Progress Report

June 2008 – June 2009

Health Sector Strategic Plan - Support Project (HSSP-SP)

Final Report Submitted February 2010

Title	**Health Sector Strategic Plan Support Project**
Project Number	**104794**
Country	**Timor-Leste**
Client	**Ministerio De Saude**
Address	**Postal 374, Dili, Rua de Caicoli**
Task Team Leader	**Timothy Johnston, Senior Health Specialist, World Bank**
Operations Officer	**Tanya Wells-Brown, Health Specialist, World Bank, Dili, Timor-Leste**
Financing	**Australian Agency for International Development International Development Association**
Date of report	**Drafted August 2009, reviewed by AusAID October 2009 Re-submitted February 2010**
Reporting Period	**June 2008 - July 2009**

Executive Summary

The Health Sector Strategic Plan–Support Project (HSSP-SP) aims to improve the quality and coverage of preventive and curative health services, especially for women and children in the Democratic Republic of Timor-Leste through:-

(1) Direct financial support using the Health Sector Strategic Plan and Medium Term Expenditure Framework (MTEF)[1] (focused on the HSSP's three objectives:-

- Improved accessibility to, and demand for, quality health services
- Strengthened management and planning systems
- Strengthened coordination, planning and monitoring

(2) Addressing challenges and innovations needed for the health sector to be prepared for "the next generation" of issues.

The project is expected to contribute to the following results)

- % of children under 1 year vaccinated with (i) DPT3 and (ii) measles.
- % of births attended by skilled health personnel.
- % of pregnant women receiving four or more prenatal visits
- % of children (6-59 months) receiving four or more prenatal visits.
- % of women (married or cohabitating) using modern contraceptives.

This is the first annual progress report for the (HSSP-SP). During the early stages of project implementation, the focus is not so much on measuring results but making sure that the project, as conceptualized and designed, is under implementation. Therefore, this first progress report largely focuses on implementation to date[2].

The overall project disbursements 12 months after implementation are $2.6 million. This is lower than the expected disbursements for year 1 implementation which were anticipated to be $4.3 million.

- During the implementation phase the Department of Partnership (DPM), where external donor partners and projects are managed was constructed on the grounds of the Ministry of Health.
- Support staff for the Department of Partnership Management recruited.

- Key advisors as per the legal agreement were recruited: Procurement Advisor, Finance Advisor

- World Bank Operations Officer covering health and education was replaced by World Bank Health Specialist covering the health projects.

[1] Budget plans have not followed the MTEF to date. The MTEF is currently under review.

[2] The report is complementary to the Aide Memoire released in August 2009, which specifically examined the implementation phase through the first year. The review team, comprising AusAID, World Bank and the Ministry of Health concur that multiple factors attributed to the slow implementation in the first months.

- Project coordination between Bank, DPM and Directorate of Planning and Finance was fortified.

- Advisors for the Ministry of Health were gradually recruited during the course of the first year; District Support Advisor, Pediatric Advisor, Biomedical Equipment Advisor, Information, Communication and Technology Advisor, Health Management Information System Advisor

- Vehicles purchased for district supervision and monitoring and strengthened health service delivery.

- Mopeds purchased for district health service delivery through the community outreach service.

1. Situational Analysis of Project Goals

- **Improved accessibility, demand for quality health services**

Accessibility, and demand for quality health services pose challenges for the Ministry of Health of Timor-Leste. This was further reiterated in the study by the University of New South Wales on Health Seeking Behaviour (2009). Distance to health services and quality of service delivery is a particular impact on the demand for services. Lack of privacy for services for women's reproductive health is a major barrier in contraceptive uptake and birthing with a skilled birth attendant. Lack of transportation is a major impediment with many districts having insufficient cars to be able to conduct service delivery efficiently and effectively. Lack of midwives in remote locations further exacerbates the situation.

During the first year of implementation sixty motor cycles were purchased for the community outreach services and thirteen four-wheel drive vehicles for monitoring of services. In addition, plans have been drawn up for the rehabilitation of ten clinical health posts and fourteen clinical health posts to have birth room extensions and the renovation of three clinical health posts. The Institute of Health Sciences in 2009 launched the curriculum for upgrading midwives from diploma I to diploma III. These midwives were selected from remote districts. The project funded the teachers to deliver this curriculum.

- **Strengthened management and planning systems**

There is a shortage of skilled in the Directorate of Planning and Finance. Skill transfer is difficult because the directorate staff are too busy and committed to their "day to day" work and therefore advisors find it difficult to plan time for capacity building. Previously management, planning and finance trainings have been pitched at too high a level to enable sustainable skill transfer and development. In addition, the courses that have been conducted have not been followed up and consequently there are punctuated efforts in management and planning. Linkages between the Directorate of Planning and Finance, the training facility, The Institute of Health Sciences and the Human Resource Directorate are weak.

- **Strengthened coordination, planning and monitoring**

The Department of Partnership Management, building was constructed on site at the Ministry of Health in 2008. The DPM was intended to strengthen MoH capacity for donor coordination. There was little evidence during the first year that coordination between donors and MoH improved, in spite of the appointment of a Head of Department. It was clear that the senior advisor, experienced in donor coordination is required to develop this department. The line departments were marginally involved in project implementation.

The budget planning cycle changed during 2009. Because of this it was difficult to refer to the MTEF as part of the planning process and the district planning cycle followed the same process as in previous years. A further initiative from the Office of the Prime Minister, a twenty year visioning plan detracted from the Health Sector Strategic Plan. This involves the development of a national health strategic plan.

2. Summary of Progress since June 2008

Project implementation progress

The project was approved in November 2007 and became effective in June 2008. The four components of the project and indicative funding allocations with percentage of total disbursement until June 2009 are:-

1. Health Service Delivery ($12 million) (37%)
2. Support Services, Human Resources, and Management ($4 million) (60%)
3. Coordination, Planning and Monitoring ($2 million) (3%)
4. Innovation and Program Development (US$2.3 million) (0%)

Project Coordination

The Minister for Health is responsible for project policy and execution management in his role as HSSP-SP Director. The DPM is the coordinating body of all the health sector partnerships and the Ministry of Health. The day-to-day coordination of the project takes place between the DPM and the Directorate of Planning and Finance, procurement department, and the various MOH line departments.

There is growing ownership and understanding of the Project mechanism, although further socialization is required in the service delivery directorates. Project implementation has improved as a result of more intensive support from the World Bank. There is still a need to socialize the HSSP-SP into other key program areas such as Community Health and Maternal and Child Health.

Technical Assistant Coordination and Supervision

Project supervision has focused on the project modus operandi to date. Less time has been spent on technical assistant supervision. This is a priority for 2010. Standardized work plans and evaluation formats are required. Coordination of TA is a priority between donor partners and will be the focus of concerted effort between the key donors in health, AusAID, USAID, EC and WB in 2010.

Health Sector Coordination

A key objective during project design was to increasingly shift responsibility for sector coordination to the MOH. Despite continued challenges, in the past year the MOH organized the first Joint Annual Health Sector Review (JAHSR) in June 2008 and Joint Annual Health Planning Summit (JAHPS) in September 2008. In addition, quarterly health coordination meetings with (key) donors and NGO representatives are now being led by the DPM. The first health coordination meeting was held in January 2009, the second in April 2009, and a third in June 2009. Aide Memoires are written after these coordination meetings and progress is marked against these Aide Memoires.

The Joint Annual Health Sector Review (JAHSR) was postponed this year due to a change in the budget planning cycle (with Ministry of Finance commencing budget preparations earlier than in previous years and requesting budget submission in June rather than October). Ministerial travel and the priority of the national strategic planning process initiated by the Government were also factors in the decision to postpone. The Ministry of Health organized a retreat in Coliate, Ermera in July with district teams and stakeholders provide input into the 20 year strategic vision. A

combined Joint Annual Health Sector Review and Planning Summit is scheduled for the last week of September 2009. Partners will discuss during this review how to revise the schedule for future JAHSR and JAHPS.

Coordination and collaboration with the European Commission-financed SIHSIP technical assistance project has improved (this project will end in December 2009). Recruitment of technical specialists has been complementary, and there has been coordination between TA on the development of the new MTEF and further strengthening the sector-wide approach (SWAp). The SIHSIP team leader has taken on some advisory roles within the DPM, and has assisted with the coordination and leadership for the joint annual sector reviews.

Progress on key performance indicators

Annex 1 provides a summary of progress on key performance indicators, including baselines, targets and actual performance in 2008, and targets for subsequent years. Most indicators were obtained through the Health Management Information System (HMIS) Contraceptive prevalence rate data is collated by UNFPA and not through HMIS. Interim indicators should be developed in a logical framework to assist with project monitoring.

The HMIS data indicates steady progress in project indicators

- immunization coverage increased approximately 10% for measles immunization and DPT3,
- antenatal coverage increased from 34.5% to 43% assisted deliveries increased from 32% to 35% between 2007 and 2009.
- contraceptive use has increased from 10% in 2003 to 19.1%

The data suggest a possible decline in ANC4 and percentage of children receiving vitamin A supplementation, but the reliability of data for these indicators is also less certain. Improvement in data quality and coverage for these key indicators will be a key issue for dialogue in the coming year, and will be among the priorities for NGO contracting as well as other project-financed technical support (see discussion below).

Of note, the HMIS data did not capture data from the Ministry of Health's newly established community service delivery initiative 'Sistema Integradu Saude Communitaria' SISCa program[3]. This program is delivered by the Ministry of Health in each suco (village) in preventative and curative health services. A series of service delivery tables provide growth monitoring and nutrition supplementation, immunization, antenatal services, health promotion and information, education and health promotion.
[4] For 2010 this data should be integrated into the HMIS which could indicate an increase in coverage. Strengthening SISCa service delivery is planned through the project in or 2009 and 2010.

3. Project Components

[3] SISCa commenced in 2008 after the project design was finalized. It was not part of the Health Sector Strategic Plan or the Health Sector Strategic Plan-Support Project. It is a priority of the Ministry of Health and the project, which was designed to support district service delivery has modified easily to include this priority. Mechanisms need to be established for monitoring this input.

Component 1 – Health service delivery

a) Implementation of the Basic Service Package (BSP) for primary health care and for improving district-level planning and management capacity through:

(i) Support for financing for international and local advisors to provide "hands-on" technical assistance to districts

5

A public health specialist with advanced Tetum language skills was recruited as a district advisor to complement the District Management Team and support three districts health teams with the establishment of district implementation plans (DIPs) and strengthen implementation of service delivery, data collection and monitoring of services.

The advisor and district support team have contributed to progress on a number of key areas:-.

- The development of the district implementation plans (DIPs), sub-district plans which provide guidance to district health teams on their annual work plan[6].
- The socialization of the DIPS, the national planning cycle and budget process with a national 3-day convention.
- In coordination with the district advisory team, and other key members of the directorate of community health, district implementation plans (DIPs) have been launched and a format for quarterly reporting was established in 2008, which shows coverage of all programs.
- Family registration has been piloted in most districts, data collation forms trialed and consultations with *Chefe de Sucos* (village chiefs) and family health promoters (PSFs) about appropriate methodology for collecting this data. Workshops on decentralization, planning and budgeting were conducted in Oecusse.
- Community health outreach, SISCa simulations have been conducted in three districts in the first *quarters of* 2009

Tools/Documentation developed during 2008/09 with support from the district advisory team include:

- SISCa supportive indicator tool monitors the participants at SISCa, the PSF member attendance and staff members. It also allows the documentation of key health indicators captured, such as growth monitoring, immunization, antenatal checks and pregnancy registration. These indicators are also being used for the NGO contracting.
- Supportive supervision tool for Integrated Management of Child Illness to improve implementation of child preventative and curative interventions.
- National key indicators for all technical programs established.

The district advisory team provided input into the Demographic Health Survey 2009, health promotion tool evaluation in the nutrition working groups, maternal and child health working group, as well as assisting with the immunization campaign.

In summary, the district support adviser has contributed to improved planning cycle process, implementation of family registration, improved management improved use of district implementation plans and improved data collation in the districts she is working in.

(ii) improved transportation (vehicles and motorcycles)

Sixty motor cycles/mopeds for SISCa and district health service delivery. Thirteen four wheel drive vehicles have been purchased, which will be used for the district support teams to support district development and monitoring.

(iii) direct financing for BSP implementation through district annual plans, including for outreach services to remote areas

In mid-August 2009, the MOH Directorate of Community Health submitted to the WB a financing proposal support of operational costs for SISCa through HSSP-SP.

b) Strengthening community nutrition and health services, through:

(i) Direct financing for community-level activities by health districts

The financing of community level activities will be the focus of the project 2010 onwards.

(ii) Financing of contracts for local and international NGOs to provide integrated community nutrition and health service in partnership with MOH and districts

The purpose of the NGO contracting is an attempt for increased collaboration and improved coverage and strengthened data collection in the districts of health service delivery. Many informal arrangements have been forged between NGOs and the Ministry of Health at the district level in terms of assistance with SISCa.

Seven NGOs applied for the contracts with the Ministry of Health and five were selected to work in the districts of Oecusse, Viqueque, Manatuto, Cova Lima, Bobonaro and Ainaro.

(iii) Technical support to the MOH in developing nutrition policies and implementation strategies

No direct funding has been allocated through HSSP-SP for this sub-component to date.

c) Improving hospital care and the referral system, through

(i) Support for implementation of the Hospital Service Package (HSP)

A technical advisor for the hospital directorate has not been recruited. In view of move toward district service delivery support the need for this position should be re-evaluated and only pursued if other project funds are secured

A technical advisor is developing the standard treatment guidelines and standard operating procedures[7].

Neonatal Quality Improvement

The paediatric quality control advisor was recruited to assist with the implementation of paediatric and neonatal quality control procedures and equipment training in and the paediatric unit at HNGV. This role was identified as priority for technical assistance in the JASPS mission of June 2008.

She conducted the first assessment of quality of care on the neonatal ward at HNGV and this document identified a number of key areas for improvement. She was appointed the coordinator for the Breath for Life Program from Vietnam neonatal improvement program approved by the Ministry for Health.

(ii) Financing of technical assistance for "commissioning" of the new regional hospitals

N/A in 2008/9

(iii) Support for "twinning" arrangements with hospitals in the neighboring countries to strengthen hospital management and key support services (such as hospital pharmacies and laboratories).

[7] During the joint annual health sector planning summit (JAHPS) in October 2008, the key issues and priorities presented were about strengthening the quality of hospitals because of the lack of hospital based policies and treatment protocols. These included the establishment of Standard Operating Procedures (SOP) for all hospitals the establishment of Standard Treatment Guidelines (STGs), which are currently prepared by an advisor funded under HSSP-SP.

The MOH has initiated a process to explore the possibility of a twinning arrangement with Royal Darwin Hospital to strengthen the specific disciplines of pediatric services and management systems. An initial draft memorandum of understanding for the twinning was prepared in collaboration with the Director of GNVH, Director of Human Resource Directorate and the Department of Partnership Management. A mission team from MOH traveled to Darwin to meet with a team from Royal Darwin Hospital in August 2009. They were accompanied by a consultant hospital management specialist financed the World Bank, Dr. Stephen Christley. The current draft MoU proposes a focus on pediatric strengthening, pharmacy capacity building in hospitals, medical record management through exchange of personnel. This will be further developed in 2010.

d) Assuring quality of care throughout the health system/services delivery, through:

(i) Improvements in infrastructure and equipment at health facilities, with an initial focus on upgrading existing Community Health Centers (CHCs) to include maternity rooms and equipment;

The Basic Service Package includes Basic Emergency Obstetric Care (EMOC) and equipped health facilities for women to birth at Clinical Health Centres in Timor-Leste. These interventions are essential to reduce maternal mortality in Timor-Leste. An assessment by UNFPA in 2008 revealed that only 10 of the 65 CHCs have such facilities and obstructing the implementation of EMOC

Plans and bidding documents, based on the assessment from United Nations Population Fund (UNFPA, 2008) have been developed to for the birthing facilities at the following CHCs:- Metenaro, **Dili**[8], Lequido, Remexio, **Aileu**, Ainaro Vila, HatuUdo, **Ainaro**, Alas, **Manufahi**, Ossu, Watilari, **Viqueque**, Iliomar, **Lautem**, Bazatete, **Liquica**, Balibo, Lolotoe, **Bobonaro**, Zumalai, Fohorem, **CovaLima.**

Renovation and extension to include birthing room:- Cassa, **Ainaro**, Ilheu, **Manatuto**, Laga, Vermasse, **Baucau**, Asmano, **Liquica**, Passabe, **Oecusse**[9].

Utilization of birthing facilities is limited. While there are many factors that contribute to low utilization it will be important to monitor the utilization rates with development partners such as UNFPA.

(ii) Ensuring adequate disposal of biomedical waste.

[8] Bold text represents District

[9] currently on hold and being reviewed by Minister for Health.

An environmental mission was undertaken by Josefo Tuyor (Senior Operations Officer, EASPS) in March 2009 to review the projects compliance with agreed environmental and waste management guidelines the key findings and recommendations are documented in Aide Memoire of June 2009.

Twenty Incinerators are being supplied and installed in the following clinical health posts:- Laulara, **Aileu**, Turescain, **Manufahi**, Atsabe, Letefoho and Railako, **Ermera**, Laclo, Soibada, **Manatuto**, Laga, **Baucua**, Viqueque Vila, Ossua, Watucarbau, **Viqueque**, Lautem Vila, and Iliomar, **Lautem**, Bazatete, **Liquicia**, Cailaco, **Bobonaro**, Tilomar, Maukatar **Cova Lima** and Nitebe**, Oecusse**.

Component 2 – Support Services, Human Resources, and Management

(i) Strengthening the capacity of the Institute of Health Sciences (IHS) to provide technical and management training to health staff, including through establishing a "twinning" arrangement with a training institution in neighbouring countries.

The twinning arrangement was not pursued in 2009 because the international teaching costs were not covered. Individual teaching contracts were developed to cover the midwifery and nursing curriculum[10].

(ii) Based on the updated Health Workforce Plan

- Direct support for priority local and international training for Timorese staff.
- Support improved human resource development and management practices (in cooperation with the EC technical assistance.
- Support MoH efforts to improve the identification, mobilisation and management of priority technical assistants.

Training and scholarships

Current scholarships funded under HSSP-SP are based on a MoH Training Plan. Scholarships have been granted in medical specialties (orthopedics and psychiatry) as well as post graduate scholarships in public health specialties, epidemiology, public finance, pharmacy, health legislation and policy, health management; undergraduate medical students, nursing and

[10] The IHS is currently supported by Fundação Calouste Gulbenkian, a private foundation from Portugal that provides technical support in the area of curriculum development, course implementation and management. When the project was designed the current twinning arrangement was not in place. Fundação Gulbenkian is working on the design phase for a program from 2010 onwards and the twinning arrangement should complement this relationship thereafter.

midwifery. 95 students in total are enrolled in a range of overseas courses largely in Indonesia but also in Papua New Guinea, Australia and Malaysia that will complement the work force of the Ministry of Health. 55 students were carried over from EC funding to the HSSP-SP.

These scholarships will continue for the coming years, with no new overseas scholarships expected to be funded under HSSP-SP unless based on an endorsed, robust work force plan.

A workforce plan was constructed under SIHSIP and although referred to was not fully endorsed by the Ministry for Health. In May and June 2009 a health workforce study was conducted by the University of New South Wales, with financing from a regional trust fund managed by the World Bank.

The human resource specialist under the EC project will finish in December 2009. Recommendations are that a human resource specialist, punctuated with short term specific TA is vital for the human resource directorate to establish and strengthen links with the training institutions in Timor-Leste, coordinate the scholarships with the workforce plan and preparations for the medical students who will return from Cuba in 2010.

Training
The DPM national staff member attended a procurement training course in Philippines in December 2008.

Recruitment Development

Through HSSP-SP the recruitment of international technical assistance is the responsibility of the Ministry of Health. The successfulness of recruitment and turnaround time has varied depending on the position, but the professionalism with which some of the recruitment has been dealt with is worthy of note. The review committee scores and shortlists candidates and then an interviewing committee, comprising relevant disciplines and technical assistants is established to interview the shortlisted candidates.

(i) Strengthen procurement, distribution and management of essential drugs and supplies, including through:

HSSP-SP supported a number of key advisors to support the strengthening of SAMES as a semi-autonomous entity.

The procurement advisor assisted with the development of an organization structural plan and job descriptions/terms of reference for the Director, procurement officers and assistants as well as the capacity development in routine procurement of drugs, laboratory, consumables and medical supplies. In addition, standardized documentation in routine procurement was developed, a commodities data base established, lists of pre-qualified suppliers were established and the commencement of standard framework contracts. Appropriate training courses were identified and some procurement staff attended a Drug Management Supply course in the Netherlands in March 2009.

The Quality Improvement Advisor developed standard operating procedures, Quality control procedures and laboratory procedures prepared and under translation through HSSP-SP.

Infrastructure – the preparation of plans and bidding documents for the expansion of the storage warehouse for SAMES was completed.

Impact

Overall, this support has resulted in less stock out for SAMES, improved quality improvement procedures, the identification of re-call and out of date drugs. However there is still further work to improve forecasting to avoid stock out.

A supervision mission was undertaken by Pharmacist Specialist with on-going recommendations for reform.

(iv) Strengthen core MOH "support" and fiduciary functions, including for planning and supervision of civil works, logistics and maintenance of infrastructure and equipment; procurement; financial management; and information and communications technologies (ICT). The project will support technical assistance, training, and local contractual staff for key functions in these service units (including for Finance, Procurement, and Infrastructure), as well as "contracting out" of certain technical services (including for maintenance of computer equipment, and use of procurement agents for complex procurements).

The procurement advisor's role is to coordinate the development of the procurement plan, update the plan and maintain the flow of work between the World Bank and Ministry of Health.

The Infrastructure Support Unit (IFU) under the Logistics Department of the Directorate of Administration, Logistics and Procurement and implements both donor and budget financed civil works. One engineer and two national civil works staff are employed under the project and assist with the oversight of infrastructure development, preparation of bidding documents, site inspection, site location identification and plans.

The medical equipment advisor will create an inventory of all assets, maintain medical equipment assets, assist in all district hospitals and health clinics with repairs and maintenance, prepare procurement documents for medical equipments and advise and coordinate all medical equipment procured by other donors.

The ICT advisor has identified the following priorities:-

1. Overhaul of the internet connection
2. The establishment of Government of Timor-Leste email addresses
3. Document management/version control
4. HMIS database (working with newly recruited HMIS advisor and team within the Ministry)
5. IT policies
6. Review of asset register
7. Recruitment of national assistants
8. Basic computing training (skill level based)
9. Procurement of assets under EC grant.
10. Site licensing

These TA positions are important for the ongoing strengthening of core MOH support and fiduciary functions and improved communication between departments, programs and districts and will continued into 2010.

Component 3 – Coordination, planning and monitoring

(a) Support for establishment of the Department of Partnership Management to strengthen MOH capacity for donor coordination, including the financing of an International Program Consultant for this department, while ensuring that line departments take the lead in implementation of Project- and donor-financed activities

- No International Program Consultant recruited.
- Weak coordination between the other directorates and departments so line departments have not taken the lead in project implementation. For example direct proposals to the HSSP-SP were received from the pharmacy department and not via DPM and were not funded.
- Health Specialist from SIHSIP assumed role of advisor to DPM and assisted with donor coordination.

(b) Technical assistance (in collaboration with the EC) for strengthening the annual planning and budgeting process at central and district level, including integration of external assistance into annual plans and reporting;

During the October 2008 JAHPS, the MOH provided integrated budget plans for 2009 which included the general state budget the proposed HSSP-SP financing and funding from many donor partners. This was a notable step forward.

The Finance advisor and the EC Financial management advisor were not utilized sufficiently in the budgeting process for 2010. The MTEF was not used as a basis for the 2010 budget. The Ministry of Finance's budgeting cycle changed significantly in 2009 and it was not possible to follow previous planning cycles. The MOH's budget request was cut significantly by MOF and the Minister has requested further assistance from the Bank and partners in costing health sector. However since the September 2009 JAHPS the financial management specialist under the SIHSIP program has been utilized more and consequently his contract will be picked up through HSSP-SP after the closure of SISHIP.

(c) Further strengthening the MoH HMIS including technical assistance, operational support and support for related hardware and software.

The Health Management Information System advisor was recruited in mid 2009 and this role is to assist with strengthening data coverage and quality will be recruited in August 2009. His role is to work closely with the Head of the Health Management Information System Division, the district support advisor and monitoring and evaluation advisor to strengthen the health management information systems. The expected outputs will be to introduce timelier and robust data methods, sharpen indicators and provide guidance to improved analysis Interim (key) indicators will be developed to enhance the ability to monitor and report on HSSP-SP progress.

The HMIS report for 2008 was distributed in June 2009.

(d) Direct financing of surveys and other evaluations, including through the national statistics bureau as well as through other public, private and non-governmental organizations;

No surveys have been financed through the project so far, in part out of concerns to not overstretch MOH capacity. The Bank and AusAID were willing to contribute funds to the Demographic and Health Survey (DHS) but MOH has indicated preference to use other funding sources.

Improved policy development and research capacity within MOH, including targeted support for operational research.

The MoH research department is under development. No specific items under this category were funded in 2008 – 2009. Policy development is on-going in the maternal and child health department with technical advisor input in the development of the updated maternal, neonatal and child health strategy.

Component 4 – Innovation and Program Development

Contracting with NGOs for community health and nutrition is portrayed in the project appraisal document as innovation. Five NGOs were short-listed for MoH partnership contracts. Progress of the contractual obligations of each party will be followed through the establishment of a monitoring framework.

Innovations 2009/2010: community mobilization, incentives for remote placements, family registration, suco mapping, piloting of behavior change communication tools.

Issues during Implementation 2008 – 2009

The MOH restructuring in 2008, which involved the establishment of new departments, including a new integrated Directorate of Planning and Financing (DPF), and a new Department of Partnership Management (DPM) has developed slowly. This restructuring meant that Line

directorates/departments, rather than a Project Management Unit, would be responsible for the sector wide implementation and it has taken longer than anticipated for these new structures to become fully staffed and for roles and functions to be reconciled. This re-structuring also meant that all development partners, NGOs and UN agencies were supposed to report through DPM and then be referred out to program heads or heads of department. However, the DPM did not reside over line departments and therefore it has been difficult to establish “buy in” from the departments as there was no direct reporting of line departments to the DPM. External partners still reported directly to the line departments they work with bypassing DPM or reporting directly to the Director General or Vice Minister. In addition, delays occurred because the DPM was not fully staffed and roles and terms of references were not clearly established. The international DPM advisor position was a critical position to provide guidance and direction to the newly formulated DPM has still not been recruited despite being advertised several times.[11]

Procurement of medical equipment and vehicles in particular has been a challenge for the Ministry of Health. The MOH has limited expertise to design successful procurement exercises, including quantification and needs assessment, development of appropriate technical specifications, assessing bids from companies, and prompt payment of suppliers. Due to the volume of work the international procurement advisor is overextended. In addition, because Timor-Leste is a small, fragile state, suppliers are sometimes reluctant to submit bids. These factors have contributed to delays in the procurement process.

Much of the time of the Bank’s local health specialist is taken up with problems arising from procurement problems in the HSSP-SP, EC grant, or the recently closed HSRDP2 project. A number of steps have been taken to address these constraints including: recruitment of an international medical equipment specialist who is helping to develop minimum standard equipment lists and specifications for hospitals and health centers, and to establish systems for maintenance, asset registry, and planning for equipment replacement due to age with some accuracy from the Asset Register.

While delays were partly due to the above-mentioned delayed recruitment of the procurement advisor, it was agreed that complexity of some of the World Bank procurement procedures and/or unfamiliarity with these procedures and processes by most MOH staff is a contributing factor.

Recommendations
As the above issues relate to all procurement processes and not only those of the World Bank, it was agreed that more assistance is required in the area of procurement across the Ministry of Health. In the project design the Bank allowed for more flexible procurement procedures whenever appropriate to facilitate procurement. This flexibility was not always utilized.

Technical Assistants recruited under HSSP-SP have not been maximally utilized during the first year of implementation. Notably, this is the viewed from the perspective of the international technical assistants. Sometimes a direct counterpart is not always appointed or the technical advisor and counterpart/s are not seated in the same location. There is sometimes a misconception that the advisors work within the Department of Partnership Management and just work on the donor projects. Work plans are not always developed between counterpart and advisor, and if they are, they are not fully operationalised or implemented. Evaluation of progress against plans is not monitored. Roles and responsibilities in terms of technical assistant’s outputs in capacity building have not been measured**.** There tends to be a phase-in-phase-out approach of

[11] The terms of reference were reviewed and amended again by the committee in August 2009, after another round of unsuccessful applicants. The position has been re-submitted for advertisement.

working with the advisors and often their services are utilized more when a specific function has been identified within the Ministry. Technical assistants are less than satisfied with not being utilized and often do not extend their contracts hence there is a rolling process of recruitment.

Recommendations
When the terms or reference are drawn up by the Ministry a direct counterpart should be identified. On appointment the counterpart needs to allocate time to create a capacity building work plan and line function work plan with the technical assistant based on the terms or reference. A third party focal point within the Ministry of Health should be identified as well as a member of the Human Resource Directorate in order to monitor performance of TA, including achievements against the capacity building plan or identify reasons why achievements are not met. There is a high degree of TA management for the Ministry for Health. It is unclear whether there is too much work for the counterpart to do to fully utilize the advisor and that perhaps variations for utilization should be investigated, one month on off, three month on off, part time.

Project indicators have been difficult to measure and report on. The indicators selected when the project was designed have been superseded by key indicators drawn up by the Ministry of Health (August 2009).

Recommendations
Suitable progress indicators should be established to enable quarterly or bi-annually reporting. Indicators should be updated to coincide with the key indicators of the Ministry of Health. Technical assistant capacity building progress should be included as measurable indicators**.** The indicator list could be formally revised in 2010 based on agreed indicators and tools for collecting and monitoring performance**.**

Policy Dialogue
To date, discussion with the Ministry of Health has been focused more on project implementation, with little opportunity to policy dialogue. The rapid, and changing nature of plans, is challenging and in 2010 the intention is to move towards district service delivery and avoid bureaucratic hindrances at central level.

Recommendations
The development of a health donor harmonization mechanism or shadow alignment of the health coordination sector should be established to assist with this.

Annex 1: **Arrangements for results monitoring**

			Target	Actual	Target Values				Data Collection and Reporting		
Project Outcome Indicators	**Baseline**		**2008**	**2008**	**2009**	**2010**	**2011**	**2012**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
	2003 DHS*	2006 HMIS									
% of children under 1 year vaccinated with (i) DPT3 and (ii) measles	56 47	63 61	70 70	79.1 73.3	80 80	85 85	90 90	90 90	Semester (HMIS data and EPI surveys) Every 2-3 years (household surveys)	HMIS (2008)	MOH (for HMIS) DNS (National Department of Statistics for HH data)
% of births attended by skilled health personnel		27	32	35.6	35	38	42	45	Semester (HMIS data) Every 2-3 years (household surveys)	HMIS (2008)	MOH DNS
% of pregnant women receiving at least four antenatal visits		36	40	34.5	43	47	51	55	Semester (HMIS data) Every 2-3 years (household surveys)	HMIS (2008)	MOH DNS
% of children (6-59 months) receiving vitamin A supplements	36		40	31.0	50	60	70	**80**	Every 2-3 years (household surveys) Semester (estimated coverage from HMIS)	HMIS (2008)* previous indicator DHS	MOH DNS
% married or cohabitating women using modern contraceptives	10		15	19.8	17	19	22	**25**	Every 2-3 years (household surveys); Semester (couple-years protection estimated from HMIS)	TLSLS/ household surveys * previous indicators DHS	MOH DNS
Intermediate Outcome Indicators		**2006** HMIS	2008	2008	2009	2010	2011	**2012**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
1: Improve accessibility, demand, and quality of health services											
% of health clinics providing the comprehensive Basic Service Package (BSP)*		0	20	*	40	60	70	**80**	Annual	BSP supervision	MOH
% of pregnant women receiving tetanus toxoid (TT2) injection			ND	58.3					Semester (HMIS data) Every 2-3 years (household surveys)	HMIS	MOH, Survey
Cesarean section rate			NF	65					Semester	HMIS (ACTUAL	MOH

Project Outcome Indicators	Baseline		Target 2008	Actual 2008	Target Values 2009	2010	2011	2012	Data Collection and Reporting: Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
	2003 DHS*	2006 HMIS									
				total 0.1%						FIG)	
Number (%) of children (6 mo – 3 yrs) participating in integrated community nutrition programs		TBD	No data	*				60%	Semester (project report data) Every 2-3 years (household surveys)	Project reports TLSLS/ household surveys	MOH DNS
Number of referral hospitals implementing the Hospital Service Package*		0	2	*	4	6	6	**6**	Annual	Supervision reports	MOH Hospitals
Number of referral hospitals implementing guidelines* for hospital management and clinical quality, including (i) monthly clinical review meetings; (ii) maternal death audits		0	0	0	2	4	6	**6**	Annual	Supervision reports	MOH Hospitals
2. Strengthen support services and management											
Availability of tracer essential drugs at (i) SAMES; (ii) health facilities		88% n.a.	94 90		95 92	96 94	97 95	**98%** **95%**	(i) Semester/ (ii) Annual	SAMES database HMIS Facility surveys	SAMES MOH
Percentage of biomedical equipment in hospitals that is out of order (non-functional)*		TBD						10%	Annual	HMIS (from 2009) Facility surveys, supervision reports	MOH
(i) total health staff trained with Project		0	i2					(i) TBD	Annual	Training and human resource	MOH, HIS

			Target	Actual	Target Values				Data Collection and Reporting		
Project Outcome Indicators	**Baseline** 2003 DHS*	**Baseline** 2006 HMIS	**2008**	**2008**	**2009**	**2010**	**2011**	**2012**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
financing; (ii) Percentage of district and CHC managers that have received management training								(ii) 70%		database	
3. Strengthen coordination, planning, and monitoring											
% of health facilities/ submitting completed HMIS monitoring reports 1 month after end of each quarter		TBD	No data					90%	Semester	HMIS	MOH
(i) % recurrent expenditures on hospitals (<40%); (ii) % State Budget allocated to health; (iii) % execution of health budget		38	<40		<40	<40	<40	<40	Annual	Annual budget execution report	MOH, MFP
Number of partners submitting to MOH a fully costed work program for forthcoming year		3	4		5	6	7	8	Annual	Annual Joint Sector Review reports	MOH partners
4. Promote innovation and learning											
Number of pilot initiatives (i) financed by Project and implemented; (ii) evaluated with lessons disseminated; (iii) scaled up and/or influenced policy		0	1 1 0	0	3 3 2	6 6 3	10 8 4	12 10 5	Annual	Annual reports	MOH
Number of formal MOH-		1	2	0	4	6	8	10	Annual	Annual reports	MOH

Project Outcome Indicators	Baseline		Target	Actual	Target Values				Data Collection and Reporting		
	2003 DHS*	2006 HMIS	2008	2008	2009	2010	2011	2012	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
private sector/NGO partnership contracts signed											

- *Notes:
- Data collected from the 2003 DHS cover the 2001/02 period for most service coverage indicators. The Timor-Leste Survey of Living Standards (TLSLS) was fielded in 2007, and preliminary data should be available by the end of 2007. These household data will update the 2002 DHS for many of the baseline health indicators.
- The HMIS system is still being strengthened, including through the introduction of new reporting forms in 2009. Several key indicators are not being reliably reported through the current system (e.g., contraceptive prevalence, % equipment out of order), so baselines and targets may need to be updated in 2009 based on revised data.
- Supervision checklists to define the extent to which a given district or hospital are implementing the BSP or HSP, respectively, will be defined in the first year of implementation. Similarly, clinical guidelines and standards for referral hospitals will be developed in the first year, and will be the basis for developing a monitoring checklist and baselines for these indicators.
- data compiled in report on rolling out of Basic Service Package 2008 – 2009 [under review]