat Disagree<br>1 (4 %) Don't Know<br>1 (4%) missing |
| | **Client IEC** | Information, education, and communication (IEC) materials on PPFP are available for use in maternal and newborn health facilities | 18 (72 %) Fully Agree<br>3 (12%) Neutral<br>2 (8%) Somewhat agree<br>1(4%) Somewhat Disagree<br>1 (4 %) Don't Know |
| | **Health Promotion** | There are adequate initiatives and interventions to promote the benefits of postpartum and post-abortion FP to women attending for care. | 17 (68 %) Fully Agree<br>4 (16%) Neutral<br>3 (12%) Somewhat agree<br>1 (4 %) Don't Know |
| **Medicine & Technology** | **Infrastructure** | There is adequate infrastructure to deliver PPFP | 19 (76 %) Fully Agree<br>4 (16%) Neutral<br>1 (4%) Somewhat agree<br>1 (4 %) Somewhat Disagree |
| | **Supplies** | Health facilities have commodities, equipment and other supplies required to deliver PPFP | 17 (68 %) Fully Agree<br>4 (16%) Neutral<br>3 (12%) Somewhat agree<br>1 (4 %) Fully Disagree |
| **Service Delivery** | **Management** | There is effective health management to support delivery of PPFP | 17 (68 %) Fully Agree<br>3(12%) Somewhat agree<br>2(8%) Neutral<br>2 (8%) Fully Disagree<br>1 (4 %) Don't Know |
| | **Supervision** | There is adequate clinical supervision to support PPFP | 16 (64 %) Fully Agree<br>4 (16%) Somewhat agree<br>3(12%) Neutral<br>1 (4 %) Fully Disagree<br>1 (4 %) Don't Know |
| | **Team Work & coordination** | Different teams involved in PPFP work together to ensure its delivery | 17 (68 %) Fully Agree<br>4(16%) Somewhat agree<br>3 (12%) Neutral<br>1 (4 %) Somewhat Disagree |
| | **Service Organization & Scheduling** | Maternal health services are structured and scheduled to ensure access to PPFP | 20 (80 %) Fully Agree<br>3(12%) Somewhat agree<br>1 (4 %) Neutral<br>1 (4 %) Somewhat Disagree |
| | **Referral system** | Referral systems between different health facility units effectively support access to PPFP | 16 (64 %) Fully Agree<br>4(16%) Somewhat agree<br>3 (12%) Neutral<br>2 (8 %) Fully Disagree |
| | **Fees** | There are no additional fees charged to women in maternity, | 20(80%) Fully Agree<br>2(8 %) Neutral |

| BNA Framework | Categories | Question | Respondents opinion of the BNA PPFP ( n: 25) |
|---|---|---|---|
| | | post-natal care and post-abortion care for taking FP | 2 (8%) Somewhat Disagree<br>1 (4%) Somewhat agree |
| **Human Resource** | | Pre- and in-service training of health workers is adequately supporting PPFP provision | 17 (68 %) Fully Agree<br>5(20%) Neutral<br>2 (8%) Somewhat agree<br>1 (4 %) Fully Disagree |
| | **Capacity** | Health workers in MNH services have capacity to deliver PPFP | 15 (60%) Fully Agree<br>5(20%) Neutral<br>4(16%) Somewhat agree<br>1 (4 %) Don't Know |
| | **Roles** | PPFP provision is included in maternity/post-natal and abortion clinical staff job descriptions | 17(68 %) Fully Agree<br>3(12%) Neutral<br>2 (8 %) Somewhat agree<br>1 (4%) Somewhat Disagree<br>1 (4 %) Fully Disagree<br>1 (4 %) Don't Know |
| | **Skills & competences** | MNH staff have the requisite skills and competencies to deliver PPFP | 18 (72 %) Fully Agree<br>4 (16%) Somewhat agree<br>2 (8%) Neutral<br>1 (4%) Somewhat Disagree |
| | **Motivation** | MNH staff (working in ANC, maternity, PNC, infant care, abortion care) are motivated to provide **Training & Education, Capacity, Roles, Skills & competences, Motivation** PPFP | 17 (68 %) Fully Agree<br>4(16%) Somewhat agree<br>2(8%) Neutral<br>1 (4%) Somewhat Disagree<br>1 (4 %) Fully Disagree |

From the table above shows that Respondents' opinion on the implementation of the Post-Partum and Post Abortion Family Planning Scale up in Timor-Leste

**1. Implementation Status Post Pregnancy Family Planning (PPFP):**

- **Key Insight**: A large majority of respondents (72%) agree that postpartum and post-abortion family planning is adequately implemented and scaled-up nationally. This indicates relatively strong national implementation, signaling that significant progress has been made in integrating PPFP services within health systems.
- **Implication**: There appears to be widespread support for PPFP, with ongoing efforts likely leading to increased access and use of these services. However, there's still room for improvement in ensuring consistent nationwide coverage focusing on data collection and address the context in the policy and strategy and formulation of manual implementation and guideline.

**2. Governance:**

- **Leadership and Commitment (68%)**: The majority of respondents agree that there is adequate leadership and commitment to support the scale-up of PPFP, which is a positive indicator for future growth and sustainability of these programs.
- **Accountability and Regulation (64%)**: Respondents largely agree that there is accountability and adequate regulation to support PPFP. These results reflect a favorable governance structure in terms of holding policymakers and program managers accountable and ensuring that regulations are in place to ensure access to these services.

- **Guidance Formulation (52%)**: Half of the respondents agree that guidance and policies related to PPFP are up-to-date and available to all relevant health teams. This suggests a need for continuous updates and wider distribution of policies to ensure consistency in service delivery.

**3. Financing:**

- **Budgeting and Spending Allocation (56% to 52%)**: While a majority (56%) agree that there is an adequate budget for PPFP at all levels, the 52% agreement on spending allocation matching the allocated budget indicates potential misalignment or inefficiencies in funding distribution.
- **Donors and Insurance (60%)**: 60% of respondents agree that donors adequately finance PPFP scale-up, and a similar percentage believe that national health insurance schemes cover access to contraceptives within post-partum and post-abortion care. These findings reflect a strong reliance on external financing and a good integration of PPFP within insurance schemes.
- **Equity and Planning (60% to 68%)**: The relatively high percentages (60%-68%) agree that there is equitable allocation of resources and that there is a national plan for PPFP scale-up, showing some success in addressing demographic disparities in access and ensuring structured planning.

**4. People Engagement:**

- **Knowledge & Awareness (64%)**: A solid majority of respondents (64%) agree that there is adequate knowledge and awareness of recommended PPFP policies. This shows that most stakeholders are informed, though efforts can still be made to ensure universal understanding.
- **Acceptability and Coordination (64% to 68%)**: Respondents largely agree that PPFP is accepted at all levels of the health system, and there is good coordination between stakeholders. However, the moderate scores in consultation (52%) and network support (56%) suggest that engagement could be expanded to ensure all voices are heard in policy formation and service delivery.
- **Community Engagement (68%)**: The high percentage (68%) agreement regarding community engagement indicates that local outreach efforts are effectively promoting PPFP, suggesting a solid foundation for continued scaling-up of services.

**5. Information Systems:**

- **Reporting and Data (60% to 60%)**: The consistent 60% agreement that there is adequate reporting on PPFP uptake and that an effective HMIS supports data collection and performance management is a positive sign of data-driven decision-making, though improvements may be needed in more widespread use of data for real-time adjustments.
- **Guidelines & Tools (68%)**: A significant number of respondents agree that updated guidance on PPFP is available and used. This indicates a relatively high level of support for ensuring health workers are equipped with relevant tools and guidelines.
- **IEC and Health Promotion (72% to 68%)**: The availability of IEC materials and effective health promotion initiatives to communicate the benefits of PPFP is very positively received, signaling that health promotion efforts are well-targeted and widely implemented.

**6. Medicine & Technology:**

- **Infrastructure and Supplies (76% to 68%)**: There is strong agreement that adequate infrastructure (76%) and supplies (68%) are in place to deliver PPFP. This is a critical enabler for the successful delivery of these services, as access to necessary commodities and equipment directly affects service delivery.

**7. Service Delivery:**

- **Management and Supervision (68% to 64%)**: The general agreement on effective health management (68%) and adequate clinical supervision (64%) suggests that PPFP services are well-supported by robust managerial and supervisory frameworks, which ensures quality and consistency in service delivery.
- **Teamwork and Coordination (68%)**: High agreement on teamwork and coordination (68%) suggests that various healthcare providers and teams are collaborating effectively to ensure PPFP services are delivered efficiently.
- **Service Organization and Scheduling (80%)**: The highest agreement (80%) is found in the organization and scheduling of services to ensure access to PPFP, which points to well-organized maternal health services that prioritize family planning access during key moments, such as after childbirth and abortion care.
- **Referral Systems and Fees (64% to 80%)**: The 80% agreement that there are no additional fees for FP services in maternal and post-abortion care is a critical finding, as it highlights the affordability of services and ensures that women are not deterred by financial barriers. The moderate agreement on the referral system (64%) indicates there might be areas to improve how PPFP services are linked across different health facility units.

**8. Human Resources:**

- **Training and Education (68%)**: A significant percentage of respondents (68%) agree that pre-service and in-service training adequately supports PPFP provision. This shows a good level of capacity-building among health workers, though there may still be gaps that require attention.
- **Capacity and Motivation (60% to 72%)**: Respondents generally agree that health workers have the capacity (60%) and motivation (68%) to provide PPFP services. However, the lower figure on capacity suggests that further investment may be needed to build or sustain workers' skills in the area of PPFP.
- **Roles and Competencies (68% to 72%)**: High percentages (68%-72%) of respondents agree that PPFP provision is integrated into job descriptions and that health workers possess the requisite skills and competencies to deliver these services. This is an encouraging finding that signals a well-prepared workforce for PPFP delivery.

**Key Recommendations for Improvement:**

1. **Strengthen Stakeholder Consultation and Network Support**: While most respondents agree on the effectiveness of consultation and professional networks, there's room to deepen involvement of a wider range of stakeholders, particularly at local levels, to ensure comprehensive policy development and implementation.
2. **Improve Spending Allocation and Budget Alignment**: Despite a positive outlook on budgeting, the gap in government spending allocation matching the allocated budget should be addressed. This ensures that the funds available are utilized optimally for PPFP scale-up.
3. **Expand Data Utilization and Reporting**: Although data collection and reporting mechanisms are in place, improving the real-time use of data for decision-making could enhance the responsiveness and effectiveness of PPFP programs.
4. **Enhance Capacity Building and Training**: Focus on expanding the capacity of health workers to deliver PPFP services effectively, through enhanced training, and increase the motivation and support for providers to ensure long-term success.
5. **Improve Referral Systems**: Strengthen referral systems across health facilities to ensure that women accessing PPFP services are seamlessly referred for further care when needed

**Conclusion:**

The survey indicates that postpartum and post-abortion family planning (PPFP) services are being relatively well implemented and scaled up, with strong leadership, adequate infrastructure, and a generally supportive policy environment. However, the results highlight areas that need further attention, such as improving stakeholder consultation, strengthening the capacity of health workers, ensuring better alignment of funds with spending, and refining referral systems. By addressing these areas, PPFP services can be even more effective and accessible, improving maternal and reproductive health outcomes.

**TASK SHARING**

**Table 8. Respondents' opinion of the implementation of the Task Sharing Scale up in Timor-Leste can be seen in the following table:**

| BNA Framework | Categories | Question | Respondents' opinion of the BNA Task Sharing (n: 26) |
|---|---|---|---|
| **Implementation Status** | | Task-sharing for family planning is adequately implemented and scaled-up nationally | 9 (34.6%) Somewhat agree<br>6 (23.1%) Neutral<br>5 (19.2 %) Fully Agree<br>5 (19.2 %) Fully Disagree<br>1 (3.8%) Somewhat Disagree |
| **Governance** | **Leadership and commitment** | There is adequate leadership and commitment to support scale-up of task-sharing for FP. | 13 (50%) Fully Agree<br>9 (34.6%) Somewhat agree<br>2 (7.7 %) Neutral<br>1 (3.8 %) Fully Disagree<br>1 (3.8 %) Don't Know |
| | **Accountability** | There is adequate accountability for task-sharing for FP among policy makers and programme managers | 12 (46.2%) Fully Agree<br>7 (26.9 %) Somewhat agree<br>3 (11.5 %) Neutral<br>3 (11.5 %) Fully Disagree<br>1 (3.8%) Somewhat agree |
| | **Regulation** | There is adequate regulation to ensure effective task-sharing for FP. | 13 (50 %) Fully Agree<br>6 (23.1 %) Somewhat agree<br>3 (11.5 %) Neutral<br>3 (11.5%) Fully Disagree<br>1(3.8%) somewhat Disagree |
| | **Guidance Formulation** | Guidance (including policies, guidelines and tools) on task-sharing for FP is up-to-date and available to all district health teams, health facilities and education establishments. | 12 (46.2 %) Fully Agree<br>8 (30.8%) Somewhat agree<br>3 (11.5% Neutral<br>2 (7.7%) Fully Disagree<br>1 (3.7%) Don't Know |
| **Financing** | **Budgeting** | There is adequate budget available at all levels to support task-sharing for FP scale up | 13 (50 %) Fully Agree<br>6 (23.1 %) Somewhat agree<br>6 (23.1 %) Neutral<br>1 (3.8 %) Don't Know |
| | **Donors** | Donors adequately finance scale-up of task-sharing for FP | 14 (53.8 %) Fully Agree<br>6 (23.1 %) Somewhat agree<br>5 (19.2 %) Neutral<br>1 (3.8 %) Fully Disagree |
| | **Insurance** | National health insurance schemes cover access to | 10 (38.5%) Fully Agree<br>6 (23.1%) Somewhat agree<br>5 (19.2%) Neutral |

| BNA Framework | Categories | Question | Respondents' opinion of the BNA Task Sharing (n: 26) |
|---|---|---|---|
| | | contraception through community health workers | 3 (11.5%) Don't Know<br>1 (3.8%) somewhat Disagree<br>1 (3.8%) Fully Disagree |
| | **Spending Allocation** | Government expenditure on task-sharing matches the allocated budget | 12 (46.2 %) Fully Agree<br>5 (19.2%) Neutral<br>4 (15.4%) Fully Disagree<br>2(7.7%) Somewhat agree<br>2 (7.7%) Don't Know<br>1(3.8%) Somewhat Disagree |
| | **Planning** | There is a national plan for task-sharing scale-up | 11 (42.3 %) Fully Agree<br>7 (26.9%) Somewhat agree<br>4 (15.4%) Neutral<br>3 (11.5 %) Fully Disagree<br>1 (3.8 %) Don't Know |
| | **Equity** | There is equitable allocation of budget for implementation and scale-up of task-sharing nationally according to population or other health and demographic criteria | 11 (42.3%) Fully Agree<br>6 (23.1%) Somewhat agree<br>4 (15.4%) Neutral<br>2 (7.7 %) Fully Disagree<br>2 (7.7%) Don't Know<br>1 (3.8%) somewhat Disagree |
| **People** | **Knowledge & Awareness** | There is adequate knowledge and awareness of recommended task-sharing policies and practices | 15 (57.7 %) Fully Agree<br>4 (15.4.2%) Somewhat agree<br>4 (15.4%) Neutral<br>2 (7.7 %) Fully Disagree<br>1 (3.8%) somewhat Disagree |
| | **Acceptability** | There is acceptance of recommended task-sharing policies and practices at all levels. | 15 (57.7 %) Fully Agree<br>5 (19.2%) Somewhat agree<br>4 (15.4%) Neutral<br>1 (3.8 %) Fully Disagree<br>1 (3.8 %) Don't Know |
| | **Consultation** | Key stakeholders have been adequately consulted during the creation of task-sharing policy and practice guidance. | 15 (57.7 %) Fully Agree<br>5 (19.2%) Somewhat agree<br>3 (11.5%) Neutral<br>2 (7.7 %) Fully Disagree<br>1 (3.8 %) Don't Know |
| | **Coordination** | There is adequate coordination between different stakeholders to ensure effective scale-up of task-sharing for FP | 13 (50 %) Fully Agree<br>8 (38.8%) Neutral<br>4(15.4%) Somewhat agree<br>1 (3.8 %) Fully Disagree |
| | **Networks** | There are effective professional networks supporting scale-up of task-sharing | 12 (46.2 %) Fully Agree<br>6 (23.1%) Somewhat agree<br>5 (19.2%) Neutral<br>2 (7.7 %) Don't Know<br>1 (3.8 %) Fully Disagree |
| | **Community Engagements** | There is adequate community engagement on task-sharing | 13(50 %) Fully Agree<br>6 (23.1%) Somewhat agree<br>4 (15.4%) Neutral<br>2 (7.7 %) Fully Disagree<br>1 (3.8 %) Don't Know |
| **Information** | **Reporting** | There is adequate reporting on task-sharing. | 14 (53.8 %) Fully Agree<br>5 (19.2 %) Somewhat agree<br>4 (15.4 %) Neutral |

| BNA Framework | Categories | Question | Respondents' opinion of the BNA Task Sharing (n: 26) |
|---|---|---|---|
| | | | 2 (7.7 %) Fully Disagree<br>1 (3.8 %) Don't Know |
| | **Data/HMIS** | There is an effective HMIS to support data collection on task-sharing and data is used regularly for performance management. | 13 (50 %) Fully Agree<br>7 (26.9 %) Somewhat agree<br>5 (19.2 %) Neutral<br>1 (3.8 %) Fully Disagree |
| | **Guideline & Tools** | Updated guidance on task-sharing is available and used. | 17 (65.4 %) Fully Agree<br>4 (15.4%) Neutral<br>3 (11.5%) Somewhat agree<br>1 (3.8%) Somewhat Disagree<br>1 (3.8%) Fully Disagree |
| | **Client IEC** | Information, education, and communication (IEC) materials exist to support task-sharing | 13 (50 %) Fully Agree<br>7 (26.9%) Somewhat agree<br>3 (11.5%) Neutral<br>2 (7.7%) Fully Disagree<br>1 (3.8 %) Don't Know |
| | **Health Promotion** | The benefits of task-sharing are adequately communicated via effective health promotion activities. | 15 (57.7 %) Fully Agree<br>6 (23.1%) Somewhat agree<br>3 (11.5%) Neutral<br>2 (7.7%) Fully Disagree |
| **Medicine & Technology** | **Infrastructure** | There is adequate health infrastructure to deliver task-sharing for FP | 14 (53.8 %) Fully Agree<br>6 (23.1%) Neutral<br>4 (15.4%) Somewhat agree<br>2 (7.7%) Fully Disagree |
| | **Supplies** | Health facilities and community health programmes have commodities, equipment and other supplies required to deliver task-sharing | 11 (42.3 %) Fully Agree<br>9 (34.6%) Somewhat agree<br>5 (19.2%) Neutral<br>1 (3.8 %) Fully Disagree |
| **Service Delivery** | **Management** | There is effective health management to support task-sharing | 15 (57.7 %) Fully Agree<br>5 (19.2%) Neutral<br>4 (15.4%) Somewhat agree<br>2 (7.7 %) Fully Disagree |
| | **Supervision** | There is adequate clinical supervision to support task-sharing | 14 (53.8 %) Fully Agree<br>5 (19.2%) Neutral<br>4 (15.4%) Somewhat agree<br>3 (11.5 %) Fully Disagree |
| | **Team Work & coordination** | Different teams involved in task-sharing work together to ensure its delivery | 11 (42.3 %) Fully Agree<br>6 (23.1%) Neutral<br>5 (19.2%) Somewhat agree<br>2 (7.7 %) Fully Disagree<br>1(3.8%) Somewhat Disagree<br>1 (3.8 %) Don't Know |
| | **Service Organization & Scheduling** | The organization of services makes task-sharing feasible (which providers allocated to which rooms/depts. etc.) | 14 (53.8 %) Fully Agree<br>5 (19.2%) Somewhat agree<br>4 (15.4%) Neutral<br>2 (7.7 %) Fully Disagree<br>1 (3.8 %) Don't Know |
| | **Referral system** | Referral systems support task-sharing | 13 (50 %) Fully Agree<br>7 (26.9%) Somewhat agree<br>4 (15.4%) Neutral |

| BNA Framework | Categories | Question | Respondents' opinion of the BNA Task Sharing (n: 26) |
|---|---|---|---|
| | | | 1(3.8%) Somewhat Disagree<br>1(3.8%) Fully Disagree |
| | **Fees** | There are no additional fees when FP methods are shared to lower cadre providers (i.e. for injectable when delivered by CHWs, and implants when delivered by auxiliary nurses) | 11 (42.3%) Fully Agree<br>7 (26.9%) Somewhat agree<br>5 (19.2%) Neutral<br>3 (11.5%) Fully Disagree |
| **Human Resource** | **Training & Education** | Task-sharing is integrated adequately into pre- and in-service training of health workers | 12 (46.2 %) Fully Agree<br>6 (23.1%) Somewhat agree<br>4 (15.4%) Neutral<br>3 (11.5%) Fully Disagree<br>1 (3.8%) Somewhat Disagree |
| | **Capacity** | Health workers in MNH services have capacity to deliver task-sharing | 9 (34.6%) Somewhat agree<br>7 (26.9%) Fully Agree<br>4(15.4%) Neutral<br>3 (11.5 %) Fully Disagree<br>2 (7.7%) Somewhat Disagree<br>1 (3.8% missing/error |
| | **Roles** | The relevant FP method provision is included in job descriptions of staff who are assuming new FP provision | 12 (46.2 %) Fully Agree<br>6 (23.1%) Somewhat agree<br>5 (19.2%) Neutral<br>3 (11.5 %) Fully Disagree |
| | **Skills & competences** | Competency assessments take account of task-sharing and additional support needs. | 14 (53.8 %) Fully Agree<br>7 (26.9%) Somewhat agree<br>3 (11.5%) Neutral<br>2 (7.7 %) Fully Disagree |
| | **Motivation** | Providers involved in task-sharing have positive attitudes towards the policy | 13 (50 %) Fully Agree<br>8 (30.8%) Somewhat agree<br>3 (11.5%) Neutral<br>2 (7.7 %) Fully Disagree |

The table above shows respondents' opinions on the implementation of the Postpartum and Post-Abortion Family Planning scale-up in Timor-Leste on Task Sharing Scale up in Timor-Leste in Timor-Leste.

1. **Implementation Status Task Sharing**

- **Key Insight**: The low percentage of respondents who fully agree that task-sharing for FP is adequately implemented and scaled up nationally (34.6%) indicates that task-sharing is not yet fully integrated or operationalized across the country.
- **Implication**: There are significant barriers in scaling up task-sharing, which may include lack of resources, coordination, or political will.

**2. Governance:**

- **Leadership and Commitment (50%)**: Half of the respondents agree that leadership and commitment to scale-up task-sharing for FP is adequate. While this is promising, it suggests that leadership commitment could be more robust to push task-sharing forward.
- **Accountability (46.2%)**: Slightly under half of the respondents agreed on the adequacy of accountability for task-sharing. This might point to gaps in monitoring and enforcement, making it difficult to track and hold accountable those responsible for implementing task-sharing practices.

- **Regulation and Guidance (50% agreement)**: Although respondents are split on the adequacy of regulation and guidance, the middle-ground results suggest that policies and regulations around task-sharing for FP may exist but may not be widely understood or enforced effectively.

**3. Financing:**

- **Budgeting (50%)**: While there is a relatively even split between agreement and disagreement on adequate budgeting, it suggests that while some levels of government or organizations are committing resources to task-sharing, funding remains a critical issue.
- **Donors (53.8%)**: The support from donors is acknowledged but remains moderate. Task-sharing for FP may rely heavily on external funding, which could be unstable or insufficient in the long term.
- **Insurance (38.5%)**: The low level of agreement on health insurance coverage for contraception via community health workers indicates a significant gap in integrating task-sharing into national health insurance schemes. This could be a major hurdle for ensuring sustainable and equitable access to services.
- **Spending Allocation and Equity (42.3%)**: Both government spending allocation and equitable distribution of resources for task-sharing are areas where improvements are necessary. The relatively low agreement suggests that funding may not be appropriately distributed to the most underserved or vulnerable populations.

**4. People Engagement:**

- **Knowledge & Awareness (57.7%)**: There is general agreement that there is sufficient knowledge and awareness of task-sharing policies. This is a positive sign, suggesting that stakeholders are familiar with the key concepts of task-sharing.
- **Acceptability and Consultation (57.7%)**: These positive results indicate that task-sharing policies are broadly accepted and that key stakeholders have been adequately consulted in the process of developing task-sharing policies. However, the numbers also suggest that efforts in this area could still be improved by ensuring ongoing buy-in and consultation.
- **Coordination and Community Engagement (50%)**: While half of the respondents agree on adequate coordination and community engagement, the mixed response highlights room for improvement in ensuring seamless coordination among stakeholders and that community members are meaningfully engaged.

**5. Information Systems:**

- **Reporting and Data Collection (53.8% to 50%)**: The general sentiment that task-sharing activities are adequately reported and supported by data is a positive sign. However, the 50% agreement shows that there are still gaps in effectively capturing and reporting task-sharing activities, which could hinder timely decision-making.
- **Guidelines & Tools (65.4%)**: A higher agreement here indicates that updated guidance and tools are available and used in the field, which is a key enabler for successful task-sharing implementation.
- **IEC and Health Promotion (50% to 57.7%)**: The availability of IEC materials and communication efforts to promote task-sharing show moderate to positive results. This indicates that health promotion efforts to communicate the benefits of task-sharing are reaching key stakeholders, though there may be opportunities to improve reach or messaging.

**6. Service Delivery:**

- **Management and Supervision (53.8% to 57.7%)**: The relatively high agreement that management and clinical supervision are adequate shows that, in general, task-sharing is supported by effective health management structures and oversight.
- **Teamwork and Coordination (42.3%)**: The low agreement on teamwork and coordination suggests that there are challenges in aligning the various teams involved in task-sharing. This may result in inefficiencies or gaps in service delivery.
- **Referral Systems and Fees (50% to 42.3%)**: While 50% of respondents agree on the adequacy of referral systems to support task-sharing, the relatively low score on the absence of fees for lower cadre providers delivering FP services signals that there may be logistical or financial barriers in the task-sharing process.

**7. Human Resources:**

- **Training and Education (46.2% to 50%)**: A significant portion of respondents agree that task-sharing is integrated into training curricula. However, the low percentages (around 46-50%) reflect that training may not be comprehensive or widespread enough to ensure that all relevant health workers are adequately prepared for task-sharing roles.
- **Capacity and Skills (34.6% to 53.8%)**: The particularly low agreement (34.6%) regarding health workers' capacity to deliver task-sharing is concerning, as it indicates a serious gap in ensuring health workers are equipped with the necessary skills and confidence to carry out task-sharing effectively. On the other hand, 53.8% agreement on the adequacy of competency assessments for task-sharing is a promising sign.
- **Motivation (50%)**: Half of the respondents agree that providers have positive attitudes towards task-sharing, but there's room for improvement in boosting morale and motivating health workers to fully embrace task-sharing roles.

**Key Recommendations for Improvement:**

1. **Increase Awareness and Buy-in**: While awareness and acceptability are relatively positive, further efforts are needed to ensure task-sharing is widely embraced at all levels, from policymakers to frontline health workers.
2. **Enhance Coordination**: Strengthen the coordination among various health system stakeholders, especially between community health workers, health facilities, and government bodies, to ensure seamless delivery of task-sharing interventions.
3. **Address Capacity Gaps**: Invest in training and building the capacity of health workers to deliver task-sharing effectively. Addressing gaps in both pre-service and in-service training will be crucial for scaling up task-sharing.
4. **Secure and Allocate Adequate Financing**: The financing landscape for task-sharing needs to be more robust, especially in terms of insurance coverage and equitable resource allocation. Ensure that task-sharing interventions are not solely reliant on external donors and that national budgets reflect the commitment to scaling up these interventions.
5. **Improve Data and Reporting Systems**: Strengthen the health management information systems (HMIS) for task-sharing to improve data collection, analysis, and decision-making. Regular reporting will help ensure transparency and accountability.

**Conclusion:**

While there are some positive findings indicating progress with task-sharing for family planning, the survey reveals several critical areas for improvement. These include enhancing coordination, addressing financing and insurance gaps, improving training, and ensuring that the system is adequately supported by data and supervision. Focusing on these areas could help accelerate the effective scaling up of task-

sharing, ensuring that family planning services are more widely available, accessible, and sustainable across the country.

## SOCIAL BEHAVIORAL CHANGE COMMUNICATION (SBCC)

**Table 9. Respondents' opinion of the implementation of the social behavior Change Communication (SBCC) Scale up in Timor-Leste can be seen in the following table:**

| BNA Framework | Categories | Question | Respondents opinion of the BNA SBCC ( n: 27) |
|---|---|---|---|
| **Implementation Status** | | SBC for family planning is adequately implemented and scaled-up nationally | 20 (74.1 %) Fully Agree<br>3(11.1%) Somewhat agree<br>2(7.4%) Don't Know<br>1 (3.7%) Neutral<br>1 (3.7%) Fully Disagree |
| **Governance** | **Leadership and commitment** | There is adequate leadership and commitment to support scale-up of SBC for FP. | 19 (70.4%) Fully Agree<br>4 (14.8 %) Somewhat agree<br>2 (7.4 %) Neutral<br>1 (3.7 %) Somewhat Disagree<br>1 (3.7 %) Don't Know |
| | **Accountability** | There is adequate accountability for SBC for FP among policy makers and programme managers | 19 (70.4%) Fully Agree<br>3 (11.1 %) Somewhat agree<br>2 (7.4 %) Somewhat Disagree<br>1 (3.7%) Neutral<br>1 (3.7 %) Don't Know<br>1 (3.7 %) Not applicable |
| | **Regulation** | There is adequate regulation to ensure effective SBC for FP. | 14 (51.9 %) Fully Agree<br>4(14.8 %) Somewhat agree<br>4(14.8 %) Neutral<br>3 (11.1%) Fully Disagree<br>2(7,4 % )Don't Know |
| | **Guidance Formulation** | Guidance (including policies, guidelines, and tools) on SBC for FP is available and up to date | 16 (59.3 %) Fully Agree<br>4 (14.8%) Somewhat agree<br>5 (18.5% Neutral<br>1 (3.7%) Fully Disagree<br>1 (3.7%) Don't Know |
| **Financing** | **Budgeting** | There is adequate budget available at all levels for scale-up of SBC for FP. | 12 (44.7 %) Fully Agree<br>6 (22.2%) Somewhat agree<br>6 (22.2% Neutral<br>1 (3.7 %) Somewhat Disagree<br>1 (3.7%) Neutral<br>1 (3.7 %) Don't Know |
| | **Donorss** | Donors adequately finance scale-up of SBC for FP | 16 (59.3 %) Fully Agree<br>7 (25.9%) Somewhat agree<br>3(11.1% Neutral<br>1 (3.7%) Don't Know |
| | **Insurance** | National health insurance schemes cover access to contraception through community health workers | 18 (66.7 %) Fully Agree<br>3 (11.1%) Somewhat agree<br>3(11.1%) Neutral<br>2 (7.4%) Fully Disagree<br>1 (3.7%) Don't Know |
| | **Spending Allocation** | Government expenditure on SBC matches the allocated budget | 14 (51.9 %) Fully Agree<br>5(18.5%) Somewhat agree<br>4(14.8%) Neutral<br>2 (7.4%) Fully Disagree |

| BNA Framework | Categories | Question | Respondents opinion of the BNA SBCC ( n: 27) |
|---|---|---|---|
| | | | 2 (7.4%) Don't Know |
| | **Planning** | There is a national plan for SBC scale-up: | 15 (55.6 %) Fully Agree<br>8(29.6%) Somewhat agree<br>2 (7.4%) Neutral<br>1 (3.7 %) Fully Disagree<br>1 (3.7 %) Don't Know |
| | **Equity** | There is equitable allocation of budget for implementation and scale-up of SBC for FP nationally according to population or other health and demographic criteria | 13 (48.1%) Fully Agree<br>6 (22.2%) Somewhat agree<br>3 (11.1%) Neutral<br>3 (11.1%) Don't Know<br>1 (3.7 %) somewhat Disagree<br>1 (3.7 %) Fully Disagree |
| **People** | **Knowledge & Awareness** | There is adequate knowledge and awareness of recommended SBC policies and practices: | 16 (59.3 %) Fully Agree<br>6(22.2%) Somewhat agree<br>3 (11.1%) Neutral<br>1 (3.7 %) Fully Disagree<br>1 (3.7 %) Don't Know |
| | **Acceptability** | There is acceptance of recommended SBC policies and practices at all levels. | 14 (51.9 %) Fully Agree<br>7 (25.9%) Somewhat agree<br>3 (11.1%) Neutral<br>2 (7.4 %) Don't Know<br>1 (3.7 %) Fully Disagree |
| | **Consultation** | Key stakeholders have been adequately consulted about SBC recommended approaches (or guidance if it exists) | 16 (59.3 %) Fully Agree<br>5 (18.5%) Somewhat agree<br>5 (18.5%) Neutral<br>1 (3.7 %) Fully Disagree |
| | **Coordination** | There is adequate coordination between different stakeholders to ensure effective scale-up of SBC for FP | 20 (74.1 %) Fully Agree<br>4 (14.8%) Neutral<br>3(11.1%) Somewhat agree |
| | **Networks** | There are effective professional networks supporting scale-up of SBC for FP | 20 (74.1 %) Fully Agree<br>4 (14.8%) Somewhat agree<br>2 (7.4%) Neutral<br>1 (3.7 %) Don't Know |
| | **Community Engagements** | There is adequate community engagement on SBC for FP | 16 (59.3 %) Fully Agree<br>6 (22.2%) Somewhat agree<br>4(14.8%) Neutral<br>1 (3.7 %) Don't Know |
| **Information** | **Reporting** | There is adequate reporting on SBC activities. | 19 (70.4 %) Fully Agree<br>5 (18.5%) Somewhat agree<br>3 (11.5%) Neutral |
| | **Data/HMIS** | There is an effective HMIS to support data collection on SBC activities and/or referral from demand-generation activities, and data is used regularly for performance management. | 17 (63 %) Fully Agree<br>6 (22.2%) Neutral<br>4 (14.8%) Somewhat agree |

| BNA Framework | Categories | Question | Respondents opinion of the BNA SBCC ( n: 27) |
|---|---|---|---|
| | **Guideline & Tools** | Updated guidance on SBC for FP is available and used. | 16 (59.3 %) Fully Agree<br>4 (14.8%) Somewhat agree<br>4 (14.8%) Neutral<br>2 (7.4%) Fully Disagree<br>1 (3.7 %) Don't Know |
| | **Client IEC** | Information, education, and communication (IEC) materials exist to support SBC for FP | 16 (59.3 %) Fully Agree<br>9 (33.3%) Somewhat agree<br>2 (7.4%) Neutral |
| | **Health Promotion** | Communication on FP is integrated with health promotion activities. | 17 (63 %) Fully Agree<br>7 (25.9%) Somewhat agree<br>3 (11.1%) Neutral |
| **Medicine & Technology** | **Infrastructure** | There is adequate health infrastructure to deliver SBC for FP | 14 (51.9 %) Fully Agree<br>9 (33.3%) Somewhat agree<br>3 (11.1%) Neutral<br>1 (3.7 %) Fully Disagree |
| | **Supplies** | Health facilities and community health programmes have commodities, equipment and other supplies required to deliver SBC for FP | 16 (59.3 %) Fully Agree<br>7 (25.9%) Somewhat agree<br>3 (11.1%) Neutral<br>1 (3.7 %) Fully Disagree |
| **Service Delivery** | **Management** | There is effective health management to support SBC | 18 (66.7 %) Fully Agree<br>4(14.8%) Somewhat agree<br>3(11.1%) Neutral<br>2 (7.4%) Fully Disagree |
| | **Supervision** | There is adequate supervision to support SBC | 17 (63 %) Fully Agree<br>5(18.5%) Somewhat agree<br>4(14.8%) Neutral<br>1 (3.7 %) Fully Disagree |
| | **Team Work & coordination** | Community health teams and CHWs work in a coordinated way with health facilities | 20 (74.1 %) Fully Agree<br>4 (14.8%) Neutral<br>3 (11.1%) Somewhat agree |
| | **Service Organization & Scheduling** | The organization of services makes SBC feasible | 17 (63 %) Fully Agree<br>7(25.9%) Somewhat agree<br>3 (11.1%) Neutral |
| | **Referral system** | There are effective referral systems between community outreach workers/SBC agents/CHWs and static health facilities | 18 (66.7 %) Fully Agree<br>4(14.8%) Somewhat agree<br>4(14.8%) Neutral<br>1(3.7%) Don't Know |
| | **Fees** | There are no fees for accessing FP services, or specific methods | 22(81.5 %) Fully Agree<br>4 (14.8 %) Neutral<br>1 (3.7%) Somewhat agree |
| | **Training & Education** | There is adequate training on SBC for FP | 20 (74.1 %) Fully Agree<br>4 (14.8%) Somewhat agree<br>3 (11.1%) Neutral |
| | **Capacity** | Health facilities have capacity to deliver SBC for FP | 17 (63 %) Fully Agree<br>5(18.5%) Somewhat agree<br>4(14.8%) Neutral |

| BNA Framework | Categories | Question | Respondents opinion of the BNA SBCC ( n: 27) |
|---|---|---|---|
| **Human Resource** | | | 1 (3.7 %) Fully Disagree |
| | **Roles** | SBC is included in the relevant provider and manager job descriptions | 16 (59.3 %) Fully Agree<br>6 (22.2%) Somewhat agree<br>4(14.8%) Neutral<br>1 (3.7 %) Fully Disagree |
| | **Skills & competences** | Health promotion managers and officers have sufficient skills and competencies to design and implement effective SBC approaches for SBC | 17 (63 %) Fully Agree<br>6 (22.2%) Somewhat agree<br>4(14.8%) Neutral |
| | **Motivation** | Health workers involved in SBC have positive attitudes towards the policy | 18 (66.7 %) Fully Agree<br>5(18.5%) Somewhat agree<br>4(14.8%) Neutral |

From the table above shows that Respondents' opinion of the implementation of the social behavior Change Communication (SBCC) Scale up in Timor-Leste:

**Key Findings:**

1. **Implementation Status Social Behavior Change Communication (SBCC)**
    - A high percentage (74.1%) of respondents believe that SBC for family planning has been adequately implemented and scaled-up nationally, which indicates a strong sense of progress in implementation.
2. **Governance:**
    - **Leadership and Commitment (70.4%)** and **Accountability (70.4%)** are seen as areas of strength. This suggests that there is significant leadership support and accountability among policymakers and program managers to drive SBC for FP.
    - **Regulation (51.9%)** and **Guidance Formulation (59.3%)** have more mixed responses. While guidance exists, its adequacy and timeliness may still need further attention. Regulation is seen as less robust, which might indicate a gap in the enforcement of policies to ensure effective SBC.
3. **Financing:**
    - **Donor Financing (59.3%)** is viewed positively, but other areas like **Budgeting (44.7%)** and **Equity (48.1%)** show lower agreement. There is a perception that funding is insufficient or inequitably distributed for SBC scale-up across different regions or populations.
    - **National Plan for SBC Scale-up (55.6%)** has moderate approval, which implies that a national roadmap exists but might need more strategic alignment or improvement to ensure effective implementation.
4. **People Engagement:**
    - **Coordination (74.1%)** and **Networks (74.1%)** have strong approval, meaning that there are effective professional networks and collaboration between stakeholders to support SBC for FP.
    - **Community Engagement (59.3%)** and **Acceptability (51.9%)** suggest that while some community engagement exists, there may be room for improvement in terms of local-level acceptance and participation in SBC activities.
5. **Information Systems:**
    - **Reporting (70.4%)** and **Data Collection (63%)** are perceived to be adequately handled, indicating that monitoring and evaluation systems are generally in place for SBC activities.

- However, there is more mixed feedback on the availability and usage of updated guidelines, tools, and client IEC materials, with responses between 53.9% and 59.3% indicating areas for potential improvement.

6. **Service Delivery:**
   - **Management (66.7%)**, **Supervision (63%)**, and **Teamwork & Coordination (74.1%)** reflect a generally strong framework for service delivery. Community health workers and health facilities seem to be working well together to deliver SBC.
   - The **Referral System (66.7%)** and **Service Organization & Scheduling (63%)** are seen positively, but there might still be opportunities to streamline and enhance service delivery processes.
7. **Human Resources:**
   - **Training (74.1%)** is another area of strength, indicating that there is significant investment in ensuring health workers are equipped with the necessary skills to implement SBC for FP.
   - **Motivation (66.7%)** is relatively strong, suggesting that health workers generally have positive attitudes towards the policy. However, **Skills & Competencies (63%)** and **Capacity (63%)** indicate that while training exists, there might be room to further develop competencies and improve capacity in certain areas.

**Areas for Improvement:**

- **Financing:**
  - **Budgeting and Equity**: These areas received relatively low ratings (44.7% and 48.1%), suggesting that funding for SBC scale-up is insufficient or unequally distributed, potentially limiting access to family planning services for marginalized groups or regions.
- **Regulation and Guidance:**
  - While there are some policies in place, **Regulation** (51.9%) and **Guidance Formulation** (59.3%) might need stronger emphasis to ensure consistency and quality in SBC implementation at all levels.
- **Community Engagement and Acceptability:**
  - With **Community Engagement** and **Acceptability** receiving lower ratings, there may be barriers to widespread local adoption of SBC strategies. More work could be done to ensure that the community is both involved in and supportive of the approaches used.
- **Data and Information Systems:**
  - While **Reporting** and **HMIS** systems have moderate to high ratings, areas like **Guidelines & Tools** (59.3%) and **Client IEC** (53.9%) could benefit from more consistent updates and wider dissemination to ensure all levels of the health system are aligned.

**Conclusion:**

The report indicates that while there are several areas of strength—especially in terms of **implementation, governance, coordination, and service delivery**—there are notable challenges in **financing, regulation, community engagement**, and the **equity** of the SBC scale-up. Moving forward, addressing these gaps could help in ensuring more effective, sustainable, and equitable expansion of SBC for family planning across regions

### 7.2 Challenges

There are several points of challenges, obstacles, or 'bottlenecks' that hinder the effectiveness of improvement of postpartum and/or post-abortion family planning, task sharing and SBCC implemented in Timor-Leste as mentioned by participants in the following table that has been created based on WHO Six Building Blocks as follows:

1. Training of Health Workers
2. Budget
3. Human Resources
4. Availability of family Planning
5. Supervision and Monitoring
6. Data reporting/others (Policy)

**The challenges, barriers, or 'bottlenecks' that hinder the effectiveness of improvement of postpartum and/or post-abortion family planning, task sharing and SBCC implemented in Timor-Leste.**

The information gathered from participants when filling out the questionnaire will be used as the basis for discussion during the workshop to identify underlying causes, solutions to address the causes, the lead agency responsible for the solutions, and agencies that will support the lead agency. The table below shows data on many obstacles identified by respondents:

**Table 10. Information on several bottlenecks of the PPFP/PAFP, Task Sharing and SBCC can be seen in the following table:**

| No | PPFP | Task Sharing | SBCC |
|---|---|---|---|
| 1 | Lack of Funding (Budget) for family planning | Lack of define policy for Nurses to be part of the FP Program | Lack training of nurses to promote FP Method |
| 2 | Allocation of health provider not based on community necessity to implement Scale up PF | Lack of define TOR for nurses to give FP services | Lack of budget allocation for community based SBCC program for FP Utilization |
| 3 | Lack of Sustainability and Availability of family planning commodities in health facilities | Training nurses to provide services such as Depo, Pills and Condoms/all family planning services & Counselling. | Cultural limitation on promotion contraception in the mass media |
| 4 | Lack Transport for providers to Providing family planning services in Community | Lack of Training certificate of health workers for FP services | Frontline workers unaware of existing policies |
| 4 | Lack of the Training to all Midwives and doctors about family planning | Limited scopes of FP Training within pre-service curriculum | |

| | | | |
|---|---|---|---|
| 5 | Lack of the Traditional family planning method to be Promoted as per family planning Policy | | |
| 6 | Lack of the Training and dissemination of the Policy, strategy, and guideline of the FP to stakeholders | | |
| 7 | Monitoring and supervision not adequate | | |
| 8 | Indicators for monitoring family planning services in HMIS not update regularly | | |

## 8.Data Review for PPFP, Task Sharing and SBCC

### 8.1 Data Review for PPFP

**Annex A3: Data review for PPFP**

| | | | | Responses *(Enter ND if no data available)* | | | | |
|---|---|---|---|---|---|---|---|---|
| **Background: Current FP status** | **Module** | **Potential Data source** | **Suggested breakdown** | **All WRA** | **Rural WRA** | **Urban WRA** | **<20 WRA** | **>=20 WRA** |
| % of FP accessed in the public sector | All | DHS 2016 | Rural/urban, <20/>=20 | 92 % | | | | |
| % of FP accessed in the non-profit private sector: Obtained their method from HP: 43% and CHC: 31 % | All | DHS 2016 | Rural/urban, <20/>=20 | | | | | |
| % of FP accessed in the for-profit private sector: Obtained their method from private medical 3 % and Mary stopes 4% | All | DHS | Rural/urban, <20/>=20 | | | | | |
| Modern contraceptive prevalence (% among women of reproductive age) | All | DHS or PMA | Rural/urban, <20/>=20 | 24% | | | | |
| % all women of reproductive age relying on Long Acting or Permanent methods of FP Sterilization : HNGV: 52% referral Hospital: 38% | All | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % all current contraceptive users relying on Long Acting or Permanent methods of FP | All | DHS or PMA | Rural/urban, <20/>=20 | 25% | | | | |
| % of women with unmet need for FP | All | DHS or PMA | Rural/urban, <20/>=20 | 25% | | | | |

| | | | | Responses *(Enter ND if no data available)* | | | | |
|---|---|---|---|---|---|---|---|---|
| **Background: Current FP status** | **Module** | **Potential Data source** | **Suggested breakdown** | **All WRA** | **Rural WRA** | **Urban WRA** | **<20 WRA** | **>=20 WRA** |
| % of women with unmet need for FP for spacing births | All | DHS or PMA | Rural/urban, <20/>=20 | N/A | | | | |
| % of all WRA who are < 12 months postpartum and not using modern contraception | PPFP | DHS or MICS | Rural/urban, <20/>=20 | | | | | |
| % of women who give birth in facility who are <12 mo postpartum and not using MC | PPFP | DHS or MICS | Rural/urban, <20/>=20 | | | | | |
| % women < 2 years postpartum who discontinue contraception within 3 months of use *(may require analysis of DHS calendar data)* | PPFP | DHS | Rural/urban, <20/>=20 | | | | | |
| % of women who receive ANC from a skilled provider | PPFP | DHS or HMIS or DHS | Rural/urban, <20/>=20 | 110% (ANC 1 coverage HMIS 2023 data) | | | | |
| % of women with recent birth who have a post-natal check-up within 6 weeks | PPFP | DHS | Rural/urban, <20/>=20 | 89% HMIS 2023 | | | | |
| Median duration of exclusive breastfeeding | PPFP | DHS | Rural/urban, <20/>=20 | | | | | |
| Median duration of partially exclusive breastfeeding | PPFP | DHS | Rural/urban, <20/>=20 | | | | | |
| Median birth interval and/or % women with birth to pregnancy interval of at least 2 years | PPFP | DHS | Rural/urban, <20/>=20 | | | | | |

| | | | | Responses *(Enter ND if no data available)* | | | | |
|---|---|---|---|---|---|---|---|---|
| **Background: Current FP status** | **Module** | **Potential Data source** | **Suggested breakdown** | **All WRA** | **Rural WRA** | **Urban WRA** | **<20 WRA** | **>=20 WRA** |
| % of women who give birth with a skilled attendant | PPFP | DHS or MICS | Rural/urban, <20/>=20 | 94% HMIS 2023 | | | | |
| % of women who give birth in a health facility | PPFP | DHS or MICS | Rural/urban, <20/>=20 | 82% HMIS 2023 | | | | |
| % ANC visits where FP counselling occurs | PPFP | HMIS or facility surveys | | | | | | |
| % of women delivering in facility who receive FP counselling before discharge | PPFP | HMIS or facility surveys | | 65% (HMIS 2023) | | | | |
| % of women delivering in facility who receive FP method before discharge | PPFP | HMIS or facility surveys | | N/A, data might be obtained from Maternity/ Hospital support | | | | |
| % of women attending for post-abortion or abortion care who receive FP method before discharge | PPFP | HMIS or facility surveys | | N/A, data might be obtained from Maternity/ Hospital support | | | | |
| % of post-natal care clients (usually 2-6 weeks postpartum) who receive FP counselling | PPFP | HMIS or facility surveys | | Data can be obtained through each | | | | |

| | | | | Responses *(Enter ND if no data available)* | | | | |
|---|---|---|---|---|---|---|---|---|
| **Background: Current FP status** | **Module** | **Potential Data source** | **Suggested breakdown** | **All WRA** | **Rural WRA** | **Urban WRA** | **<20 WRA** | **>=20 WRA** |
| | | | | facility/ FP focal point to obtain data | | | | |
| % of immunization clients who receive FP counselling | PPFP | HMIS or facility surveys | | Data can be obtained through each facility/ FP focal point to obtain data | | | | |
| % of women delivering in facility who receive breastfeeding counselling before discharge | PPFP | HMIS or facility surveys | | 68% (HMIS 2023) | | | | |

## Annex A4 Policy & Guidance Alignment Assessment for PPFP

| Q # | Question | Prompts for question | Level of policy and guidance alignment (full/partial/none) | Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.) | Information sources (if document, state name of document & year; if key informant, state name/role) |
|---|---|---|---|---|---|
| 1 | ANC policies, guidelines and tools recommend counselling on FP during at least one of the routine ANC visits | | Full | | National Standard ANC Guidelines & Protocol page 13, 35. |
| 2 | Maternity or immediate post-natal care policies, guidelines and tools recommend counselling on FP in the immediate postpartum period | | Full | | National Standard IPC Protocol, page. 63 |
| 3 | Post-natal care policies, guidelines and tools recommend counselling on FP at the first post-natal care check-up | | Full | | National standard PNC Guidelines/ protocol, page. 13, 23. |
| 4 | Immunization policies, guidelines and tools recommend counselling on FP during child health checks/immunization visit | | | | |
| 5 | MNH policies, guidelines and tools clearly state the 3 criteria for Locational Amenorrhoea Method (LAM) | LAM criteria are i.<6 months postpartum; fully or nearly fully breastfeeding; no return of menses | Full | | RMNCAH Strategy 2015-2019--- updated RMNCAH Strategy 2024-2030 (under revision process) |
| 6 | Infant feeding/nutrition policies, guidelines and tools clearly state the 3 criteria for Locational Amenorrhoea Method (LAM). | LAM criteria are i.<6 months postpartum; fully or nearly fully breastfeeding; no return of menses | Partial | Ad-hoc evidence of implementation | RMNCAH Strategy |
| 7 | MNH policies, guidelines and tools provide guidance on how to reach women | | Partial | Unclear guidance | RMNCAH Strategy 2015-2019--- updated RMNCAH |

| Q # | Question | Prompts for question | Level of policy and guidance alignment (full/partial/none) | Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.) | Information sources (if document, state name of document & year; if key informant, state name/role) |
|---|---|---|---|---|---|
| | who did not have a facility delivery with FP | | | | Strategy 2024-2030 (under revision process) |
| 8 | MNH policies, guidelines and tools encourage women to transition from LAM to another method of contraception at 6 months postpartum<br>MNH, | | | Ad-hoc evidence of implementation | RMNCAH Strategy 2015-2019--- updated RMNCAH Strategy 2024-2030 (under revision process) |
| 9 | Do policies, guidelines and tools align precisely with WHO's latest PPFP compendium and Handbook for postpartum and post-abortion FP? | Does guidance allow immediate initiation of progestogen-only pills & implants after birth? And do they allow initiation of combined and progestogen-only methods immediately post-abortion (both surgical and medical))? | None | | Advocate to be adopted within the Postpartum FP SOP/ guide |
| 10 | FP policies and guidelines align with WHO Selected Practice recommendations and WHO Handbook on initiation criteria for breastfeeding amenorrhoea women <6 months postpartum. | Breastfeeding amenorrhoea women less than 6 months' post-partum can initiate POPs and implants at any time without need for a backup method. They can initiate DMPA between 6 weeks and 6 months postpartum without the need for a backup method. | None | Unclear guidance | FP Policy 2022 |

| Q # | Question | Prompts for question | Level of policy and guidance alignment (full/partial/none) | Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.) | Information sources (if document, state name of document & year; if key informant, state name/role) |
|---|---|---|---|---|---|
| 11 | FP policies and guidelines align with WHO Selected Practice recommendations on initiation criteria for post-abortion women. | IUD/IUS can be initiated immediately after 1st and 2nd tri abortion.<br>All progestogen-only methods and combined hormonal method can be initiated immediately post-abortion. | None | | Needs advocate to include in Post-partum/Post abortion FP guide |
| 12 | PPFP and PAFP Policies and guidelines align with WHO's human rights framework for the provision of contraception, including on informed consent procedures, offer of range of methods, recommendations on privacy and confidentiality, and non-allowance for conscientious objection to provision of FP information and services | Review WHO Human Rights for Contraceptive Services framework | Partial | | FP policy limiting access of contraceptives to unmarried adolescents |

Policy & Guidance Alignment Assessment for PPFP, there are several documents crucial that are not yet available, and as evidence to provide attention and improvement in the future by MOH-National MCH Director on its implementation such as:

1. Policies, guidelines and tools align precisely with WHO's latest PPFP compendium and Handbook for postpartum and post-abortion FP
2. FP policies and guidelines align with WHO Selected Practice recommendations and WHO Handbook on initiation criteria for breastfeeding amenorrhoeic women <6 months postpartum.
3. FP policies and guidelines align with WHO Selected Practice recommendations on initiation criteria for post-abortion women.

## Annex A5: Case studies summary (use one table per module)

| Title of project or programme with short description (Select 2-3 case studies) | Where was the project or programme implemented? (States, regions, districts) | Who implemented it? | What were the achievements? | What were some of the health systems factors that made the project a success? (Review Bottlenecks Framework) | What were some of the challenges? (Review Bottlenecks Framework) | Any other relevant information? |
|---|---|---|---|---|---|---|
| Community Outreach in remote areas | National | MoH | | Programa Integradu Saude (PIS)<br>SISCa | Human Resources to provide routine FP, Transportation to reach remote areas.<br><br>The provision of PPFP is not reinforced in the National Family Planning policy. | |
| Involve man accompany wife get PF services | 3 Municipalities Ermera, Liquica, oecusee, Dili, 2022 espansaun Maliana, Ainaro 2023 | Marie Stopes (MSTL) | | | Family planning methods are not provided at health posts, and health professionals are not trained.<br><br>Collaboration from partners should also lead to initiatives for government ownership of the program and should not be viewed as a project to accomplish goal coverage objectives alone. | The National Family Planning Policy states that only competently qualified health personnel can provide family planning services or contraception methods in the community and in health facilities. |

### 8.2 Data Review for TASK-SHARING

**Annex B3: Policy & Guidance Alignment Assessment for TASK-SHARING**

| Q # | Question | Prompts for question | Level of policy and guidance alignment (full/partial/none) | Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.) | Information sources (if document, state name of document & year; if key informant, state name/role) |
|---|---|---|---|---|---|
| 1 | There is a national task-sharing policy for RMNCH including FP | | None | | |
| 2 | National FP guidelines have been updated with the 2017 WHO *FP Task Sharing guidance* | Record date of publication or last update, or if date of publication/update not available. | Partial | | Not fully adopted |
| 3 | National FP / TS policy and guidelines includes *"who can provide"* table. | | Partial | | Not specifically who but where in health facilities level |
| 4 | National FP and TS policies and guidelines use clear and consistent definitions and labels/terms throughout for CHWs and auxiliary nurses/midwives | | Partial | | |
| 5 | National FP and TS policies and guidelines provide clear and consistent requirements for CHWs and auxiliary nurses/midwives, specifying education & training, residency etc. | | None | | |
| 6 | Task-sharing policy, guidelines and tools align precisely with WHO recommendations on practice, namely that **Community health workers** can safely and effectively provide family planning education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms; and | | None | | |

| Q # | Question | Prompts for question | Level of policy and guidance alignment (full/partial/none) | Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.) | Information sources (if document, state name of document & year; if key informant, state name/role) |
|---|---|---|---|---|---|
| | hormonal injectable, **under targeted monitoring and evaluation.** | | | | |
| 7 | Task-sharing policy, guidelines and tools align precisely with WHO recommendations on practice, namely that **auxiliary nurses and auxiliary nurse midwives** can safely and effectively provide family planning education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms, hormonal injectable, and contraceptive implants; and (for auxiliary nurse midwives) IUDs | | Partial | | Only for those who have been trained using the WHO FP TRP |
| 8 | TASK-SHARING policies and guidelines align with WHO's human rights framework for the provision of contraception, including on informed consent procedures, offer of range of methods, recommendations on privacy and confidentiality, and non-allowance for conscientious objection to provision of FP information and services | Review WHO Human Rights for Contraceptive Services framework | Partial | | Declared within the National FP policy however, limitations/ restriction of services for unmarried adolescents |
| 9 | There are national-level/subnational policies that support the development and deployment of CHW programs | | Partial | Only for ANC/IPC/ PNC services sometimes including MPDSR notification & child development & nutrition intervention | |
| 10 | There are national/subnational policies that explicitly refer to CHWs, with a formal governance structure, funding support, training agenda, job description, and appropriate support from public health facilities. | | None | | |

| Q # | Question | Prompts for question | Level of policy and guidance alignment (full/partial/none) | Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.) | Information sources (if document, state name of document & year; if key informant, state name/role) |
|---|---|---|---|---|---|
| 11 | There are national and/or subnational standards on the duration and content of CHW/health workforce education and training | | Full | Ad hoc Evidence of implementation | INSPTL FP Training Plan & implementation report |
| 12 | There are national and/or subnational mechanisms for accreditation of CHW/health workforce education and training institutions and their programmes | | None | | |
| 13 | There are national education plans for the health workforce, aligned with the national health plan and the national health workforce strategy/plan, which match health worker competencies with population/health systems/labour market needs | | Partial | Conflicting guidance | RHCS 2022-2024, FP Policy 2022, NHSSP 2020-2030 |
| 14 | There are national systems for continuing professional development | | Full | Ad hoc evidence of implementation | INSPTL FP Training using WHO TRP & FUAT |

Policy and Guidance Alignment Assessment for TASK-SHARING, there are several points that are not yet available or cover in task sharing policy dan program , and as evidence to provide attention and improvement in the future by MOH-National MCH Director on its implementation such as:

1. National task-sharing policy for RMNCH including FP,
2. National FP and TS policies and guidelines provide clear and consistent specifying education and training, residency, etc for nurses to provide family planning
3. Task-sharing policy, guidelines, and tools. align precisely with WHO recommendations on practice where nurses safely and effectively provide family planning education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms; as well as hormonal injectable, under targeted monitoring and evaluation,
4. National/subnational policies that explicitly refer to nurses, with a formal governance structure, funding support, training agenda, job description, and appropriate public support.

5. National and/or subnational mechanisms for accreditation of nurse education and training institutions and programs academics.

## Annex B4: Data review for TASK-SHARING

| | | | | Responses *(Enter ND if no data available)* | | | | |
|---|---|---|---|---|---|---|---|---|
| **Background: Current FP status** | **Module** | **Potential Data source** | **Suggested breakdown** | **All WRA** | **Rural WRA** | **Urban WRA** | **<20 WRA** | **>=20 WRA** |
| % of FP accessed in the public sector | All | DHS | Rural/urban, <20/>=20 | 92% | | | | |
| % of FP accessed in the non-profit private sector | All | DHS | Rural/urban, <20/>=20 | | | | | |
| % of FP accessed in the for-profit private sector | All | DHS | Rural/urban, <20/>=20 | | | | | |
| Modern contraceptive prevalence (% among women of reproductive age) | All | DHS or PMA | Rural/urban, <20/>=20 | 18.1% | | | | |
| % all women of reproductive age relying on Long Acting or Permanent methods of FP | All | DHS or PMA | Rural/urban, <20/>=20 | 25,3% (implant) | | | | |
| % all current contraceptive users relying on Long Acting or Permanent methods of FP | All | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % of women with unmet need for FP | All | DHS or PMA | Rural/urban, <20/>=20 | 14.4% (Modern method (mUN)) | | | | |
| % of women with unmet need for FP for spacing births | All | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| National Family Planning Effort Index | All | Track20 | | | | | | |
| Number of health workers (all reported cadres) national/subnational | Task-sharing | NATIONAL STRATEGIC PLAN for Human Resources for Health (NSPHRH) 2020 - 2024 | | 4,911 Public Sector's Health Staff as of August 2017 not | | | | |

| | | | | Responses *(Enter ND if no data available)* | | | | |
|---|---|---|---|---|---|---|---|---|
| **Background: Current FP status** | **Module** | **Potential Data source** | **Suggested breakdown** | **All WRA** | **Rural WRA** | **Urban WRA** | **<20 WRA** | **>=20 WRA** |
| | | | | including RAEOA | | | | |
| Doctors per 1000 population | Task-sharing | National/state Health info stats | Rural/urban or by state | 76% (JAHSR 2014, p. 38) | | | | |
| Nurses per 1000 population | Task-sharing | National/state Health info stats | Rural/urban or by state | | | | | |
| CHWs per 1000 population | Task-sharing | National/state Health info stats | Rural/urban or by state | | | | | |
| % of workforce that are CHW | Task-sharing | National/state Health info stats | Rural/urban or by state | | | | | |
| Ratio of unfilled posts to total number of posts, by cadre | Task Sharing | National/state Health info stats | Rural/urban or by state | | | | | |

In the Data Review for TASK-SHARING section, where the Current FP state does not yet include multiple indicators, the following indicators must be created to monitor future achievements:

1. % of FP accessed in the non-profit private sector
2. % of FP accessed in the for-profit private sector
3. % all current contraceptive users relying on Long Acting or Permanent methods of FP
4. % of women with unmet need for FP for spacing births
5. National Family Planning Effort Index

## Annex B5: Case studies summary (use one table per module)

| Title of project or programme with short description (Select 2-3 case studies) | Where was the project or programme implemented? (States, regions, districts) | Who implemented it? | What were the achievements? | What were some of the health systems factors that made the project a success? (Review Bottlenecks Framework) | What were some of the challenges? (Review Bottlenecks Framework) | Any other relevant information? |
|---|---|---|---|---|---|---|
| Family Planning assistance in remote area provided by Nurse including Pill, Depo Injection, condom method and family planning counselling. | Across the country. Health post | MoH, DHS, INSPTL | Injection increase | | | |
| Provision of Contraceptive methods including comprehensive counselling on routine Integrated health service program | Domiciliary visit | MoH, DHS, CHC's | | Integrated unit of health care practitioners (Integrated HR team) | Not all health care providers are competent in providing long term contraceptive methods and no tasks sharing guidance and or Sop to facilitate the implementation of tasks sharing. | |

8.3 Data Review for SBC

## Annex C3: Policy & Guidance Alignment Assessment for SBC

| Q # | Question | Level of policy and guidance alignment (full/partial/none) | Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.) | Information sources (if document, state name of document & year; if key informant, state name/role) |
|---|---|---|---|---|
| 1 | Policy & guidance documents recommend scale-up of SBC interventions | Partial | Conflicting guidance | FP Policy 2022 |
| 2 | Policy & guidance documents recommend use of community health workers for RMNCH health promotion, including FP | Partial | RMNCAH Strategy | 2015-2019 RMNCAH strategy |
| 3 | Policy & guidance documents recommend use of mass media to promote FP | Full | Ad-hoc evidence of implementation | FP Policy 2022 |
| 4 | Policy & guidance documents recommend use of community groups to promote FP | Partial | Clear guidance | FP Policy 2022, P. 43 |
| 5 | Policy & guidance documents on MNH recommend use of community groups for health promotion, including FP | Partial | Clear guidance | Reaching the un-reached through INTEGRATED HEALTH PROGRAM (IHP) 2023 |
| 6 | Policy & guidance documents recommend use of digital health to promote FP | Partial | Unclear guidance | Liga Inan Program |
| 7 | Policy & guidance documents aim to address social and gender norms that may inhibit use of FP | None | | |
| 8 | Policy & guidance documents aim to involve men and promote healthy couple communication | None | | Suggested within the revised RMNCAH strategy 2024-2030 |

| Q # | Question | Level of policy and guidance alignment (full/partial/none) | Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.) | Information sources (if document, state name of document & year; if key informant, state name/role) |
|---|---|---|---|---|
| 9 | Policy & guidance documents aim to strengthen the knowledge, attitudes, beliefs and self-efficacy of individual women and girls | Partial | Unclear guidance | FP Policy 2022, P. 43 |
| 10 | Policy & guidance documents recommend working with religious leaders, or other trusted opinion leaders, to promote FP | Full | Clear Guidance | FP Policy 2022 |
| 11 | Policy & guidance documents set out standards for SBC in family planning, including adherence to rights-based programming principles | None | | Suggested within the revised RMNCAH strategy 2024-2030 |
| 12 | Policy & guidance documents advise on effective approaches for SBC in family planning, along with strength of evidence in the local context | None | | Suggested within the revised RMNCAH strategy 2024-2030 |
| 13 | Policy & guidance documents advise structured processes for SBC intervention design, including needs for formative research/insight gathering, (human-centered) design according to behavioural theory, monitoring/testing, or design iteration (or adaptive programming) | None | | Suggested within the revised RMNCAH strategy 2024-2030 |
| 14 | There are clear indicators for success for SBC in policy and guidance documents | None | | |
| 15 | Policy & guidance documents advising mass media include guidance on formative research, pre-testing messaging, targeting of communication, selection of appropriate channels, audience segmentation, working with local community platforms or infrastructure, and the need to address equity in SRH. | Partial | Unclear guidance | FP Policy 2022, P. 43 |
| 16 | Policy & guidance documents advising community health groups empower participants for collective action and promote community agency | None | | |

Policy & Guidance Alignment Assessment for SBC, there are several points that are not yet available or cover in SBCC Policy and program, and as evidence to give attention and improvement in the future by MOH-National MCH Director on its implementation such as:

1. Policy & guidance documents aim to address social and gender norms that may inhibit use of FP
2. Policy & guidance documents aim to involve men and promote healthy couple communication
3. Policy & guidance documents set out standards for SBC in family planning, including adherence to rights-based programming principles
4. Policy & guidance documents advise on effective approaches for SBC in family planning, along with strength of evidence in the local context
5. Policy & guidance documents advise structured processes for SBC intervention design, including needs for formative research or insight gathering, (human-cantered) design according to behavioural theory, monitoring/testing, or design iteration (or adaptive programming)
6. There are clear indicators for success for SBC in policy and guidance documents
7. Policy & guidance documents advising community health groups empower participants for collective action and promote community agency

| | | | | Responses *(Enter ND if no data available)* | | | | |
|---|---|---|---|---|---|---|---|---|
| **Background: Current FP status** | **Module** | **Potential Data source** | **Suggested breakdown** | **All WRA** | **Rural WRA** | **Urban WRA** | **<20 WRA** | **>=20 WRA** |
| Modern contraceptive prevalence (% among women of reproductive age) | **All** | DHS or PMA | Rural/urban, <20/>=20 | 16 (PHC 2022) 18.1% (TL 2023 FPET) | | | | |
| % all women of reproductive age relying on Long Acting or Permanent methods of FP | **All** | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % all current contraceptive users relying on Long Acting or Permanent methods of FP | **All** | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % of women with unmet need for FP | **All** | DHS or PMA | Rural/urban, <20/>=20 | 14.5% (TL 2023 FPET) | | | | |
| % of women knowing at least 3 modern methods | **All** | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % of FP users with full method information index (informed of side effects, told what to do if experience side effects, informed of other methods of FP) | **SBC** | DHS or PMA | Rural/urban, <20/>=20 | 26% (2016 DHS) | | | | |
| % of women intending to use FP in the future (or next 12 months) | **SBC** | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % of women practicing covert FP use | **SBC** | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % of women not using FP due to health concerns or fears of side effects | **SBC** | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % of female non-users intending to use FP in the future | **SBC** | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % of women FP users making decisions about FP on their own or jointly with their husband | **SBC** | DHS or PMA | Rural/urban, <20/>=20 | | | | | |

| | | | | Responses *(Enter ND if no data available)* | | | | |
|---|---|---|---|---|---|---|---|---|
| **Background: Current FP status** | **Module** | **Potential Data source** | **Suggested breakdown** | **All WRA** | **Rural WRA** | **Urban WRA** | **<20 WRA** | **>=20 WRA** |
| % of women FP non-users making decisions about FP on their own or jointly with their husband | **SBC** | DHS or PMA | Rural/urban, <20/>=20 | | | | | |
| % of FP clients involved in decisions about their care during FP consultations | **SBC** | DHS SPA FP exit | Rural/urban, <20/>=20 | | | | | |
| % of women exposed to different FP messages (via different channels: radio/TV, newspapers, mobile phone) | **SBC** | DHS 2016 | Rural/urban, <20/>=20 | 25% | | | | |
| % of facilities with available visual aids for FP (flip charts, leaflets) | **SBC** | DHS SPA Inventory | | | | | | |
| No. or % of districts with active health promotion teams | **SBC** | HMIS (?) | | | | | | |
| No. or % of health facilities with community outreach for RMNCH | **SBC** | HMIS (?) | | 100% SISCa | | | | |

In the Data Review for SBC, where the Current FP state does not yet include multiple indicators, the following indicators must be created to monitor future achievements:

% all women of reproductive age relying on Long Acting or Permanent methods of FP
% all current contraceptive users relying on Long Acting or Permanent methods of FP
% of women knowing at least 3 modern methods
% of women practicing covert FP use
% of women not using FP due to health concerns or fears of side effects
% of female non-users intending to use FP in the future
% of women FP users making decisions about FP on their own or jointly with their husband
% of women FP non-users making decisions about FP on their own or jointly with their husband
% of FP clients involved in decisions about their care during FP consultations
% of facilities with available visual aids for FP (flip charts, leaflets)
No. or % of districts with active health promotion teams

## Annex C5: Case studies summary (use one table per module)

| Title of project or programme with short description (Select 2-3 case studies) | Where was the project or programme implemented? (States, regions, districts) | Who implemented it? | What were the achievements? | What were some of the health systems factors that made the project a success? (Review Bottlenecks Framework) | What were some of the challenges? (Review Bottlenecks Framework) | Any other relevant information? |
|---|---|---|---|---|---|---|
| Healthy Birth spacing campaign | Across the Country | MoH, MCH department, Family planning section coordinator. | Produce family planning Information and education by His Eminence the Bishop Metropolitan Dili, Timor-Leste. Video is available waiting for launching to use widely across the country. | Project support by Donor include UNFPA and Japan | | |
| Community awareness raising during SISCa & HIS program | Targeted areas identified by low coverage-high demand/ remote areas | MoH, DHS, CHC's | Increase coverage of contraceptive use | Integrated multispectral support | Budget-availability based intervention only<br><br>No regular schedule for continuous advocacy & awareness raising | |

9. Bottleneck Analysis National Validation Workshop

The workshop has brought together a group of stakeholders to reach an agreement on the most significant bottlenecks impeding the scale-up of post-pregnancy FP (PPFP) in Timor-Leste, as well as to identify solutions to address the challenges and barriers. The participants of the workshop include: Policymakers and programme managers at national & municipalities levels, Facility Directors, managers, clinicians, and members of professional associations, and representatives from civil society. The workshop was held on November 13, 2024 and attended by 36 people. Participants were divided into 3 groups. Group 1 PPFP/PAFP, Group 2 Task Sharing and Group 3 SBCC. The groups use sheet to rank the potential bottlenecks that are inhibiting scale-up of PPFP, Task Sharing and SBCC with the rating *10 is the most important bottleneck, 1 is the least important. End of the discussion and consensus the group define the Bottlenecks, Root cause and Proposed Solutions with Primary Responsibility and Supporting Agencies can be seen in tables 11, 12 and 13 as follows:

Table 11. Potential bottlenecks that are inhibiting scale-up of PPFP

| **Bottleneck**<br>**Health System Building block** | **Proposed Solution and Strategies for scale up** | **Primary Responsibility** | **Supporting Agencies** |
|---|---|---|---|
| **Governance:**<br>1. Policy<br>2. Strategy<br>3. Guideline<br>4. Standard Operational Procedure (SOP)<br>5. Implementation manual | **1. Availability of post-partum and post abortion Family planning policies**<br>1.1 Availability of PPFP/PAFP policy at national, regional &<br>1.2 Create PPFP/PAFP guidelines<br>1.3 Availability of PPFP/PAFP policy for private for-profit facilities, facility non-Profit, NGO, Religious and to ensure implementation coordinates effectively according to policy<br><br>**2. Strategy**<br>2.1 SARMANELA/ RMNCAH<br>2.2 Community health programs have strategies to promote PPFP/PAFP for mothers who do not give birth in health facilities.<br>2.3 Promote the expansion of PPFP/PAFP by religious leaders<br><br>**3. Guideline and SOP**<br>3.1 Postpartum and post-abortion care Family Planning Guideline<br>3.2 Postpartum, Post abortion, ANC, PNC, Immunization, Pharmacy, Nutrition care guideline | Ministry of health (MoH) MNCH | WHO, UNFPA, UNICEF Agency & Merry stopes Timor-Leste (MSTL) |
| **Financial**<br>1. Budget allocation from the General State Budget | FINANCIAL<br>1. Implementation plan should cater for PPFP/PAFP. | Ministry of health (MoH)-MNCH & Finances) | WHO, UNFPA, UNICEF Agency & |

| **Bottleneck**<br>**Health System Building block** | **Proposed Solution and Strategies for scale up** | **Primary Responsibility** | **Supporting Agencies** |
|---|---|---|---|
| 2. Budget allocation by Partner<br>3. Insurance<br>4. National plan to strengthen the PPFP/PAFP program | 2. Provide appropriate domestic finances for PPFP/PAFP at the national and municipal levels.<br>3. Requires financial support from donors.<br>4. A national health insurance program should cover all contraceptive products.<br>5. Increase coverage.<br>6. A strategic plan is in place to expand PPFP/PAFP. | | Merry stopes Timor-Leste (MSTL) |
| People<br>1. Network<br>2. Community engagement (local leadership, Religious Conviction, Men, Youth, Civil society | EMA<br>1. Prioritize and Plan TWG SARMANELA.<br>2. Actively and consistently promote.<br>3. Establish a regional training network<br>4. Conduct comparison studies for other countries on PPFP/PAFP.<br>5. Conduct health promotion via CHW/SBCC, products, or other community contact lines.<br>6. Implement community health programs.<br>7. Regular follow-up of postpartum mothers who give birth at home, in partnership with mother support groups, to actively promote PPFP and birth space.<br>8. Partner involvement in PPFP promotion when mothers attend ANC or Maternal and Child Health<br>9. Community, religious, and cultural leaders should work together to expand PPFP. | MoH (National and Municipal Human Resources) local authority, religious leader, PAM | WHO, UNFPA, UNICEF Agency & Merry stopes Timor-Leste (MSTL) |
| **INFORMATION**<br>1. EIS/HMIS<br>2. IEC Material<br>3. Health promotion<br>4. Tools | 1. Provide PPFP counseling to postpartum mothers in health facilities that commence contraception methods prior to discharge.<br>2. Follow up with the mother in the postpartum phase that lasts up to six months.<br>3. IEC materials must be available in health facilities beginning with MC, PIS, PS, SSK, HR, and the National Hospital.<br>4. Distribution of IEC regular materials for ANC Care, Maternity, Post-Natal, and Health Services Immunization for newborns and pharmacies.<br>5. Consistently promote PPFP in the community through various methods.<br>6. Implement effective behavioral treatments to promote FP in ANC, PNC, and post-abortion.<br>7. Use digital technology to promote PPFP regularly to mothers who have regular phones (Liga Inan) | 1. MoH (Diresaun Nasional EPS)<br>2. MoH (M&E, HIMS)<br>3. MoH (DMNCH) | WHO, UNFPA, UNICEF Agency & Merry stopes Timor-Leste (MSTL) |

| **Bottleneck**<br>**Health System Building block** | **Proposed Solution and Strategies for scale up** | **Primary Responsibility** | **Supporting Agencies** |
|---|---|---|---|
| | 8. Format of Monitoring Report | | |
| **MEDICINE&TECHNOLOGY**<br>1. Infrastructure-mSupply, FPLMIS<br>2. Supplies<br>**3.** Equipment | 1. Family planning contraception's are available in all health facilities (National Hospital, referral Hospital, CHC & HP) that implement PPFP/PAFP<br>2. Create PF commodity management system including Postpartum and post abortion assistance<br>3. Availability of a list of necessary contraceptives. | 1. MoH, SAMES, DNFM, National Directorate of Equipment and Medicines | WHO, UNFPA, UNICEF Agency & Merry stopes Timor-Leste (MSTL) |
| **DELIVERY OF SERVICES**<br>Manual-Service Delivery (Management, supervision, coordination of services, service schedule, transfer system, Human resources) | 1. Identify the person in charge of the PPFP/PAFP who coordinates across all health facilities.<br>2. Control the quality of services and audit the implementation of PPFP.<br>3. Requires managers to constantly analyze implementation procedures and outcomes in order to identify gaps.<br>4. Map client journeys to identify interventions for PPFP in all health facilities. | MoH, (RH, Office of Quality Assurance Control, Directorate of Maternal and Child Health) | Agencies WHO, UNFPA, MSTL, UNICEF |
| **HUMAN RESOURCES**<br>Training<br>Skills & Competencies<br>Role<br>Motivations | 1. Provide training to new health workers on family planning.<br>2. Regular training or seminars on family planning are needed.<br>3. Health workers and clients must have an appropriate ratio.<br>4. Personnel responsible for the SARMANELA program must have the necessary skills to provide family planning to clients.<br>5. Officers working in ANC, Maternity, and PNC need a positive attitude towards providing family planning, nutrition, post-abortion care, LAM, ANC, PNC, and appropriate health care.<br>6. Provide recognition to midwives who excel through salaries.<br>7. Sanctions must be given to professionals who provide assistance that violates policies, | MOH, (MNCH), INSPTL | Agencies WHO, UNFPA, MSTL, UNICEF |

Table 12. Potential bottlenecks that are inhibiting scale-up of Task Sharing

| **Bottleneck**<br>**Health System Building block** | **Proposed Solution and Strategies for scale up** | **Primary Responsibility** | **Supporting Agencies** |
|---|---|---|---|
| **Governance:**<br>**Policy**<br>**Strategy**<br>**Guideline**<br>**SOP**<br>**Implementation manual** | - In the Family Planning Policy, it is recommended that midwives and doctors provide services based on the curriculum/education received during their education. Therefore, the nursing curriculum needs to add family planning services to the nursing education curriculum.<br>- Nurses are only for Health Promotion on Family Planning, Counseling and condom distribution.<br>- High-level advocacy is also needed, especially for managers, regarding family planning policies. | Ministry of Health provides Policy, INSPTL conducts orientation and training PPFP/PAFP | WHO, UNFPA, UNICEF Agency & Merry stopes |
| **Financial**<br>Budget allocation from the General State Budget<br>Donor budget allocation<br>Insurance<br>National plan to strengthen the PPFP/PAFP program | - Specified budget allocation for supporting supervision.<br>- UNFPA and MSTL provide financial support for program implementation.<br>- The implementation of Family Planning requires a plan-based financial allocation.<br>- A workforce committee is required to respond promptly to family planning situations or issues.<br>- A budget allocation is required to evaluate the PF program at the municipal level. | Director of Municipal Health Services | WHO, UNFPA, UNICEF Agency & Merry stopes |
| **People**<br>1.Network<br>2.Community engagement (local leadership, Religious Conviction, Men, Youth, Civil society | - Ensure that each health personnel perform their duties according to competence (Do not authorize nurses to provide services to PF)<br>- There is a good service for the provision of PF in some municipalities (UNFPA, MSTL)<br>- Provide training to community-based groups on PF promotion. | MoH (National and Municipal Human Resources) local authority, Religious leader, PAM | WHO, UNFPA, UNICEF Agency & Merry stopes Timor-Leste (MSTL) |
| **INFORMASAUN**<br>EIS/HMIS<br>IEC Material<br>Health promotion<br>Tools | - The national PF reporting system is ineffective, with low impact on coverage.<br>- Reproductive age partners should be targeted specifically; this objective must be allocated.<br>- Incidents have been documented, but only piloted in municipalities that support the health system from partners, as there is no national reporting system or indications for this. | MoH (National Directorate HEP/EPS)<br>MoH (M&E, HMIS)<br>MoH (DMNCH) | WHO, UNFPA, UNICEF Agency & Merry stopes Timor-Leste (MSTL) |
| **MEDICINE&TECHNOLOGY**<br>1.Infrastructure-mSupply, FPLMIS<br>2.Supplies<br>3.Equipment | - The commodity has expired, but don't know how to manage it (keep it at the facility or submit it somewhere).<br>- Every municipality must have PF product storage facilities.<br>- Some facilities must improve infrastructure to ensure the provision of PF services. | MoH, SAMES, DNFM, National Directorate of Equipment and Medicines | WHO, UNFPA, UNICEF Agency & Merry stopes Timor-Leste (MSTL) |

| | | | |
|---|---|---|---|
| **DELIVERY OF SERVICES**<br>Manual-Service Delivery (Management, supervision, coordination of services, service schedule, transfer system, Human resources) | - Socialization of family planning policies and LMIS to partners offering PF services is required to assist the government in ensuring standards.<br>- There must be ongoing supportive supervision from the national level to community health centers and health posts. | MoH, (RH, Office of Quality Assurance Control, Directorate of Maternal and Child Health) | Agencies WHO, UNFPA, MSTL, UNICEF |
| **HUMAN RESOURCES**<br>Training<br>Skills & Competencies<br>Role<br>Motivations | - Doctors and midwives require Family Planning training to assist the delivery of PF Services. | MOH, (MNCH), INSPTL | Agencies WHO, UNFPA, MSTL, UNICEF |

Table 13 Potential bottlenecks that are inhibiting scale-up of SBCC

| **Bottleneck**<br>**Health System Building block** | **Proposed Solution and Strategies for scale up** | **Primary Responsibility** | **Supporting Agencies** |
|---|---|---|---|
| **Governance:**<br>**Policy**<br>**Strategy**<br>**Guideline**<br>**SOP**<br>**Implementation manual** | **Policy:**<br>1. MHS policy development<br>2. TA Contract<br><br>Strategy: joint pastoral<br><br>Guideline<br><br>SOP:<br>1. SOP development is based on the strategy and indicators that exist<br>2. TA Contract<br><br>Deployment Manual:<br>1. Based on the existing SOP through health promotion<br>2. TA Contract | Ministry of Health (SMI, MPS) | Agencies WHO, UNFPA, MSTL, UNICEF |
| **Financial**<br>Budget allocation from the General State Budget<br>Donor budget allocation<br>Insurance<br>National plan to strengthen the PPFP/PAFP program | Budget allocation for MHS program must be certain | Ministry of Health (SMI, MPS) | Agencies WHO, UNFPA, MSTL, UNICEF |
| **People**<br>1.Network<br>2.Community engagement (local leadership, Religious Conviction, Men, Youth, Civil society | Network:<br>Community Engagement through PSF and GSI | Ministry of Health (SMI, MPS) | Agencies WHO, UNFPA, MSTL, UNICEF |
| **INFORMASAUN**<br>EIS/HMIS<br>IEC Material<br>Health promotion<br>Tools | EIS/HMIS:<br>MHS report format design<br><br>IEC Material<br>TA Contract<br>Preparation of ICE design, Produce IEC Material<br><br>Health Promotion<br>Pilot for IEC material MHS<br><br>Tools | Ministry of Health (SMI, MPS) | Agencies WHO, UNFPA, MSTL, UNICEF |
| **MEDICINE&TECHNOLOGY**<br>1.Infrastructure-mSupply, FPLMIS<br>2.Supplies<br>3.Equipment | SBCC promotion items such as Videos, Pamphlets and posters are required. | Ministry of Health (SMI, MPS) | UNFPA<br>INFPM<br>DNFM |

| | | | |
|---|---|---|---|
| **DELIVERY OF SERVICES**<br>Manual-Service Delivery (Management, supervision, coordination of services, service schedule, transfer system, Human resources) | Need to design supervision guidelines, make checklist SBCC, and provide training to DPHO EPS. | Ministry of Health (SMI, MPS) | UNFPA |
| **HUMAN RESOURCES**<br>Training<br>Skills & Competencies<br>Role<br>Motivations | - Recruitment of resources at health institutions to be able to undertake work based on each program.<br>- Design of recruitment training ToR for health professionals<br><br>Position promotion<br>Qualifications: comparative study, scholarship, certificate. | Ministry of Health (SMI, MPS) | UNFPA |

This recommendation will be written up after the workshop is held on November 13, 2024.

10. Recommendations

1. Post Pregnancy/ post-partum Family Planning and Post Abortion Family Planning

| No | Short Term | Medium Term | Long Term |
|---|---|---|---|
| 1 | Stakeholder meeting to disseminate the result of BNA on FP result | Sensitization of the Post pregnancy Family Planning to health workers at hospital and CSI's | Adaptation of the WHO's Post pregnancy FP compendium and handbook |
| 2 | Advocate for the inclusion of development of necessary policies and guidance for PPFP within the RMNCAH strategy document. | Develop SOP and or guide for Post Pregnancy (post-partum & Post Abortion) Family Planning services at all health facility level | Capacity building or orientation training for trainers on the PPFP guidelines for Health workers |
| 3 | Conduct mapping of health workers trained in provision of FP/ PPFP | Develop/ revise training manual for introduction of PPFP in coordination with INSPTL | Develop National Action plan for health workers capacity building for the next 3 years and Scale up PPFP training across Timor-Leste |

2. Task Sharing and Task shifting.

| No | Short Term | Medium Term | Long Term |
|---|---|---|---|
| 1 | Mapping of tasks sharing possibilities across health facility levels, types of services and across profession | Advocate for inclusion of Tasks sharing policies within the pre-service curriculum for medical, midwifery, and nursing education. | Inclusion of the Task sharing policies within the pre- service curriculum for medical, midwifery, and nursing education and continuous education for health professional through INSPTL |
| 2 | Advocate for the inclusion of development of necessary policies and guidance for Task sharing within the RMNCAH strategy for RMNCAH including FP services | Develop SOP for task sharing across health facility level, types of services and across profession<br>Develop Job aid for task sharing and inclusion within the Job description/ ToR. | Develop Tasks sharing policy related to RMNCAH service provision |
| 3 | Inclusion of key indicators for monitoring of task sharing on RMNCAH and FP services within the national HMIS routine report. | Orientation training on the Job aid for task sharing including key indicators on task sharing. | Sensitization and dissemination of the task sharing policy |
| 4 | Develop monitoring and supervision tools to facilitate national & municipality level M&E | Socialization of the M& E and Supportive Supervision check lists for managers at the national and municipality level appointed for FP services. | Clear and targeted Budget allocation for FP program implementation |

3. Social Behavior Change Communication (SBCC)

| No | Short Term | Medium Term | Long Term |
|---|---|---|---|
| 1 | Situation analysis on Social and behavior change communication | Rapid survey on SBCC for FP and or RMNCAH services | Develop targeted (culturally sensitive, based on needs) for SBCC for RMNCAH and FP in coordination with HEP/ PES directorate |
| 2 | Advocate for the inclusion of development of necessary policies and guidance for SBCC within the RMNCAH strategy for RMNCAH including FP services | Create a mechanism for active involvement of community in SBCC through PSF and MSG | Train health care providers on developed IEC materials (Utilization for health education & promotion) |
| 3 | Conduct desk review to identify existing guidance document for SBCC on RMNCAH including FP | Revise/Develop guidance document to address social & gender norms, involve men and promote healthy couple communication, set out standards for SBC in FP including adherence to the rights-based programming principles | Consultation of the draft document with relevant stakeholder's including faith-based organization and Socialization of the developed document to all stakeholders. |

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|---|---|---|---|
| 4 | Inclusion of key indicators for monitoring of SBCC on RMNCAH and FP services within the national HMIS routine report. | Orientation training on the Job aid for task sharing including key indicators on SBCC | |