Document of
The World Bank

FOR OFFICIAL USE ONLY

Report No: 40747-TP

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED IDA GRANT

IN THE AMOUNT OF SDR 640,000
(US$1 MILLION EQUIVALENT)

TO THE

DEMOCRATIC REPUBLIC OF TIMOR-LESTE

FOR A

HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

November 14, 2007

Human Development Sector Unit
East Asia and Pacific Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective October 31, 2007)

Currency Unit = US Dollars
1 SDR = US$1.56936

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ANC	Antenatal care	IMCI	Integrated Management of Childhood Illness
AusAID	Australian Agency for International Development	IMF	International Monetary Fund
BSP	Basic Service Package	IFR	Interim Financial Reports
CAS	Country Assistance Strategy	IP	Indigenous Persons
CCT	Conditional Cash Transfer	JAPS	Joint Annual Planning Summit
CHC	Community Health Center	JASR	Joint Annual Sector Review
DPM	Department for Partnership Management of the MOH	MDGs	Millennium Development Goals
EC	European Commission	MOF	Ministry of Finance
FMIS	Financial Management Information System	MOH	Ministry of Health
FMR	Financial Management Report	MTEF	Medium Term Expenditure Framework
GDP	Gross Domestic Product	NDP	National Development Plan
GVNH	Guido Valadarez National Hospital	PFMCBP	Public Finance and Management Capacity Building Program
GoTL	Government of Timor-Leste	POM	Project Operational Manual
HSP	Hospital Service Package	PPP	Public-Private Partnership
HSR	Health Sector Review	SAMES	Autonomous Medical Supply System (*Servico Autonomo de Medicamentos e Equipamentos de Saude)*
HSRDP2	Second Health Sector Rehabilitation and Development Project	SWAP	Sector Wide Approach
HSSF	Health Sector Support Fund	TLSLS	Timor-Leste Survey of Living Standards
HSSP	Health Sector Strategic Plan	TFET	Trust Fund for East Timor
HSSP-SP	Health Sector Strategic Plan Support Project	UNFPA	United Nations Population Fund
HSSU	Health Services Support Unit	UNICEF	United Nations Fund for Children
IDA	International Development Association	USAID	United States Agency for International Development
IDP	Internally Displaced Persons	WHO	World Health Organization
IHS	Institute of Health Sciences		

Vice President:	James W. Adams
Country Director:	Nigel Roberts
Sector Director	Emmanuel Y. Jimenez
Sector Manager:	Fadia M. Saadah
Task Team Leader:	Timothy A. Johnston

TIMOR-LESTE
Health Sector Strategic Plan Support Project

CONTENTS

I. STRATEGIC CONTEXT AND RATIONALE

A. Country and sector issues

1. ***Country Context***. Shortly after declaring independence from Portugal in 1975, Timor-Leste was invaded and illegally occupied by neighboring Indonesia. In a 1998 referendum, the majority of the Timorese voted for independence, but the Indonesian government responded with an orchestrated campaign of violence, which left over 1,000 people dead, the majority of the population displaced, and the country's private and public physical infrastructure in ruins – including nearly 80 percent of health centers. Most Indonesian citizens departed, leaving Timor-Leste with limited human resources and institutional capacity.

2. Following the intervention of a multi-lateral peacekeeping force, the United Nations Transitional Administration in East Timor was established. Elections for a Constituent Assembly and Presidential elections were subsequently organized, and the country formally declared independence in May 2002. The international community maintained a significant presence, however: a 900-person United Nations Mission of Support in East Timor was created, and succeeded in May 2005 by the United Nations Office in Timor-Leste. Most of the government's recurrent budget was financed by the UN, with most of the development budget financed through the multi-donor Trust Fund for East Timor (TFET), which was managed by the World Bank.

3. Political tensions and growing discontent among urban youth contributed to periodic unrest. Beginning April 2006, however, a major political crisis led to violence between the police and armed forces and exacerbated regional tensions. Over 40 people were killed initially, and subsequently thousands of homes were burned in a cycle of violence and retribution that lasted several months. An estimated 150,000 people – out of a population of just over a million – fled their homes and settled in Internally Displaced Person (IDP) camps (about half in Dili, and the rest in surrounding districts).

4. Remarkably, the Ministry of Health (MOH) continued to function throughout the crisis, one of the few government ministries to do so. Many central MOH staff relocated with their families to IDP camps on the grounds of the national hospital in Dili. Senior MOH officials held daily meetings and maintained regular telephone and radio contact with district health team, to ensure that health service remained functional in both Dili and in rural areas. The MOH also sought to ensure effective coordination of the international response to the crisis, including coordinating NGOs providing health services to IDP camps. Despite heightened political tensions and regional divisions, senior officials repeatedly stressed to health staff and to the public that the Ministry of Health and health professionals were fully neutral, and would maintain their professional standards.[1]

5. The return of international peacekeeping forces helped restore a measure of stability. Presidential and parliamentary elections were held in April 2007 and May 2007, respectively, and resulted in the installation of a new coalition government. The elections were preceded by periodic unrest; in April 2007, for example, several buildings of the Ministry of Education were

[1] See *Timor-Leste: Health Sector Resilience and Performance in a Time of Instability* (AusAID, 2007).

burned. A relative calm has returned following the elections, but tensions remain. An estimated 70,000 are still in IDP camps.

6. The government's fiscal position has improved dramatically in the past two years as a result of growing petroleum revenues, but capacity to execute the budget has emerged as a major constraint. Poverty levels remain among the highest in the sub-region, and unemployment among youth, particularly in urban areas, further contributes to social tensions. In this context, it is extremely important for the government to demonstrate to its population that it can effectively deliver services. Improving the quality and coverage of health services, while maintaining the sense of professionalism that sustained the MOH through the crisis, is thus of vital importance for the stability of the country as well as the health of the population.

7. The Bank's most recent Country Assistance Strategy (CAS) for Timor-Leste was discussed by the Board on July 19, 2005. The CAS was developed with the participation of a broad range of stakeholders, including all levels of government, development partners, private sector representatives, civil society organizations, communities, religious groups, and youth. The three CAS pillars—delivering sustainable services, creating productive employment, and strengthening governance—support National Development Program (NDP) objectives and provide the strategic framework for the Health Sector Strategic Plan Support Project (HSSP-SP).

8. ***Sector Context***. The health sector has made significant progress since independence in reestablishing basic infrastructure and services, despite the unrest of the past two years. But it now must confront important and more complex "second generation" challenges in order to further develop the health system and improve health outcomes. Key challenges include:

- *Persistent poor health status and outcomes*. Child and maternal mortality, child malnutrition, and fertility indicators for Timor-Leste remain among the highest in the region. In 2003, the child mortality rate was 83 per 1,000 children, and nearly two-thirds of children under five were underweight. Fertility rates are among the highest in the world, with women having an average of 7.7 children. High fertility and low rate of skilled health personnel attendance during childbirth contributes to high maternal mortality rates, estimated at 660 per 100,000 births. Communicable diseases such as diarrhea, tuberculosis (TB), and malaria are also prevalent.

- *Utilization and quality of health services*. Despite progress in reestablishing basic services and infrastructure, problems persist with inadequate quality and low utilization of health services, particularly for preventive services such as vaccination and prenatal care. Vaccination rates have improved, but only 18 percent of children were fully immunized in 2003, and only 18 percent of births were attended by skilled personnel. Low utilization is a consequence of both supply and demand factors. Quality of health services is compromised by continued shortages of key inputs – such as essential drugs, laboratory supplies, or fuel for field outreach services – and inadequate training, motivation, and supervision of health personnel.

- *Human resource development*. The recent influx of over 300 Cuban doctors has helped reduce shortages of medical personnel, and over 600 Timorese have been sent to Cuba

for medical training. This has vastly improved the availability of medical personnel compared to the situation at independence, and the Cuban doctors played an important role in maintaining health services following the April 2006 political crisis. But it has created new challenges in human resource management, as doctors now stationed in health clinics originally designed to be staffed by nurses, are prescribing a much wider range of drugs. Geographic coverage has improved and the total number of health personnel is approaching international norms, except for continued shortages for some key staff (including midwives). Access to qualified health personnel remains difficult for some rural areas, however, and inadequate training, supervision, and motivation of health workers represent an important constraint on the quality of care.

- *Hospital and the referral system.* The Guido Valadarez National Hospital (GVNH) in Dili and three regional referral hospitals are in the final stages of construction and rehabilitation, with support from the Second Health Sector Rehabilitation and Development Project (HSRDP2) and European Commission Grants, with an additional two regional hospitals being constructed with the national budget. This construction will complete the planned hospital referral network. While national legislation gives hospitals a degree of autonomy, further reforms, capacity building, and strengthened systems for management and quality assurance will be necessary to ensure good quality of services. The referral system among hospitals and districts also needs to be strengthened.

- *Strengthening planning, monitoring, and evaluation*. While the Ministry of Health (MOH) has made progress in establishing systems for planning, monitoring, and evaluation, the planning process is not yet clearly linked to budgeting, and there is limited financial devolution to districts. Health facilities collect and report on routine health service data, but quality remains uneven and data is not sufficiently used for planning and monitoring of service delivery. A system of results-based management still needs to be further strengthened at central and district levels.

- *Improving budget execution and expenditure management*. The health sector has been among the best-performing ministries in terms of performance and budget execution, but the recent increases in government revenues poses a challenge to ensure efficient utilization and execution of both budgetary resources and international assistance, particularly at the district level. The Ministry of Finance has taken important steps to delegate responsibility for procurement and financial management to the MOH and other key line ministries, which should allow significant improvements in service delivery, but will require strengthened capacity and accountability at national and district levels.

- *Inadequate demand for services and household health practices*. Low utilization rates of health services also reflect weak demand for these services by the population. The low demand is partly a consequence of perceived shortcomings in quality or access to services, but also a low priority accorded to reproductive health and child services by the populace. There is also a situation of medical pluralism, in which treatment by traditional healers coexists with Western/biomedical services. Gender relations also influence the use of key services, including facility-based delivery and decisions regarding family planning. In addition, certain household behavioral practices contribute to poor health

and nutrition outcomes, such as inappropriate weaning practices for infants, or low use of impregnated bednets. While some health districts and nongovernmental organizations support community-level health or demand-generating activities, these have not been scaled up.

- *Need for capacity building and innovative approaches*. After over six years of reconstruction efforts, the health sector now has sufficient staff, facilities, and financing to significantly improve health outcomes. A key challenge is to improve implementation capacity, and to seek new approaches to improve service access and quality, and to strengthen demand for health services. The government is also interested in piloting innovative mechanisms to generate increased demand for key services, strengthen health promotion and community participation, and promote public-private partnerships for delivery of clinical and community health and nutrition services.

9. While the MOH had earlier developed a Sector Strategy and a Sector Investment Plan (SIP), the latter was not fully operationalized. Despite the crises of the past year, the MOH has sought to develop a medium term vision and financing framework for the sector. With technical assistance financed by the European Commission, the MOH has developed a new Health Sector Strategic Plan (HSSP) (2007-2012), accompanied by a Medium Term Expenditure Framework (MTEF) for the sector. These have been fully endorsed by the new government and Minister of Health. A Health Sector Review (HSR), which has been undertaken jointly by the World Bank and MOH, informed the development of the new Health Sector Strategic Plan (see below).

10. The MOH and donors have sought to establish a sectorwide approach from the start, including semi-annual joint donor missions which have been led by the World Bank. The MOH wishes to further strengthen the sectorwide approach (SWAp), however, to further improve donor coordination, harmonize implementation arrangements, and increase the impact of development assistance (both financial assistance and technical assistance).

B. Rationale for Bank and AusAID involvement

11. There are several reasons for moving forward with this joint World Bank/AusAID project. First, the Bank has played a leadership role in health sector dialogue and coordination since independence, including leading the bi-annual Joint Donor Review Missions. The government and partners would like the Bank to maintain this engagement, even though the Bank's grant resources are limited. AusAID has been an active participant in the sector, and wishes to increase its financial contribution as well as its engagement in policy dialogue, but would like to do so jointly with the Bank. This builds on the earlier engagement of AusAID with the sector through TFET, in which AusAID has supported the sector wide program through the multi-donor trust fund to the health sector. Second, both the Bank and AusAID are closely engaged in the dialogue on macro-economic and budgetary issues, which will facilitate dialogue on improved planning and budget execution for the MOH. Third, the proposed project will facilitate donor coordination and dialogue and create a framework to further reduce the burden of donor requirements on the government. It also complements the efforts of the European Commission (EC), which provides support to the health sector both through direct technical assistance (including for development of the HSSP and MTEF), as well as through two Trust

Fund grants managed by the World Bank. Finally, while government revenues from petroleum are rapidly increasing, national legislation for the Petroleum Fund sets ceilings on sustainable budgetary expenditure levels (currently limited to approximately $300 million annually). Thus funding gaps persist relative to the needs for attaining the Millennium Development Goals (MDGs). External funding is also required to meet the evolving yet continued needs for international technical assistance. The proposed project will also seek to strengthen the capacity of government to more effectively plan, execute, and monitor its own budgetary resources.

C. Higher level objectives to which the Project contributes

12. The proposed Health Sector Strategic Plan Support Project (HSSP-SP) is consistent with the Government's 2002 National Development Plan, which calls for meeting the MDG targets for health by 2015. The World Bank's Country Assistance Strategy (CAS) for Timor-Leste (FY06-08) aims to support Timor-Leste in consolidating its early progress and moving from a focus on post-conflict issues to creating conditions for growth and poverty reduction. The three "strategic pillars" are to support the NDP and SIP objectives to deliver sustainable services, create productive employment, and strengthen governance. The proposed Project will support the first and third of these objectives. In addition, it will support several of the key "principles of engagement" of the CAS, including building institutional capacity, deepening the results orientation, and consolidating and extending international partnerships. In this spirit, the proposed Project will be designed and implemented jointly with AusAID, which will provide the majority of the financing. The proposed Project is also consistent with AusAID's Country Strategy for Timor-Leste, Policy for Australian Development Assistance in Health (2006), and the recent White Paper: *Australian Government's Overseas Aid Program* (2006). The latter calls for doubling funding development assistance, including for investing in people and expanding partnerships (including with the World Bank).

II. PROJECT DESCRIPTION

A. Lending instrument

13. The HSSP-SP will be financed through an IDA Sector Investment Grant of US$1.0 million equivalent, and a US$19.3 million equivalent contribution from AusAID (AUD 21.9 million), which will be managed by IDA through a trust fund arrangement.[2] AusAID anticipates mobilizing up to an additional AUD 4 million for the fifth year of implementation, to be confirmed based on satisfactory implementation in the first two years. The Health Sector Strategic Plan Support Project (HSSP-SP) refers to the combined funding from the IDA and AusAID grants. The proceeds from the IDA grant and the Trust Fund will support the health sector through a pooled financing mechanism (the Health Sector Support Fund (HSSF)), which will be allocated based on the health sector Medium Term Expenditure Framework (MTEF) and annual MOH Work Programs. The MTEF and the annual Work Program will serve as an integrated framework for all health sector financing, including government budgetary resources, pooled sector financing, and traditional project support from donor partners.

[2] AusAID and the Bank have agreed to establish a Multidonor Trust Fund (MDTF), in order to facilitate the entry to other development partners in the future.

14. Project scope is broadly defined by the Health Sector Strategic Plan (2007-2012) and the Medium Term Expenditure Framework, and utilizes a consistent performance and monitoring framework. The Project is designed to be flexible so that it can adapt to rapidly evolving sector and country conditions. During Project appraisal, the MOH agreed on a first year's financing and a 12-month procurement plan, which seeks to strike a balance between addressing high priority interventions that will yield visible results in the near term, with efforts to strengthen sector capacity in the medium term. Subsequent annual allocations from the pooled fund will be agreed following the Joint Annual Health Sector Review (JASR) in May of each year, and a specific programming of the pooled fund, budgetary resources, and other donor contributions will be agreed during the Joint Annual Planning Summit (JAPS) in October/November.

15. The MTEF and Annual Plans will distribute both budgetary and Project resources among central, regional, and district levels of the health system according to a transparent allocation formula (including population, geographic area, and performance). This financing formula will be phased in gradually at the district and hospital level, however, to avoid disruptive changes in funding allocations, and to allow for strengthening monitoring systems and capacity for result-based planning and implementation. Project dialogue and monitoring will focus on key constraints to achieving the MDGs, including strengthening the performance and management capacity of district health services, enhancing health promotion, strengthening hospital referral services, and improving monitoring, evaluation and results orientation at all levels of the system.

B. National Program objectives

16. The MOH's recently completed Health Sector Strategic Plan (HSSP) provides the overall framework for the Health Sector Strategic Plan Support Project for the next five years. The proposed investment operation will support the three major goals of the HSSP:

HSSP Goal 1 – *Improved accessibility to and demand for quality health services*, including: (i) improve coverage and use of primary health care services with a focus on the Basic Service Package (BSP) and integration of priority programs; (ii) improve the Hospital Service Package (HSP), quality of care and the referral system; (iii) strengthen and expand community-based health services and community participation; (iv) assure quality of care throughout the health system; and (v) strengthen health district development.

HSSP Goal 2 – *Strengthened management, human resource development, and support systems*, including: (i) improve overall governance and management of the health sector; (ii) improve human resource planning, recruitment, deployment, training and management; (iii) improve procurement, distribution and management of health commodities; (iv) strengthen management of other support services; and (v) improve management and maintenance of health infrastructure, equipment and assets.

HSSP Goal 3 – *Strengthened coordination, planning and monitoring,* including: (i) definition of sector policies; (ii) improve coordination with stakeholder groups; (iii) strengthen planning and budgeting; (iv) establish and implement a sector monitoring and evaluation plan.

17. The HSSP is oriented around attainment of the Millennium Development Goals (MDGs), and the delivery of a Basic Service Package (BSP) of cost effective interventions for primary health care, and a Hospital Service Package (HSP) for referral and tertiary care. The HSSP also identifies a number of essential cross-cutting strategies in ten "priority areas of work", including strengthening health services delivery; improving the quality, distribution, and motivation of human resources; behavioral change and health promotion; quality improvement; health financing; asset management; health management information systems; gender equity; and research (see Box A1, Annex 1). The HSSP further notes that policies and approaches need to be piloted and further developed in a number of areas: for example, it recommends piloting various approaches to improve incentives and motivation for health care providers, for strengthening community participation and demand for health services, and expanding collaboration with NGOs and the private sector.

18. The Medium Term Expenditure Framework (MTEF) provides the framework for financing of the national program, encompassing both budgetary resources and external financing. Several issues remain to be fully costed and integrated into the MTEF, however, including updating the Health Workforce Master Plan, costing of the Hospital Services Package, and contracting out of services to NGOs and the private sector. An initial updating of the MTEF is planned for early 2008, to incorporate the former issues, the financing from this Project, as well as any additional financing from the Global Fund (funding decisions for new GoTL tuberculosis and malaria proposals will be made in late November 2007). As part of the HSSP and MTEF, the MOH has adopted a set of key indicators and monitoring framework for sector performance, which were selected based on their priority in attaining the MDGs. A subset of these same indicators also will be used to monitor the operation (see Annex 3).

C. Project development objectives and key indicators

19. The overall objective of the Project is to improve the quality and coverage of preventive and curative health services, particularly for women and children, in order to accelerate progress toward the health MDGs. The HSSP-SP will have two parts: (a) direct financial support using the Health Sector Strategic Plan and MTEF framework and (b) addressing challenges and innovations needed for the health sector to be prepared for the next generation of issues.

20. Specific objectives for the first part would be fully aligned with the three goals of the HSSP, namely: (i) improve accessibility, demand and quality of health services; (ii) strengthen support services, human resource development, and management; and (iii) strengthen coordination, planning and monitoring. Progress toward achievement of these objectives will be monitored using a combination of sector-wide health service indicators (such as vaccination coverage, contraceptive prevalence, trained birth attendance, etc.), together with intermediate indicators linked with activities and outputs supported by the Project (including number of children participating in community nutrition/health programs, percentage of health clinics offering the full Basic Service Package (BSP), percentage of health center and district managers receiving management training, and availability of essential drugs at health facilities (see Annex 3 –Results Framework).

21. Within the broad framework of the HSSP, the Project initially will give particular focus to several key priorities, which should yield visible results in the first year, including: support for the roll-out of the Basic Service Package at district level; and expanding community health and nutrition programs. To strengthen service quality and capacity in the medium term, the project will support implementation of the Hospital Service Package (HSP); improvement in hospital management and service quality, and strengthening the training capacity of the Institute for Health Sciences, including for management training at district and health center levels.

22. The specific objective for the second part is to promote innovation and program development (linked to priorities identified in the HSSP) by providing resources to pilot and evaluate priority health sector innovations, such as demand-side and service-provider incentives, public-private partnerships. The Rapid Results Initiative approach is expected to be introduced as a methodology to pilot new approaches and to build capacity for results-based management. Pilot activities and other innovations that prove successful will be scaled up and integrated into the MTEF and annual Work Programs and budgets. Key indicators for this objective will include: (i) the number of pilot initiatives that are (a) financed by the project; (b) monitored and evaluated, with findings/lessons disseminated; and (c) scaled up or influencing national policies; and (ii) number of formal partnership contracts signed between MOH and NGOs or private providers.

23. The HSSP-SP will seek to contribute to progress toward the health MDGs (broadly defined to include health, nutrition, population and HIV), including reducing child and maternal mortality, child malnutrition, and fertility rates, and combating malaria, TB, and other communicable diseases. To strengthen performance management, the amount of annual support from the HSSP-SP will be reviewed yearly based on progress toward key performance indicators and agreed reforms.

D. Project components

24. The proposed Project would have four components, corresponding to the specific development objectives. The content and allocation of funds among these components were validated during appraisal based on the draft HSSP and the proposed MTEF. A detailed costing of activities for the first year and a 12-month procurement plan were agreed upon during appraisal and negotiations. Subsequent decisions regarding the level of annual funding will be made based on the Joint Annual Sector Reviews (in April/May), and decisions as to what will actually be funded with pooled resources will be agreed during the Joint Annual Planning Summits (JAPS) in October/November, and the MOH's Annual Planning and Combined Sources Budgeting process, in consultation with participating partners and line with the goals and objectives set out in the HSSP.

25. **Component 1 – Health Service Delivery (approximately US$12.0 m).** Priorities for support through this component will include support for: (a) implementation of the Basic Service Package (BSP) for primary health care and for improving district-level planning and management capacity. Initial priorities for support include financing for international and local advisors to provide "hands-on" technical assistance to districts; improved transportation (vehicles and motorcycles); and direct financing for BSP implementation through district annual plans, including for outreach services to remote areas; (b) strengthening community nutrition and

health services, through direct financing for community-level activities by health districts, financing of contracts for local and international NGOs to provide integrated community nutrition and health service in partnership with MOH and districts, and technical support to the MOH in developing nutrition policies, health promotion interventions, and implementation strategies, (c) improving hospital care and the referral system, through support for implementation of the Hospital Service Package (HSP); financing of technical assistance for "commissioning" of the new regional hospitals, and support for "twinning" arrangements with hospitals in the sub-regions to strengthen hospital management and key support services (such as hospital pharmacies and laboratories); (d) assuring quality of care throughout the health system, including 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, and ensuring adequate disposal of biomedical waste. The Project financing will remain flexible to cover gaps in anticipated financing from other externally financed programs, [3] or in the event of an influenza pandemic or other public health crisis. In addition, the findings and recommendations of a Health Seeking Behavior Study, which will be undertaken in 2008 with AusAID financing, will further inform the design and implementation of activities under this component.

26. **Component 2 – Support Services, Human Resource Development, and Management (approximately US$4.0 m).** Priorities for this components will include: (a) 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 the subregion; (b) based on the updated Health Workforce Plan, provide direct support for priority local and international training for Timorese staff, support improved human resource development and management practices (in cooperation with EC technical assistance), and support the MOH's efforts to improve the identification, mobilization and management of priority Technical Assistance services; (c) strengthen procurement, distribution and management of essential drugs and supplies, through support for senior technical advisors to SAMES (continuation of support through an EC trust fund) and support for further strengthening of SAMES management and reforms; and (d) 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).

27. **Component 3 – Coordination, Planning and Monitoring (approximately US$2.0m).** Support from this component will include: (a) support for establishment of the Department for Partnership Management (DPM) to strengthen MOH capacity for donor coordination, including financing a senior advisor for this Department, while ensuring that line departments take the lead

[3] The MoH has submitted Global Fund proposals for TB and malaria, which would cover most of the financing needs for these programs. Funding decisions are expected by mid- November 2007. Depending on the outcome of funding decisions and effectiveness dates of these new grants, the Project could help fill any remaining funding gaps for these diseases control programs, or for HIV and STI prevention as needed.

in implementation of Project- and donor-financed activities; (b) technical assistance (in collaboration with EC) for strengthening the annual planning and budgeting process at central and district level, including integration of external assistance into annual plans and reporting; (c) further strengthening the MOH Health Management Information System (HMIS), including technical assistance and support for related hardware and software; (d) direct financing of surveys and other evaluations, through the national statistics bureau as well as through other public, private and nongovernmental organizations; (e) improved policy development and research capacity within MOH, including targeted support for operational research.

28. **Component 4 – Innovation and Program Development (approximately US$2.3m):** Component 4 will provide flexible support to piloting new initiatives or further developing promising approaches, together with technical assistance for implementation, evaluation, and lesson-sharing. Successful initiatives will be scaled up and incorporated into MTEF and annual plans and budgets, and/or will contribute to revisions in national policies. The following are likely to be priorities: (a) promote community demand for health services, including the Family Health Promoter Program, and piloting financial incentives for use of key services (e.g., assisted deliveries); (b) provide incentives to service providers, particularly to attract and retain key health personnel in remote/rural areas, including performance-based incentives; (c) establish effective public-private partnership options and contracting mechanisms. The Rapid Results Initiative (RRI) approach will be adapted as a methodology to pilot new initiatives and to build local implementation capacity and strengthen the focus on results, initially in coordination with the roll-out of the BSP. An MOH committee will be established to provide oversight for the fund and vet proposals. Annual "lesson sharing" events will be organized to share results and assess priorities for scaling up. The guidelines for selecting, financing, and evaluating activities under this component will be included in the Project Operational Manual.

E. Lessons learned and reflected in the project design

29. The proposed sector support Project will build on lessons and seek to consolidate gains from previous and ongoing support to the health sector in Timor-Leste. The First and Second Health Sector Rehabilitation Development Projects (HSRPD 1 and 2) -- which were/are financed through the multi-donor Trust Fund for East Timor (TFET) as well as associated trust funds from the European Commission (EC)[4] – have sought to reestablish basic infrastructure for the health sector and improve national capacity to deliver basic health and referral services. HSRDP1 is already closed, and HRSDP2 and the associated EC Trust Fund have been extended until June 30, 2008 to allow completion of planned infrastructure. Key lessons have included the importance of prioritizing project interventions to avoid overtaxing local capacity, focusing on capacity building, and seeking to enhance donor coordination. These first phase programs have focused on rebuilding basic infrastructure, staff training, and establishing the MOH. There is now a need, in the context of the forthcoming Health Sector Strategy, to strengthen and

[4] IDA is managing two single-donor health sector trust funds financed by the European Commission. The HSRDP-EC (TF051363) co-finances 82% of infrastructure and equipment for construction of three regional hospitals and rehabilitation of GVNH hospital in Dili, as well as direct financing for pharmaceuticals. The EC has been asked to extend the closing date of this grant to June 2008. A second grant ("Health Sector Program (TF054512) finances training, technical assistance for MOH and SAMES, and small civil works, and is scheduled to close in December 2009. The EC has indicated interest in financing the pooled fund, but will not able to confirm until later in 2008.

consolidate the planning, budgeting, and service delivery process at both national and district levels.

30. The key operational lessons learned and reflected in the design include:

- Particularly in the Fragile State context, keep the design simple, flexible and focused on a manageable set of high priority objectives;
- Promote partner ownership through supporting implementation of the government's sector strategic plan and by maximizing the use of partner government management and implementation mechanisms and procedures;
- Give primary focus to achievement of sector level results, not the provision of specific donor funded inputs or activities;
- Seek to achieve a balance between the need to focus on achieving visible, short-term results with the medium-term priority of building national capacity and institutions;
- Promote donor coordination and harmonization through joint planning, management and review mechanisms;
- Provide a flexible design framework which will allow donor resources to be accessed and allocated in line with an annual rolling plans process led by government.

31. In addition, the Bank and MOH have completed an extensive Health Sector Review (HSR), which provides a comprehensive analysis of progress on health indicators since independence and key constraints facing the sector. The HSR notes that despite progress, health sector indicators in Timor-Leste are among the lowest in the region, with particularly low coverage of key preventive services (e.g., vaccination, prenatal) and high rates of population growth and child malnutrition. Key challenges include the need to improve community-based health programs, improve training and motivation of health staff, and improve the planning and execution of both government budget and donor programs (see Annex 1).

F. Alternatives considered and reasons for rejection

32. The development of the Health Sector Strategic Plan Support Project has taken place over a period of more than 18 months. A decision to pursue a sector wide-approach was taken at an early stage in the process, and thus there has been no intention to establish another stand-alone project that would discretely finance a narrow range of donor-identified priorities. Rather, the intention has been to find the best financing and management mechanism that would allow AusAID, the WB and other interested donors to provide a coordinated and flexible approach to supporting the GoTL and MOH to implement and manage its own Health Sector Strategic Plan. Despite the unrest of the past 18 months, the MOH has been determined to maintain its focus on strengthening sector performance rather than lapsing into "crisis management," while acknowledging that the population is demanding tangible improvements in service delivery in the near term.

33. Other options considered include: (i) targeted or non-targeted budget support through the national budget (CFET); (ii) IDA and AusAID providing funding directly to a GoTL/MOH

Special Account (without use of a Trust Fund for AusAID finances); (iii) financing an "emergency" operation narrowly focused on a few key primary health care services. Option (i) was rejected because budget liquidity is no longer a binding constraint for Timor-Leste, and budget support alone would be insufficient to improve planning, program execution, and monitoring, nor to introduce innovations that would improve the impact of health programs. While GoTL initially expressed preference for AusAID providing support directly to a pooled Special Account, option (ii) was rejected because AusAID preferred to delegate fiduciary responsibilities to the World Bank while retaining engagement in policy dialogue. Finally, option (iii) was rejected because resolving the key constraints to improved service delivery require a systemic approach, although certain flexibilities allowed under the guidelines for post-conflict and emergency projects (OP/BP 8.0) will be applied to allow for faster implementation and better adaptation of project design to local capacity constraints.

III. IMPLEMENTATION

A. Partnership arrangements

34. The HSSP-SP is financed by the World Bank and AusAID. Project legal agreements include: a Grant Agreement between IDA and GoTL; a Grant Agreement between IDA and GoTL regarding Trust Fund arrangements; and a Trust Fund Administrative Agreement (AA) between IDA and AusAID. Although at this time AusAID is the only donor that has made a firm commitment to contribute to the Trust Fund, it will be established as a Multi-Donor Trust Fund (MDTF) to facilitate entry of other donor partners in the future. The GoTL, AusAID and the World Bank have agreed on common technical and financial, as well as project performance indicators. They have also agreed on reporting formats and to rely as much as possible on GoTL monitoring systems, which will be strengthened over the course of the Project. IDA will have primary responsibility for fiduciary oversight of the fund, while IDA and AusAID (and any future participating partners) will engage jointly in policy dialogue and technical supervision of the fund, including decisions on the annual funding allocations.

35. The current practice of twice-yearly Joint Donor Mission (JDM) led by the World Bank will be further consolidated through the establishment of a Joint Annual Sector Review (May), led by the MOH and focused on reviewing overall sector progress determining indicative funding allocations for the subsequent year. A Joint Annual Planning Summit (October/November) will then be convened by MOH to agree on specific programming of donor and budgetary resources. All donors will be encouraged to submit their fully costed annual financing proposals according to the standard MOH budget format and program categories, which will facilitate the compilation of a consolidated Annual Plan. The documentation produced by the MOH and the Aide Memoires for the joint missions will serve as the basis for supervision of pooled financing; parallel reporting requirements will be avoided as much as possible. Consistent with the sector wide approach, other donor partners and technical agencies – including United Nations (UN) agencies, other bilaterals, and NGOs – will participate in the joint annual sector reviews, and may take a lead role in providing technical or implementation support for certain activities financed by the pooled fund, according to their respective

competencies and mandates.[5] A brief "Principles of Engagement" document, which outlines the commitments and accountabilities of MOH and partners in the context of a sector approach, will be drafted for discussion at the first JASR and for eventual signature by partners.

B. Institutional and implementation arrangements

Implementation and coordination responsibilities

36. *Implementation responsibilities.* The MOH will have responsibility for HSSP-SP implementation, including procurement, disbursement, and financial management. Project policy and execution management will be the responsibility of the Minister, who will serve as Project Director. Responsibility for implementation of Project-financed activities will rest with the various line departments of the MOH. To facilitate integration of external financing with the national budget, the MOH will create a new Directorate of Planning and Financing, and establish within this Directorate a Department for Partnership Management (DPM), staffed by a Program Facilitator and "desk officers" responsible for major donor-financed activities, including this pooled fund. The Project will finance a senior advisor to support the establishment and operation of this new Department. The Project Management Unit (PMU) currently managing the HSRDP2 and the EC trust funds will be integrated into MOH structures. The current PMU coordinator and civil works contractual staff will form the basis of a new Infrastructure Support Unit (IFU) based in the Logistics Department of the Directorate of Administration, Logistics, and Procurement, which will implement both donor- and budget-financed civil works. Technical advisors will be needed for core fiduciary functions (financial management and procurement) for most of the duration of the Project, but they will be assigned to line unit and their roles will increasingly shift toward capacity building and coaching. They also will assist the DPM in assuring that Project and donor fiduciary and reporting requirements are fulfilled.

37. *Coordination and oversight arrangements***.** Coordination of GoTL and donor partner contributions to HSSP implementation will be led by the MOH, and facilitated through monthly donor Coordination Meetings, and the conduct of a Joint Annual Planning Summit (JAPS) and a Joint Annual Sector Review (JASR). Several Technical Working Groups are active, which include relevant MOH staff and interested donors. A Strategic Plan Working Group of the MOH, which meets weekly, is chaired by the Minister and includes MOH Directors and key heads of department. Although the name may change, this entity will provide policy guidance and facilitate coordination of the HSSP-SP and other donor programs. The World Bank will take the lead role in administering the HSSP-SP Trust Fund and oversight for the financial management, procurement and fiduciary arrangements. Formal supervision missions for the HSSP-SP will be undertaken concurrently with the JAPS and the JASR, although smaller implementation support

[5] For example, WHO will provide technical leadership on disease control, health management information systems, and certain key health systems issues, including rollout of the Basic Service Package; UNICEF will provide leadership and support for immunization, maternal and child health and nutrition; UNFPA will play lead technical role in reproductive health, family planning, and safe motherhood issues; and nutrition interventions will be coordinated with the World Food Program. The Global Fund will likely provide substantial financing for malaria and TB, in addition to HIV/AIDS, and could participate in annual reviews within the context of their grant agreements with GoTL, in which quarterly disbursements are released on the basis of progress toward agreed targets. International and local NGOs and faith-based organizations could contribute based on expertise and experience in technical areas (e.g., maternal and child health, or community health and nutrition activities).

missions may be undertaken at other times. The Country Coordinating Mechanism (CCM), which was established to provide oversight for Global Fund grants and includes a range of stakeholders, could also become a venue for discussing coordination with other externally financed activities, including this Project. The structure and mandate of the Health Service Support Unit (HSSU), which was established within the Directorate of Health Service to support Global Fund implementation, is expected to remain unchanged initially, however. The workload of this unit will increase substantially if the Timor-Leste malaria and TB proposals for grant funding are approved by the Global Fund Board in mid-November 2007. The HSSU will coordinate closely with the new Department for Partnership Management. It is anticipated that the structures will work toward greater harmonization and integration, taking into account timelines of the Global Fund-financed programs and the evolving nature of the new systems established under the HSSP-SP.

38. *Coordinating and managing technical assistance.* Given the high cost of expatriate technical assistance, and past experience with inadequate supervision, communication, and performance management of TA in the Health Sector, it is critical that technical assistance be better prioritized and coordinated. The MOH has proposed the establishment of a small TA oversight committee, with support from a senior advisor, which will provide support in the recruitment, supervision, and performance evaluation of international TA, as well as helping to resolve difficulties or misunderstanding that may arise between international advisors and local counterparts. In addition, the MOH would like to pursue the expanded use of Timorese/Tetum-speaking consultants to help translate and adapt the "best practice" strategies and policies generated by international advisors into simple tools and guidelines that can be applied by health districts and hospitals, and to provide "hands-on" support to local staff. The Project will finance international and local technical assistance based on priorities identified in the HSSP and MTEF, and agreed by MOH. While most individual consultants and firms will be directly contracted with Project financing, UN organizations including WHO may be contracted to ensure quality and technical oversight for TA in certain priority areas, including development of the HMIS system, and roll-out of the Basic Service Package.

39. *Strengthening supervision and capacity of districts and hospitals***.** Health districts and hospitals will be responsible for implementing service delivery activities, based on their annual plans, which will be approved and monitored by MOH. Two key challenges highlighted in both the HSSP and the Health Sector Review are the need to (i) strengthen supervision by central MOH of hospitals and districts, and to improve supervision by districts of health facilities; (ii) strengthen capacity of districts and hospitals for planning, implementation, supervision, and monitoring of health services. Many district officials lack basic management training, and many health workers lack basic technical and mathematical skills (for example, the majority of health workers have difficulty calculating percentages). The proliferation of various tools, policies, guidelines, and donor-financed initiatives further taxes limited management capacity. To address these challenges, the Project will provide flexible support for capacity building priorities identified in the HSSP. Specific priorities for support will include: (i) recruitment of a mobile team (composed of Tetum or Bahasa speakers) to provide technical assistance and training of district teams and hospital managers in BSP and HSP rollout; (ii) strengthening the Institute for Health Sciences (IHS), particularly to expand management training for district and CHC managers, including through a "twinning" arrangements with regional training institute(s); (iii)

"twinning" arrangements to strengthen hospital management and upgrade key support functions (laboratory, pharmacy); (iv) development of simple, standardized guidelines and protocols for planning and supervision (at central, district, facility level).

Annual Planning, Budgeting, and Reporting

40. *Annual planning and budgeting.* Within the overall scope of the HSSP and the sector MTEF, annual implementation plans and combined sources budgets will be prepared by the MOH in line with the GoTL's planning and budgeting procedures and calendar (see Annex 7). The Directorate of Policy and Finance will take the lead in preparation of Annual Plans and updating the MTEF. This process will increasingly be driven by the preparation of annual District Health Plans and Budgets, and resources allocated based on demonstrated need and other financial allocation targets specified in the health MTEF. Broader stakeholder involvement in the planning and budgeting process will be facilitated through the JASR and JAPS process. On the basis of the joint annual sector reviews, IDA and AusAID (and any other participating HSSP-SP partners) will announce prior to the beginning of the annual budget process the indicative contribution to the pooled fund for the forthcoming year. The level of annual contributions to pooled account will vary based on implementation performance, progress on key indicators and agreed sector reforms, and results of annual financial audits. The MOH will prepare an Annual Plan, which will include proposed allocations for the budget, HSSP-SP pooled funds, as well as other donor resources. The draft Annual Plan will be submitted to partners at least two weeks prior to the JAPS, and revised based on agreements reached during the JAPS. The proposed allocation of HSSP-SP funds, together with an updated procurement plan, will then be submitted to IDA and AusAID for approval.

41. *Review and reporting***.** Consistent with current practice, at least two weeks prior to the six-monthly sector review missions, the MOH will submit to the partners a Briefing Document that will summarize sector progress, including implementation of the budget, HSSP-SP, and other donor projects, as well as progress on key performance indicators. The MOH will also submit to IDA and AusAID quarterly Interim Financial Reports (IFRs), which will serve as the basis for replenishment of the Designated Account. Reporting on health sector performance and Project implementation progress will be based primarily on MoH data collection and reporting systems, using standard reporting formats. Nevertheless, some additional data collection work/special studies will be carried out as required, or commissioned as input to the annual joint sector reviews (with financing from the Project as needed). Based on the terms of reference of the annual reviews, donor representatives of the review/supervision missions may be tasked with providing critical insight into sector and institutional performance issues.

C. Monitoring and evaluation of outcomes/results

42. The HSSP-SP includes a range of performance indicators to assess progress toward Project and national objectives. The HSSP-SP indicators are drawn from the HSSP and fully aligned with the MOH monitoring and evaluation framework. The indicators specified in the Results Framework (Annex 3) will be collected through: (i) routine monitoring through the health management and information system (HMIS) and MOH disease surveillance systems; (ii)

household and beneficiary surveys; (iii) routine supervision and/or facility surveys; (iv) community-based monitoring; (v) evaluation of pilot activities.

43. In the context of a sector wide approach, the Project results framework seeks to strike a balance between monitoring progress on key service indicators at the sector level, while also tracking intermediate indicators more directly linked to outputs financed by the Project. Key sector performance indicators will include: (i) percentage of children vaccinated (DPT3 and measles); (ii) percentage of births attended by skilled health personnel at health facility; (iii) percentage of pregnant women receiving four or more prenatal visits; (iv) percentage of children (6-59 months) receiving vitamin A supplements; (v) percentage of married or cohabitating women using modern contraceptives; and (vi) Tuberculosis DOTS treatment cure rate. Intermediate indicators will help assess progress in key outputs and in capacity building efforts in support of the HSSP, including: (i) percentage of health facilities offering a comprehensive basic service package (BSP); (ii) percentage of children aged 6 months to three years benefiting from community nutrition programs; (iii) percentage of health center and district managers who have received basic management training; (iv) percentage of essential drugs out of stock; and (v) percentage of health facilities submitting complete HMIS reports on time. Intermediate indicators to track progress of the Innovations component will include: (i) the number of pilot initiatives that are (a) financed by the project; (b) monitored and evaluated, with findings/lessons disseminated; and (c) scaled up or influencing national policies; and (ii) number of formal partnership contracts signed between MOH and NGOs or private providers.

44. The Project will support strengthening monitoring and evaluation (both quantitative and qualitative) at all levels of the health system, as well as provide direct support for priority surveys and evaluations. Monitoring data will be disaggregated when possible to allow monitoring of progress in reducing inequities among districts, hospitals, etc., and to identify measures to support weaker performers. Data on use of health services will also be disaggregated by gender when possible, and supplemented by qualitative reviews to better understand why various groups are using or not using key services.

- *Routine monitoring*, including through the Health Management Information System (HMIS): The HMIS system is functional but needs further strengthening in terms of the timeliness, quality, and use of data, improving software systems for entering and reporting data, and improved maintenance of computer hardware and networks.
- *Household surveys and data*: Formal household surveys will be undertaken at least every two-three years, in coordination with National Department of Statistics (DNS), preferably in the context of a statistical masterplan. The Timor-Leste Living Standards Measurement Survey (TLSLS) is being completed in 2007, which will serve as baseline data for key household-level indicators. A "lighter" survey focusing on coverage of key health and social services may be undertaken in 2009/10, with the next TLSLS to be fielded in 2011/12.
- *Lot Quality Assurance Sampling (LQAS)*. Formal household surveys have limitations, however, since they do not provide timely information to health managers regarding service coverage. In addition, coverage based on HMIS data involve considerable uncertainty, since the population denominators have to be estimated from census data.

The MOH is therefore interested in piloting the Lot Quality Assurance Sampling (LQAS) methodology in the context of the BSP rollout.[6]

- *Facility surveys and evaluations of pilot activities*. Some indicators will need to be collected either through facility surveys (e.g., every two years), and/or through routine supervision. The HSSP-SP in coordination with UN agencies and EC technical assistance will support the development of routine supervision tools that will allow the monitoring and aggregation of some key service quality indicators (e.g., appropriate treatment of malaria or of acute respiratory infection). Given capacity limitations, MOH is cautious about initiating additional facility surveys, but funding for facility surveys to complement supervision data may be considered in 2009.
- *Program and pilot evaluation, operational research.* As part of the annual sector review process, the Project will finance analytic work and evaluations on priority issues identified by MOH and partners. For the Innovations component, evaluation arrangements will be built into the contracts for the larger pilots. One or two interventions of high policy interest for the Ministry of Health (e.g., health worker incentives, increasing demand for demand for health services) may be selected for more rigorous impact evaluation by an independent research institute. In addition, the MOH is seeking to develop its capacity for operational research through a partnership with the Institute for Health Sciences (IHS) and the University of New South Wales in Australia. Specific operational research activities could be supported by the Project.
- *Community-level monitoring*. Vital Registration systems are currently very weak. The Family Health Promoter program could contribute to the collection basic community-level information on births, deaths, etc. Collection of basic community-level data will be included in the contracts with NGOs supporting community health/nutrition programs. Strengthening of community-based monitoring and vital registrations systems will be a medium-term goal of the program.
- *Encouraging use of information and results-based culture.* The Project will seek to strengthen the use of information for planning and improving performance through the annual review process, performance contracting, and piloting of "Rapid Results Initiative" methodology in the BSP pilot districts. RRI will not be treated as a separate "campaign", but rather as a tool for capacity building, improving teamwork, and managing for results. If successful, the methodology could be scaled up nationally.

D. Sustainability

45. *Institutional Sustainability:* Implementation capacity remains an important constraint throughout the government and health system. The Project will seek to strengthen the likelihood of institutional sustainability through several approaches. First, consolidating and strengthening approaches for capacity development, including (i) rationalization of the selection and oversight of technical assistance, ensuring that TA contributes to building local capacity, and better linking TA to training of local staff; (ii) establishing innovative arrangements for capacity building, including "twinning" arrangements with institutions in nearby countries. Second, making use of national policy, planning, budgeting, and reporting procedures to the extent possible, and

[6] In this approach, a random sample of households in the service catchment area are visited by the district team and/or an NGO, which provides an estimate (within 5% or so) to cross-check coverage of key services. If successful, this approach could become part of routine performance management.

avoiding the creation of parallel implementation units. Third, the Project will support pilots of institutional innovations (such as demand-side and health worker incentives, contracting out of services, etc.), which could improve implementation capacity and be integrated into the national budget if proven successful. Fourth, the HSSP-SP will coordinate with other institutional reform efforts at the national and sector levels (e.g., PFMCBP, CSP) to implement policy and institutional reforms that will improve budget execution and service delivery performance.

46. *Fiscal sustainability*: The sectoral MTEF is based on projections of sustainable revenues from the petroleum fund and other sources of budgetary revenue, together with modest assumptions about future donor support. The MTEF also seeks to consolidate and limit additional investments in infrastructure, and to limit hospital recurrent expenditures at 40% of the health sector budget, in order to avoid unsustainable recurrent cost implications in the future. The additional recurrent cost implications of the NSHP are modest; no major new infrastructure is expected to be financed by the NSHP (see Annex 9).

E. Critical risks and possible controversial aspects

47. The proposed operation confronts substantial risks, but could yield high rewards. Critical risks at the country, sectoral, and program level – together with proposed mitigation measures -- are summarized in the table below:

Risk	Risk Rating	Risk-Mitigating Measure
Country-level Risks		
Political and social stability. Ongoing political and social unrest could compromise the attainment of health outcomes and improvements in health services.	Substantial	International partners will remain engaged with government and civil society to resolve the tensions that have contributed to recent unrest.
Macro-economic management. Since independence, the track record for macro-economic management by the GoTL has been good. But prudent long-term economic planning and management requires continued political commitment.	Modest	The Bank, AusAID and partners will remain engaged in macroeconomic dialogue through the CSP and other instruments.
GoTL public sector reforms, in financial management and administration. Improvement in budget execution capacity requires, among other things, greater decentralization of commitment and procurement authority to line ministries. GOTL had planned to reorganize government into regional administration (32 municipalities), which could cause disruptions in service delivery	Modest	MOF plans to further decentralize procurement and commitment authority (CPVs) to MOH and line ministries. Finance reforms are being support through the PFMCBP. Decentralization is currently "on hold" with new government; country dialogue will focus on seeking to encourage a phased transition to decentralization.
Sector-level risks		
The influx of over 300 Cuban doctors and the sending of over 600 Timorese for medical training could lead to an over "medicalisation" of the system and contribute to neglect of prevention, health promotion, and community-level activities.	Substantial	Partners will remain engaged in dialogue on human resource planning, and the design and implementation of community-level activities.

Efforts to address high fertility rates could encounter resistance from religious or traditional leaders.	Modest	Dialogue and information campaigns will seek to mitigate opposition to family planning to the extent possible.
Insufficient coordination of supply-side and demand-side interventions may undermine improvements in health outcomes.	Modest	Project design will seek to address supply- and demand-side factors; annual reviews will assess progress and take corrective actions as necessary.
Project-level risks		
Limited capacity for planning, implementation, and M&E at central, district, and hospitals levels	Substantial	Capacity constraints will be addressed through: (i) minimizing complexity of program design and reducing transaction costs; (ii) capacity building through targeted local and international TA, long- and short-term training, "twinning" arrangements for capacity development; (iii) outsourcing some service delivery and support activities to NGOs or private sector.
National systems for donor coordination, financial management and procurement are still under development, hospitals and health districts have limited experience with managing funding or procurement.	Substantial	The Project will seek to strengthen line systems while delegating responsibilities in a phased manner; a Partnership Support Unit will facilitate coordination and Project reporting.
Overall Risk Rating	**Substantial**	

F. Grant conditions and covenants

Conditions of Effectiveness

- The Recipient has adopted the Project Operations Manual, in form and substance satisfactory to the Association;

- The Multi-Donor Trust Fund Grant Agreement has been executed and delivered, and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of the Financing Agreement) have been fulfilled.

Legal/Other Covenants

- The Recipient shall appoint no later than 30 days after the Effective Date, and thereafter maintain until the completion of the Project, an internationally qualified financial management specialist and a procurement specialist, with terms of reference and experience satisfactory to the Association.

IV. APPRAISAL SUMMARY

A. Economic and financial analyses

48. The proposed Project supports the Government's plans to enhance and extend a Basic Service Package (BSP) for primary health care, and a Hospital Service Package (HSP) for hospital and referral care. The BSP has proven international value in terms of a link to population health outcomes and can be supported on the grounds of meeting public finance criteria. The HSP is aimed at increasing efficiencies in the hospital/referral care system, and in synergy with the BSP, should stabilize referral rates while increasing quality of care and cure rates. The investment under the proposed Project (which supports BSP and HSP) has large economic benefits in terms of DALYs averted (valued at local per capita income) under moderately optimistic assumptions on program effectiveness. The cost per DALY averted ranges from $500-$822, based on assumptions of Project effectiveness and a total Project cost of US$20 million. The project has a substantial economic rationale as suggested by public finance criteria, indicative benefit appraisal as well as the analysis of the program design against past international evidence.

49. The Project closely supports the Government's Health Sector Strategic Plan (HSSP) and does not impose additional recurring costs nor leads to construction of new infrastructure as currently envisaged. Therefore, the fiscal sustainability of the HSSP is the only criterion. Given conservative estimates of available resources to the Government budget from oil and gas extraction (via interest on the Petroleum Fund and general taxation revenues), the indicated gross public health spending as derived from the sectoral MTEF over the Project period (2008-12) is fiscally sustainable.

B. Technical

50. The technical content of the HSSP-SP is sound. Project design is based on the Health Sector Strategic Plan (HSSP) and the MTEF, which are oriented around the achievement of the MDGs and the delivery of a Basic Service Package (BSP). A comprehensive Health Sector Review (HSR) was undertaken jointly by the World Bank and MOH, and significantly informed the HSSP and the design of this Project. The content of the BSP is based on international evidence regarding the most cost effective interventions for reducing child and maternal mortality, including analysis undertaken by the World Bank, WHO, and a series of literature review articles published in *The Lancet.* The current challenge is to translate these policies and "best practices" into simple operational guidelines that can be implemented at district and hospital levels. The Project seeks to strike an appropriate balance between ensuring delivery of primary health care and community health services, with strengthening the hospital and referral system. The Project also seeks to pilot and introduce innovations that will improve the impact of sectoral programs, and to strengthen monitoring and evaluation so that national, district, and hospital management teams increasingly plan and implement based on results.

C. Fiduciary

51. **Financial management.** A Trust Fund will be established in Washington, into which donor contributions to the HSSF will be deposited. A Designated Account (Special Account) will be established by the GoTL at a commercial bank in Dili, into which funds will be advanced from the Trust Fund and from IDA. After the initial deposit, funds will be replenished based on quarterly expenditure statements and cash flow projections. Expenditure from the Special Account will require joint authorization from the Ministry of Health and the Ministry of Finance, in line with the procurement and financial management requirements of the grant agreement.

52. The pooled fund will finance expenditures identified in the MTEF and Annual Plans, including capital purchases, equipment and commodities, and technical assistance/professional services, small civil works, and pilots. Payments will be made through the MOH Designated Account, although direct payment to suppliers from the World Bank is retained as an option for large contracts. Financial management arrangements are detailed in Technical Annex 7 – Financial Management and Disbursement Arrangements. To ensure proper execution and accounting of Project and budget funds, MOH has agreed to: (i) hire and retain a financial management specialist in the Finance Department of MOH; (ii) recruit a small team (2-3) of local consultants who will provide ongoing, field-based support to health districts and hospitals with respect to financial management and budget execution. To ensure timely execution of operational funds executed through the national budget and effective accounting for project funds, MOF has agreed to: (i) delegate commitment authority for Commitment and Payment Vouchers (CPVs) to the MOH, and subsequently from central MOH to certain executing structures; (ii) provide ongoing support for the project-based Financial Management Information System (FMIS) accounting software in the MOH.

53. **Procurement**. The Ministry of Health (MOH) of the Government of Timor-Leste (GOTL) will carry out procurement for the proposed project in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" dated May 2004, and revised in October 2006; and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated May 2004, and revised in October 2006, and the provisions stipulated in the Financing Agreement. For procurement through National Competitive Bidding, the provisions outlined in Attachment to Annex 8 shall be applicable (see Annex 8).

D. Social

54. The HSSP-SP will not be financing any large civil works, so no resettlement or adverse social impacts are anticipated. In addition, the entire Timor-Leste population is considered "indigenous", and no adverse impacts are expected for indigenous groups. To achieve the development objectives, however, project design and implementation will need to be adapted to the particular post-conflict context of Timor-Leste, as well as the prevailing cultural and social context and varied practices of different indigenous ethnic groups. As noted in the Health Sector Review, the modern medical system coexists with traditional beliefs and practices that influence both health seeking behavior and household health, nutrition, and fertility practices, and well as gender relations. The design of interventions that seek to improve demand for health care and

community health practices will need to address these underlying beliefs, gender, and cultural factors. In addition, the monitoring and evaluation system should allow disaggregated monitoring of key indicators according to gender, where possible. The political crisis of April 2006 and its aftermath led to over 150,000 Internally Displaced Persons (IDP), including an IDP camp on the grounds of the national hospital (GVNH). About half of IDPs have now returned to their homes, and efforts are underway to relocate those who do not feel safe returning to their original neighborhoods. The MOH and NGOs have been providing health services to the IDP camps, but the current strategy is to emphasize providing services at the community level to avoid creating tensions with local communities and to ensure services are available when IDPs return to their homes.

E. Environment

55. *Civil Works*. The project will not finance major construction of new hospitals, but may support maintenance and rehabilitation, as well as rehabilitation or extension of some health centers and health posts. As such, it is envisaged that civil works and the corresponding environmental impacts, if any, will be minimal and temporary, which will include noise, air emissions and generation of construction wastes. Procedures to address these impacts will be included in civil works contracts, where contractors will be required to formulate and implement proper housekeeping measures to address the issues.

56. *Healthcare Waste Management*. An evaluation of the health care wastes generation and management was commissioned by the Government of Timor-Leste in 2004 with Bank support as part of the preparation of the Health Sector Rehabilitation and Development Project (HSRDP1). The evaluation revealed that about 80% of the total waste generated by healthcare activities can be classified as general waste, with 20% classified as hazardous materials. The evaluation proposed a practical health care waste management at the community health centers and health posts through the use of a small efficient incinerator (or gasifier) that could be easily managed locally. All 13 community health care centers constructed under HSRDP1 were equipped with clinical waste gasifiers, or one per district. For the four hospitals being constructed under the second Health Sector Rehabilitation and Development Project (HSRDP2), similar but larger gasifiers were provided to these hospitals. The use of gasifiers in managing health care wastes will continue under this Project, including ensuring adequate maintenance of gasifiers. A Health Care Waste Management Plan was prepared during HSSP-SP preparation, and has been disclosed locally in Timor-Leste and through the World Bank's InfoShop.

57. *Asbestos Management*. The main activities of the Project that could have implications for asbestos generation and management are the rehabilitation of some health posts and hospitals. Asbestos in Timor-Leste is found mainly in cement and building materials. These are mainly corrugated roofing sheets and flat sheets that have been used for walling or ceiling panels, which are considered safe if left in position and not damaged, cut or abraded. The "Guidelines on Maintenance, Handling and Disposal of Asbestos Materials and Asbestos Waste" were formulated in September 2000 by the East Timor Transition Administration (ETTA) and contractors will be required to adhere to the guidelines during civil works.

F. Safeguard policies

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP 4.01)	[X]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[X]
Pest Management (OP 4.09)	[ ]	[X]
Physical Cultural Resources (OP/BP 4.11)	[ ]	[X]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[X]
Indigenous Peoples (OP/BP 4.10)	[ ]	[X]
Forests (OP/BP 4.36)	[ ]	[X]
Safety of Dams (OP/BP 4.37)	[ ]	[X]
Projects in Disputed Areas (OP/BP 7.60)*	[ ]	[X]
Projects on International Waterways (OP/BP 7.50)	[ ]	[X]

G. Policy Exceptions and Readiness

58. In light of the post-conflict situation in Timor-Leste, this project is being prepared under the World Bank policy guidelines for emergency operations (OP/BP 8.0), which provides additional flexibility for project preparation and implementation arrangements. The Project itself is not an emergency operation *per se*, so is using the standard format for Project Appraisal Documents. The Project complies with all Bank policies: no policy exceptions are being sought. The Project also meets Regional criteria for readiness for implementation, regarding financial management, procurement, disclosure requirements, and monitoring and evaluation mechanisms. The policy framework is already in place, including the adoption by government of the Health Sector Strategic Plan (HSSP) and medium-term expenditure framework (MTEF). With respect to fiduciary management, the MOH is recruiting a new procurement advisor, and has begun to search for a new finance advisor (current advisor is departing at the end of the year). MOH also will seek to recruit an international advisor for the new Department of Health Cooperation by January 2008. Because implementation will be the responsibility of line departments, this position does not need to be filled for the Project to become effective. No social safeguard issues are anticipated to be triggered under the project and there will be no land acquisition, nor resettlement, nor is it anticipated that there are cultural property issues.

* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

Annex 1: Country and Sector or Project Background

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

A. Country Context

1. Occupying the mountainous eastern half of the island of Timor, Timor-Leste was a Portuguese colony for 450 years. Following a brief civil war, the country unilaterally declared independence on November 28, 1975. Within days it was invaded and illegally occupied by neighboring Indonesia, though for 24 years the population of Timor-Leste maintained a staunch resistance. Following the fall of President Suharto in 1998, a referendum on autonomy for the territory was held, but an overwhelming majority of the Timorese preferred independence. Tragically, the outcome of the referendum was accompanied by a well-planned campaign of violence, which left over 1,000 people dead, the majority of the population displaced, the country's private and public physical infrastructure in ruins – including nearly 80 percent of health centers. Most Indonesian citizens departed, resulting in a severe shortage of qualified and experienced professionals and leaving Timor-Leste with very thin human resource and institutional capacity.

2. Following the intervention of a multi-lateral peacekeeping force, the United Nations Transitional Administration in East Timor (UNTAET) was established with supreme executive, judicial, and legislative authority. In 2001, elections were held for a Constituent Assembly, followed by the adoption of the Constitution and presidential elections in April 2002. The Democratic Republic of Timor-Leste fully restored its independence on May 20, 2002. The Constituent Assembly became the National Parliament, and the current Government of Timor-Leste (GoTL) was sworn in. A 900-person United Nations Mission of Support in East Timor (UNMISET) was created, and was succeeded in May 2005 by the United Nations Office in Timor-Leste (UNOTIL). Presidential and parliamentary elections were held in April 2007 and May 2007, respectively, and resulted in the installation of a new coalition government. Unrest prior to the elections disrupted service delivery, but the Ministry of Health (MOH) remained functional through this period despite difficult conditions.

3. In 2002, building on extensive consultations throughout the country, the GoTL adopted a National Development Plan, which expresses the country's strategies for sustainable growth and poverty reduction. A related Stability Program was developed in early 2003 to help prioritize NDP objectives. Sector Investment Programs, which set out the details of objectives and planned investments in key sectors were also developed, and joint GoTL-donor Sector Working Groups are to manage SIP implementation and regular updating. The NDP, Stability Program, and SIPs subsequently were presented to the Boards of the World Bank and International Monetary Fund (IMF) and endorsed as the country's Poverty Reduction Strategy Paper (PRSP).

4. Political tensions and growing discontent among urban youth contributed to periodic unrest. Beginning April 2006, however, a major political crisis led to violence between the police and armed forces and exacerbated regional tensions. Over 40 people were killed initially, and subsequently thousands of homes were burned in a cycle of violence and retribution that lasted several months. An estimated 150,000 people – out of a population of just over a million – fled their homes and settled in Internally Displaced Person (IDP) camps (about half in Dili, and the rest in surrounding districts).

5. Remarkably, the Ministry of Health (MOH) continued to function throughout the crisis, one of the few government ministries to do so. Many central MOH staff relocated with their families to IDP camps on the grounds of the national hospital in Dili. Senior MOH officials held daily meetings and maintained regular telephone and radio contact with district health team, to ensure that health service remained functional in both Dili and in rural areas. The MOH also sought to ensure effective

coordination of the international response to the crisis, including coordinating NGOs providing health services to IDP camps. Despite heightened political tensions and regional divisions, senior officials repeatedly stress to health staff and to the public that the Ministry of Health and health professionals were fully neutral, and would maintain their professional standards.[7]

6. The return of international peacekeeping forces helped restore a measure of stability. Presidential and parliamentary elections were held in April 2007 and May 2007, respectively, and resulted in the installation of a new coalition government. The elections were preceded by periodic unrest; in April 2007, for example, several buildings of the Ministry of Education were burned. A relative calm has returned following the elections, but tensions remain. An estimated 70,000 are still in IDP camps.

7. The government's fiscal position has improved dramatically in the past two years as a result of growing petroleum revenues, but capacity to execute the budget has emerged as a major constraint. Poverty levels remain among the highest in the sub-region, and unemployment among youth, particularly in urban areas, further contributes to social tensions. In this context, it is extremely important for the government to demonstrate that it can effectively deliver services to its populations. Improving the quality and coverage of health services, while maintaining the sense of professionalism that sustained the MOH through the crisis, is thus of vital importance for the stability of the country as well as the health of the population.

8. The Bank's most recent Country Assistance Strategy (CAS) for Timor-Leste was discussed by the Board on July 19, 2005. The CAS was developed with the participation of a broad range of stakeholders, including all levels of government, development partners, private sector representatives, civil society organizations, communities, religious groups, and youth. The three CAS pillars—delivering sustainable services, creating productive employment, and strengthening governance—support NDP objectives and provide the strategic framework for the Health Sector Strategic Plan Support Project (HSSP-SP).

B. Sector Context

9. While the health sector has made significant progress since independence in reestablishing basic infrastructure and services, it now must confront a wide range of "second generation" challenges. In short, Timor has done well with the first order of issues but now faces some important and more complex second generation issues in their efforts to develop the health system. Key challenges include:

- Persistent poor health status and outcomes: Child and maternal mortality, child malnutrition, and fertility indicators for Timor-Leste remain among the highest in the region. In 2003, the child mortality rate was 83 per 1,000 children, and nearly two-thirds of children under five were underweight. Fertility rates are among the highest in the world, with women having an average of 7.7 children. High fertility and low rate of skilled health personnel attendance during childbirth contributes to high maternal mortality rates, estimated at 660 per 100,000 births. Communicable diseases such as diarrhea, tuberculosis (TB), and malaria are also prevalent.

- Utilization and quality of health services: Despite progress in reestablishing basic services and infrastructure, problems persist with inadequate quality and low utilization of health services, particularly for preventive services such as vaccination and prenatal care. Vaccination rates have improved, but only 18 percent of children were fully immunized in 2003, and only 18 percent of births were attended by skilled personnel. Low utilization is a consequence of both supply and demand factors. Quality of health services is compromised by continued shortages of key inputs

[7] See *Timor-Leste: Health Sector Resilience and Performance in a Time of Instability* (AusAID, 2007).

– such as essential drugs, laboratory supplies, or fuel for field outreach services -- and inadequate training, motivation, and supervision of health personnel.

- Human resource development: The recent influx of over 300 Cuban doctors has helped reduce shortages of medical personnel, and over 600 Timorese have been sent to Cuba for medical training. This has vastly improved the availability of medical personnel compared to the situation at independence, and the Cuban doctors played an important role in maintaining health services following the April 2006 health crisis. But it has created new challenges in human resource management, as doctors are now stationed in health clinics original designed to be staffed by nurses, are prescribing a much wider ranges of drugs. Geographic coverage has improved and the total number of health personnel is approaching international norms, except for continued shortages for some key staff (including midwives). Access to qualified health personnel remains difficult for some rural areas, however, and inadequate training, supervision, and motivation of health workers represent an important constraint on the quality of care.

- Hospital and the referral system. The Guido Valadarez National Hospital (GNVH) in Dili and five regional referral hospitals are in the final stages of construction and rehabilitation, with support from the Second Health Sector Rehabilitation and Development Project (HSRDP2) and national budget. While national legislation gives hospitals a degree of autonomy, further reforms, capacity building, and strengthened systems for management and quality assurance will be necessary to ensure good quality of services. The referral system among hospitals and districts also needs to be strengthened.

- Strengthening planning, monitoring, and evaluation: While the Ministry of Health (MOH) has made progress in establishing systems for planning, monitoring, and evaluation, the planning process is not yet clearly linked to budgeting, and here is limited financial devolution to districts. While health facilities collect and report on retained information, quality remains uneven and data is not sufficiently used for planning and monitoring service delivery. A system of results-based management still needs to be further strengthened at central and district levels.

- Improving budget execution and expenditure management. The health sector has been among the best-performing ministries in terms of performance and budget execution, but the recent increases in budgetary resources pose a challenge for ensure efficient utilization and execution of both budgetary resources and international assistance, particularly at the district level. The Ministry of Finance has taken important steps to delegate responsibility for procurement and financial management to the MOH and other key line ministries, which should allow significant improvements in service delivery but will require strengthened capacity and accountability at national and district levels.

- Inadequate demand for services and household health practices: Low utilization rates of health services also reflect weak demand for these services by the population. The low demand is partly a consequence of perceived shortcomings in quality or access to services, but also a low priority accorded to reproductive health and child services by the populace. Gender relations also influence the use of key services, including facility-based delivery and decisions regarding family planning. There is also a situation of medical pluralism, in which treatment by traditional healers coexists with Western/biomedical services. In addition, certain household behavioral practices contribute to poor health and nutrition outcomes, such as inappropriate weaning practices for infants, or low use of impregnated bednets. While some nongovernmental organizations have local level community health or demand-generating activities, these have not been scaled up.

- Need for capacity building and innovative approaches. After over six years of reconstruction efforts, the health sector now has sufficient staff, facilities, and financing to significantly improve health outcomes. A key challenge is to improve implementation capacity, and to seek new approaches to improve service access and quality, and to strengthen demand for health services. The government is also interested in piloting innovative mechanisms to generate increased demand for key services, strengthen health promotion and community participation, and promote public-private partnerships for delivery of clinical and community health and nutrition services.

10. While the MOH has earlier developed a Sector Strategy and a Sector Investment Plan (SIP), the latter was not fully operationalized. Despite the crises of the past year, the MOH has sought to develop a medium term vision and financing framework for the sector. With technical assistance financed by the European Commission, the MOH has developed a new Health Sector Strategic Plan (HSSP) (2007-2012), accompanied by a Medium Term Expenditure Framework (MTEF) for the sector. These have been fully endorsed by the new government and Minister of Health. A Health Sector Review (HSR), which has been undertaken jointly by the World Bank and MOH, informed the development of the new Health Sector Strategic Plan (see below).

11. The MOH and donors have sought to establish a sectorwide approach from the start, including semi-annual joint donor missions which have been led by the World Bank. The MOH wishes to further strengthen the sectorwide approach (SWAp), however, to further improve donor coordination, harmonize implementation arrangements, and increase the impact of development assistance (both financial assistance and technical assistance). While the health sector has been among the best-performing ministries in terms of performance and budget execution, the recent increases in budgetary resources pose a challenge for ensure efficient utilization and execution of both budgetary resources and international assistance, particularly at the district/regional level.

C. Program Context: The Health Sector Strategic Plan (HSSP) and MTEF

12. The MOH's recently completed Health Sector Strategic Plan (HSSP) provides the overall framework for the Health Sector Strategic Plan Support Project for the next five years. The proposed investment operation will support the three major goals of the HSSP, consistent with the objectives of a Sector-Wide Approach:

HSSP Goal 1 – Improved accessibility to and demand for quality health services, including: (i) improved coverage and use of primary health care services with a focus on the Basic Service Package (BSP) and integration of priority programs; (ii) improve the Hospital Service Package (HSP), quality of care and the referral system; (iii) strengthen and expand community-based health services and community participation; (iv) assure quality of care throughout the health system; (v) strengthen health district development.

HSSP Goal 2 – Strengthened management and support systems, including: (i) improve overall governance and management of the health sector; (ii) improve human resource planning, recruitment, deployment, training and management; (iii) improve procurement, distribution and management of health commodities; (iv) strengthen management of other support services; and (v) improve management and maintenance of health infrastructure, equipment and assets.

HSSP Goal 3 – Strengthened coordination, planning and monitoring: including: (i) definition of sector policies; (ii) improve coordination with stakeholder groups; (iii) strengthen planning and budgeting; (iv) establish and implement a sector monitoring and evaluation plan.

13. The HSSP is oriented around attainment of the Millennium Development Goals (MDGs), and the delivery of a Basic Service Package (BSP) of cost effective interventions for primary health care, and a Hospital Service Package (HSP) for referral and tertiary care. The HSSP also identifies seventeen essential cross-cutting strategies in ten "priority areas of work." (see Box A1). As seen in the priority strategies, the HSSP highlights several policies and approaches need to be piloted and further developed in a number of areas, including piloting various approaches to improve incentives and motivation for health care providers, and for strengthening community participation and demand for health services.

Box A1: Essential "Cross-Cutting Strategies" from the HSSP

Health services delivery

1. Further improve coverage and access to health services especially for the poor, the remote and other vulnerable groups through appropriate location of health facilities and the strengthening of outreach services
2. Strengthen delivery of basic health services by ensuring that the directives of the BSP are implemented at all mobile clinics, health posts, health centres and hospitals
3. Strengthen the quality of services delivered (especially in the mother and child field) in all facilities through capacity development in areas such as BEOC, IMCI and nutrition

Behavioural change/health promotion

4. Change for the better the attitudes of health care providers sector-wide to effectively communicate with consumers especially in relation to the needs of the poor and other vulnerable groups through sensitisation and the building of good interpersonal skills
5. Strengthen IEC/BCC activities to promote better community appreciation of the value of effective evidence-based medicine and health care

Quality improvement

6. Develop a culture of quality in public health service delivery and management through the use of MOH quality practice and professional standards

Human resource development

7. Strengthen human resource planning to reduce maldistribution of workforce numbers and categories through improved needs-based deployment of staff
8. Introduce a broad-based incentive scheme to assist in appropriate deployment of qualified staff across the health care sector
9. Increase the number of skilled midwives through enhanced pre-service and articulated training opportunities and through improved supervision and control measures at work
10. Strengthen the capacity of nurses and allied health professionals in community-based work
11. Strengthen the skills, know-how and attitudes of managers at all tiers of the health system

Health financing

12. Further develop the evolved system of financial management and strengthen financial management capacity throughout the sector

Asset management

13. Develop a systematized approach to asset management that includes appropriate standards, technical guidelines, protocols and audit practices for asset procurement, maintenance and replacement, renewal and disposal

Institutional development

14. Reform administrative and management functions, structures, systems and protocols in the MOH (in line with the accepted recommendations of the functional analysis of the organisation) to promote responsiveness and capacity to effectively manage change

HMIS

15. Prepare an information master strategic plan that will guide appropriate phasing-in and implementation of required information sub-systems

Gender equity
16. Promote gender mainstreaming in the MOH, improve awareness of gender issues throughout the health workforce and provide affirmative action opportunities for women

Research
17. Establish an operational research centre to assist in developing research capacity within the health sector of Timor-Leste to address health and system challenges and to inform clinical and public health practice

14. The Medium Term Expenditure Framework (MTEF) provides the framework for financing of the national program, encompassing both budgetary resources and external financing. The MTEF notes, however, that for several issues remain to be fully costed and integrated into the MTEF, including updating the Human Resources Master Plan and costing of the Hospital Services Packages. The MTEF is aligned with the HSSP, while also identifying seven specific policy objectives, including:

- Ensure sufficient recurrent funding per capita to improve utilization and coverage of health services (BSP and HSP);
- Ensure that allocation of resources promotes equal access to health services by different population groups according to need;
- Maintain efficient balance between primary and referral levels of the health system (allocating a maximum of 40% of resources for referral care);
- Improve the efficiency of health services (primary health care and referral)
- Rationalize further capital investment
- Ensure central and support services are adequately financed
- Improve stability and sustainability of health sector financing

15. As part of the HSSP and MTEF, the MOH has adopted a set of key indicators and monitoring framework for sector performance; a subset of these same indicators will be used to monitor the operation (see Annex 3). The key indicators were selected based on their priority in attaining the MDGs.

Annex 2: Major Related Projects Financed by the Bank, AusAID and/or other Agencies

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

Sector issues	Project	Latest Supervision (ISR) Ratings (Bank-financed projects only)	
		Implementation Progress (IP)	Development Objective
Hospital construction, equipment, policy, training	Second Health Sector Rehabilitation and Development Project (2002-08, US$12 million)	S	S
	Health Sector Rehabilitation and Development Project (European Commission TF51363, 2004-08, US$18 million)	S	S
Pharmaceuticals, training, clinics	Health Sector Program (European Commission, TF054511, US $5 million)	S	S
Financial Management	Planning and Financial Management Capacity Building Program (PFMCBP)	S	S

Other development agencies financed projects

Sector issues	Project name(s)	Agency
Maternal and newborn health, health promotion, community feeding and nutrition; vaccine procurement and logistics; community & school water and sanitation, deworming programs.	- Child survival and maternal health ($1.2 m) - Immunization (EPI) ($600,000) - Water and sanitation ($200,000)	UNICEF
(i) policy/legislation development; (ii) health systems development; (iii) interventions for priority health problems; (iv) donor coordination and partnership.	WHO Country Cooperation Strategy (2004-08)	WHO
Support for national family planning program and commodities; safe motherhood, incl. emergency obstetric care; reproductive health education for adolescents; HIV/AIDS prevention including provision of condoms; support for MCH at districts and IDP camps.	(i) Family Planning: (ii) Safe Motherhood; (iii) Ending fistula; (iv) adolescent reproductive health; (v) HIV/AIDS; (vi) commodity security; (vii) Access and quality	UNFPA
TA for: developing HSSP, MTEF; HSD and IHS; BSP development; community approaches; strengthened financial management for districts and hospitals.	Technical Assistance for Support to the Implementation of the Health Sector Investment Programme (SIHSIP)	EC
HIV/AIDS prevention and treatment, particularly among high-risk groups; new proposals for TB and malaria prevention and treatment are pending.	Expanded Comprehensive Response to HIV and AIDS in Timor-Leste (US$3.6 m, 2006-9 – Phase 1)	Global Fund
Support for technical assistance through Australian Royal College of Physicians; direct support for analytic studies and technical advisors; support for MCH and nutrition programs through UNICEF and NGOs.	(i) Program of Assistance to Specialized Services (ATLASS, A8.4m); (ii) Health Seeking Behavior Study; (iii) Maternal and Child Survival Project and Immunization Project (A$2.8 million/UNICEF); (iv) nutrition support (A$5 m for WFP, CARE, Oxfam).	AusAID
Technical support to MOH, health districts & private sector through Timor-Leste Integrated Health Assistance (TAIS); Health Alliance International (HAI) and NGOs.	Child Health and infectious diseases; Child spacing; Maternal Health and Newborn Care; HIV/AIDS prevention and control.	USAID

Annex 3: Results Framework and Monitoring

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

Results Framework

High-Level Sector Objectives and MDGs		Use of MDG Outcome Information
1. Reduce infant and child mortality	Infant and child mortality rate (per 1000)	Assess trends and causes of both child and infant mortality, and adapt program interventions accordingly
2.Reduce maternal mortality	Maternal mortality ratio (per 100,000)	Review long-term trends and causes in maternal mortality
3. Reduce morbidity and mortality from Malaria and TB	Morbidity and mortality rates	Monitor incidence and efficacy of treatment and prevention programs
4. Reduce child and maternal malnutrition	Prevalence of underweight children (% under 5 years of age)	Assess trends and identify causes of malnutrition, and assess program efficacy in coverage
5. Stabilize the prevalence of HIV/AIDS	Number of persons infected with HIV (% adults, ages 15-24)	Monitor HIV prevalence in both young adult and high-risk group populations, and adapt strategies
PDO	**Project Outcome Indicators**	**Use of Outcome Information**
Improve the quality and coverage of preventive and curative health services, particularly for women and children	% of children under 1 year vaccinated with (i) DPT3 and (ii) measles	Progress in key coverage indicators for preventive and curative services cannot be attributed solely to Project, but will be monitored semesterly at national and district level to assess progress, recognize and draw lessons from strong performers (districts/hospitals), identify weak performers that need further assistance, and develop a culture of results-based management
	% of births attended by skilled health personnel	
	% of pregnant women receiving four or more prenatal visits,	
	% of children (6-59 months) receiving vitamin A supplements	
	% women (married or cohabitating) using modern contraceptives	
Intermediate Outcomes	**Intermediate Project Outcome Indicators**	**Use of Intermediate Outcome Monitoring**
1: **Improve accessibility, demand, and quality of health services**	% of health clinics providing the comprehensive Basic Service Package (BSP)	Monitor progress in BSP rollout and quality of primary health care
	Number (%) of children (6 mo – 3 yrs) participating in community nutrition and growth monitoring programs	Monitor progress in expanding coverage of integrated community nutrition programs
	% of pregnant women receiving tetanus toxoid vaccination	Monitor quality of antenatal care
	Cesarean section rate	Monitor progress in expanding access to emergency obstetric care
	Number of referral hospitals implementing the Hospital Service Package	Monitor progress in HSP implementation

	Number of referral hospitals implementing guidelines for hospital management and clinical quality, including (i) monthly clinical review meetings;.(ii) maternal death audits	Monitor progress in hospital commissioning, improvements in hospital management and service provision
2. Strengthen support services, human resource development, and management	Availability of tracer essential drugs at (i) SAMES; (ii) health facilities	Assess progress in improving procurement and logistics at SAMES, hospitals, and districts
	Percentage of biomedical equipment in hospitals that is out of order (non-functional)	Assess progress in improving maintenance of equipment and facilities
	(i) Number health personnel receiving training through Project financing (by type of training); (ii) Percentage of CHC and district managers who receive management training	Monitor output of training programs, and progress in strengthening skills in health management. Efforts will be made to undertake qualitative evaluations of training as well
3. Strengthen coordination, planning, and monitoring	% of health facilities/ submitting completed HMIS monitoring reports 1 month after end of each quarter	Indicator will monitor progress in timely submission of HMIS reports, but equal emphasis will be given to use and quality of data
	Annual health expenditures, including (i) % GoTL budget allocated to health; (ii) % recurrent expenditures on hospitals (<40%); (iii) % health budget executed	These data will be used to monitor efficient allocation and execution of budgetary resources for the MOH
	Number of partners submitting to MOH a fully costed proposed workprogram for forthcoming year (by October)	Assess progress in integrating external financing into annual planning process
4. Promote innovation and learning	Number of pilot initiatives (i) financed by Project and implemented; (ii) evaluated with lesson disseminated; (iii) replicated/scaled up	Indicators used to monitor outputs and outcomes of pilots financed by project; complemented by M&E of individual pilots
	Number of formal MOH- private sector/NGO partnership contracts signed	Monitor progress in public/private partnerships

The results framework

1. The results framework for the Health Sector Support Facility (HSSF) that is presented in this Annex is drawn primarily from existing GoTL Plan documents, particularly the Health Sector Strategic Plan and the supporting Medium Term Expenditure Framework. The results and monitoring framework are aligned with that being used by the MOH itself, given that the proposed investment is designed to:

- Support the GoTL/MOH to implement their HSSP
- Align donor support with GOTL planning, budgeting and monitoring systems
- Build capacity by using GoTL/MOH systems
- Focus on development results (rather than tracking donor inputs, activities and outputs); and
- Reduce transaction costs for GoTL/MOH through not setting up parallel management and monitoring systems.

2. Indicators for coverage of preventive and curative services will be monitored regularly at national, district, and hospital level. While improvement in these indicators will not be attributable only to

the project, the Project's success depends on catalyzing improvements in these key indicators. At the same time, intermediate indicators that are more directly linked to outputs financed by the project will also be monitored to assess the implementation progress.

Institutional issues

3. The HSSF will support capacity development within the MOH to collect, record, analyze and use critical information on health outcomes, health service delivery and health sector management. Emphasis will be given to the development of a 'minimum' information system. That is, a system that takes into account capacity constraints, and can cost-effectively collect the minimum amount of information needed to allow health policy makers, planners and operational managers make informed decisions about both strategic and operational aspects of health sector planning and service delivery management.

4. There are currently a number of different information systems in operation within MOH (such as the Health Management Information System, epidemiological surveillance, work force data, etc) which need to be managed and used in a more integrated way. Responsibilities for Monitoring & Evaluation activities within MOH need to be clarified, but it is expected that a lead role will be taken by the Department of Health Information, Monitoring and Evaluation. Technical support and resources will be provided to build systems and capacity through the HSSF, which may include financing technical assistance through WHO. Collection household survey data is the responsibility of the National Statistics Office (DNS), which has experience with survey data collection and analysis, with support from international technical assistance. Given the limited capacity and the relatively high cost of such surveys, however, it will be necessary to agree the timing and content of national household surveys. The DNS has agreed to develop a Statistical Masterplan, which will help plan and rational household surveys and data collection. Vital registration systems are not functional, but will need to be strengthened over the medium term. Systems for monitoring the quality of service delivery are also less developed. Routine monitoring will be responsibility of the MOH. The Project may also finance development of tools or surveys for monitoring service quality, such as Quality of Service Delivery Surveys (QSDS). In addition, an AusAID-financed study on Health Seeking Behavior is due to be completed in 2008.

Arrangements for results monitoring

5. The Project will support strengthening monitoring and evaluation (both quantitative and qualitative) at all levels of the health system, as well as provide direct support for priority surveys and evaluations. Monitoring data will be disaggregated when possible to allow monitoring of progress in reducing inequities among districts, hospitals, etc., and to identify measures to support weaker performers. Data on use of health services will also be disaggregated by gender when possible, and supplemented by qualitative reviews to better understand why various groups are using or not using key services.

- *Routine monitoring*, including through the Health Management Information System (HMIS): The HMIS system is functional but needs further strengthening in terms of the timeliness, quality, and use of data, improving software systems for entering and reporting data, and improved maintenance of computer hardware and networks.
- *Household surveys and data*: Formal household surveys will be undertaken at least every two-three years, in coordination with National Department of Statistics (DNS), preferably in the context of a statistical masterplan. The Timor-Leste Living Standards Measurement Survey (TLSLS) is being completed in 2007, which will serve as baseline data for key household-level indicators. A "lighter" survey focusing on coverage of key health and social services may be undertaken in 2009/10, with the next TLSLS to be fielded in 2011/12.

- *Lot Quality Assurance Sampling (LQAS)*. Formal household surveys have limitations, however, since they not provide timely information to health managers regarding service coverage. In addition, coverage based on HMIS data involve considerable uncertainty, since the population denominators have to be estimated from census data. The MOH is therefore interested in piloting the Lot Quality Assurance Sampling (LQAS) methodology in the context of the BSP rollout. In this approach, a random sample of households in the service catchment area are visited by the district team and/or an NGO, which provides an estimate (within 5% or so) to cross-check coverage of key services. If successful, this approach could become part of routine performance management.
- *Facility surveys and evaluations of pilot activities*. Some indicators will need to be collected either through facility surveys (e.g., every two years), and/or through routine supervision. The HSSP-SP in coordination with UN agencies and EC technical assistance will support the development of routine supervision tools that will allow the monitoring and aggregation of some key service quality indicators (e.g., appropriate treatment of malaria or of acute respiratory infection). Given capacity limitations, MOH is cautious about initiating additional facility surveys, but funding for facility surveys to complement supervision data may be considered in 2009.
- *Program and pilot evaluation, operational research.* As part of the annual sector review process, the Project will finance analytic work and evaluations on priority issues identified by MOH and partners. For the Innovations component, evaluation arrangements will be built into the contracts for the larger pilots. One or two interventions of high policy interest for the Ministry of Health (e.g., health worker incentives, increasing demand for demand for health services) may be selected for more rigorous impact evaluation by an independent research institute. In addition, the MOH is seeking to develop its capacity for operational research through a partnership with the Institute for Health Sciences (IHS) and the University of New South Wales in Australia. Specific operational research activities could be supported by the Project.
- *Community-level monitoring*: Vital Registration systems are currently very weak. The Family Health Promoter program could contribute to the collection basic community-level information on births, deaths, etc. Collection of basic community-level data will be included in the contracts with NGOs supporting community health/nutrition programs. Strengthening of community-based monitoring and vital registrations systems will be a medium-term goal of the program.
- *Encouraging use of information and results-based culture.* The Project will seek to strengthen the use of information for planning and improving performance through the annual review process, performance contracting, and piloting of "Rapid Results Initiative" methodology in the BSP pilot districts. RRI will not be treated as a separate "campaign", but rather as a tool for capacity building, improving teamwork, and managing for results. If successful, the methodology could be scaled up nationally.

Arrangements for results monitoring

			Target Values					Data Collection and Reporting		
Project Outcome Indicators	**Baseline**		**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	 80 80	 85 85	 90 90	 90 90	Semesterly (HMIS data and EPI surveys) Every 2-3 years (household surveys)	HMIS TLSLS/ household surveys	MOH (for HMIS) DNS (National Department of Statistics for HH data)
% of births attended by skilled health personnel		27	32	35	38	42	45	Semester (HMIS data) Every 2-3 years (household surveys)	HMIS TLSLS/ household surveys	MOH DNS
% of pregnant women receiving at least four antenatal visits		36	40	43	47	51	55	Semester (HMIS data) Every 2-3 years (household surveys)	HMIS TLSLS/ household surveys	MOH DNS
% of children (6-59 months) receiving vitamin A supplements	36		40	50	60	70	**80**	Every 2-3 years (household surveys) Semester (estimated coverage from HMIS)	TLSLS/ household surveys	MOH DNS
% married or cohabitating women using modern contraceptives	10		15	17	19	22	**25**	Every 2-3 years (household surveys); Semester (couple-years protection estimated from HMIS)	TLSLS/ household surveys	MOH DNS
Intermediate Outcome Indicators		**2006** HMIS	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 (TT) injection								Semester (HMIS data) Every 2-3 years (household surveys)	HMIS, TLSLS/ household surveys, facility surveys	MOH, Survey
Cesarean section rate								Semester	HMIS	MOH
Number (%) of children		TBD					60%	Semester (project report data)	Project reports	MOH

Project Outcome Indicators	Baseline		Target Values					Data Collection and Reporting		
	2003 DHS*	2006 HMIS	2008	2009	2010	2011	2012	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
(6 mo – 3 yrs) participating in integrated community nutrition programs								Every 2-3 years (household surveys)	TLSLS/ household surveys	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	2	4	6	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 financing; (ii) Percentage of district and CHC managers that have received management training		0					(i) TBD (ii) 70%	Annual	Training and human resource database	MOH, HIS
3. Strengthen coordination, planning,										

Project Outcome Indicators	Baseline		Target Values					Data Collection and Reporting		
	2003 DHS*	2006 HMIS	2008	2009	2010	2011	2012	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
and monitoring										
% of health facilities/ submitting completed HMIS monitoring reports 1 month after end of each quarter		TBD					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 workprogram 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	3 1 0	6 4 2	8 6 3	10 8 4	12 10 5	Annual	Annual reports	MOH
Number of formal MOH-private sector/NGO partnership contracts signed		1	2	4	6	8	10	Annual	Annual reports	MOH

*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.

Annex 4: Detailed Project Description

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

Introduction

1. The proposed investment has been designed to support the objectives of a Sector-Wide Approach. It therefore aims to:-

(i) Promote ownership by the GoTL and the MOH of health sector policies, programs and projects

(ii) Promote GoTL and MOH accountability for achieving health sector results; and

(iii) Reduce transaction costs for GoTL and MOH through better donor coordination and harmonization of approaches

2. The investment is therefore designed as a "Health Sector Support Fund." It aims to provide the Government of Timor-Leste, and in particular the Ministry of Health, with a flexible package of financial and technical advisory resources to help them manage and implement their Health Sector Strategic Plan. This concept of a Sector Support Fund can be distinguished from a more traditional Project in three main ways, namely in that:

(i) the overall objectives, components and scope of work are defined primarily by the implementing partner's sector program;

(ii) it does not try to prescribe up-front all the inputs, activities or outputs that are to be covered by donor funding; and

(iii) decisions about what the Facility will fund/support is addressed primarily through the implementing partner's own annual planning and combined sources budgeting processes, with an agreed mechanism for donor engagement in policy and planning dialogue and sector performance monitoring.

Higher Level objectives to which the Project will contribute

3. The development objectives of the Facility are aligned with those contained in the GoTL's key plan documents, including the 2002 National Development Plan (which calls for meeting the MDG targets for health by 2015.[8]), and the Health Sector Strategic Plan for 2008-2012. The key high-level health outcomes that all sector stakeholders are focusing, and to which the operation will seek to contribute, are therefore:

(i) reduced child mortality (through greater immunization coverage, integrated management of childhood illnesses, prevention of malaria and diarrhea);

(ii) improved maternal and neo-natal health (through increasing the proportion of women receiving pre- and post-natal care, and deliveries attended by skilled health workers);

(iii) reduction in communicable diseases such as Malaria, TB and HIV (through effective prevention, detection and treatment); and

[8] "Reduction of mortality of children under five years by two-thirds, reduction of maternal mortality by three-quarters, and the halting and reversal of the incidence and spread of HIV/AIDS, malaria, and other major diseases." *National Development Plan*, Planning Commission, Dili, 2002 (p. 23).

(iv) increased utilisation of health services (through improved accessibility, quality and demand).

(v) Reduce malnutrition (protein-energy malnutrition and micronutrient malnutrition) among children and mothers (through growth monitoring and nutritional counseling, and distribution of micro-nutrients of children and mothers)

4. Because these high-level outcomes are the results of a variety of factors, and progress cannot generally be monitored on a yearly basis, the specific Development Objectives of the Project focus on key health sector service delivery indicators that have been shown to contribute to the attainment of improved health outcomes (including vaccination coverage, antenatal care, assisted deliveries, micronutrient distribution, etc.), as well as intermediate outputs will be associated with project financing.

Project development objectives and key indicators

5. The overall objective of the Project is to improve the quality and coverage of preventive and curative health services, particularly for women and children, in order to accelerate progress toward the health MDGs. The HSSP-SP will have two parts (a) direct financial support using the Health Sector Strategic Plan and MTEF framework, and (b) addressing challenges and innovations needed for the health sector to be prepared for the next generation of issues.

6. Specific objectives for the first part would be fully aligned with the three goals of the HSSP, namely: (i) improve accessibility, demand and quality of health services; (ii) strengthen support services, human resource development, and management; and (iii) strengthen coordination, planning and monitoring. Progress toward achievement of these objectives will be monitored using a combination of sector-wide health service indicators (such as vaccination coverage, contraceptive prevalence, trained birth attendance, etc.), together with intermediate indicators linked with activities and outputs supported by the Project (including number of children participating in community nutrition/health programs, percentage of health clinics offering the full Basic Service Package (BSP), percentage of health center and district managers receiving management training, and availability of essential drugs at health facilities) (see Annex 3 –Results Framework).

7. Within the broad framework of the HSSP, the Project initially will give particular focus to several key priorities, which should yield visible results in the first year, including: support for the roll-out of the Basic Service Package at district level; expanding community health and nutrition programs; and implementation of the Hospital Service Package (HSP). To strengthen service quality and capacity in the medium term, strengthening the training capacity of the Institute for Health Sciences, including for management training at district and health center levels, as well as training for staff and managers; strengthening MOH capacity for planning and budget execution; and improvements in hospital management and service quality.

8. The specific objective for the second part is to promote innovation and program development (linked to priorities identified in the HSSP) by providing resources to pilot and evaluate priority health sector innovations, such as demand-side and service-provider incentives, and public-private partnerships. The Rapid Results Initiative approach is expected to be introduced as a methodology to pilot new approaches and to build capacity for results-based management. Pilot activities and other innovations that prove successful will be scaled up and integrated into the MTEF and annual Work Programs and budgets. Key indicators for this objective will include: (i) the number of pilot initiatives that are (a) financed by the project; (b) monitored and evaluated, with findings/lessons disseminated; and (c) scaled up or influencing

national policies; and (ii) number of formal partnership contracts signed between MOH and NGOs or private providers.

Project components

9. The Project will have four components, corresponding to the specific development objectives. The content and allocation of funds among these components were validated during appraisal based on the HSSP and the current MTEF. A detailed costing of activities for the first year and a 12 month procurement plan were agreed upon during Project appraisal. Subsequent decisions regarding the level of annual funding will be made based on the Joint Annual Sector Reviews (in April/May), and the detailed allocation of pooled resources will be agreed during the Joint Annual Planning Summits (JAPS) in October/November, which will be aligned with the MOH's Annual Planning and Combined Sources Budgeting process, in consultation with participating partners and line with the goals and objectives set out in the HSSP. To strengthen performance management, the amount of annual support from the HSSP-SP will be reviewed yearly based on progress toward key performance indicators and agreed reforms.

10. **Component 1 – Health Service Delivery (approximately US$12 m).** The component will support health service delivery priorities identified in the HSSP and MTEF, and will be closely coordinated with the technical assistance program of the EC (which supported HSSP and MTEF development, and is supporting "roll-out" of the BSP as well as costing of the HSP), as well as with current programs financed by UN agencies, and current and any forthcoming grants from the Global Fund. The findings and recommendations of a Health Seeking Behavior Study, which will be undertaken in 2008 with AusAID financing, will further inform the design and implementation of activities under this component.

(a) *Implementation of the Basic Service Package for Primary Health Care, and improving district planning and management capacity*. The BSP has been developed over the past several years with support from several partners, formally adopted by the MOH[9], and a committee of senior MOH staff has been established to provide oversight and support for BSP implementation. The BSP defines critical services necessary to achieve the MDGs according to the level of care (community, health posts, community health centers, referral hospitals). BSP "roll-out," including training for district staff and health workers, has been initiated in two pilot districts, with a calendar for covering all districts by the end of 2008. The costs (including commodities and recurrent costs) associated with delivering the BSP is estimated in the MTEF, and will be integrated in the Annual Plans of the MOH and health districts. In the context of Annual Plans, the Project will support the following:

(i) Technical support for BSP implementation through a "BSP Roll-out Team" composed primarily of Tetum or Bahasa speakers, who would provide "hands-on" support to health

[9] See Ministry of Health (2007), *Basic Service Package for Primary Health Care and Hospitals: Achieving the MDGs by Improved Service Delivery*. Annex 1 of the BSP document provides a summary of key services to be provided, and at which level of the health system. At community level, interventions including nutrition education, deworming; food and micronutrient supplementation; growth monitoring and referral of severely malnourished children; promotion breastfeeding; family planning promotion; distribution of treated bednets; immunization promotion, and diarrhea prevention and treatment, including oral rehydration salts. At the health post and health clinic level, key interventions include immunization services (routine and outreach); integrated management of childhood illness (IMCI); pre- and post-natal care for pregnant women and infants; family planning; diagnosis and treatment of sexually transmitted infections; normal deliveries; etc. At referral hospitals, key services include emergency obstetric care, surgery, x-rays including for TB, etc.

districts, as well as routine supervision and monitoring ensure that initial training is implemented in practice. Support will be coordinated with EC technique assistance, and will include developing simple guidelines for BSP planning, implementation, and supervision at district level.

(ii) Direct support for implementation of the BSP and for primary health care services, including improved transport (vehicles and motorcycles) for health districts, as well as direct financing for priorities identified in district Annual Plans. With respect to the latter, districts will be given an indicative allocation based on population (approximately $30,000 to $50,000), which they will program based on priority needs. Eligible expenditure items will include financing for key inputs (e.g., equipment, facility repair), staff training, support for outreach and mobile clinics, etc. Mechanisms for financing these activities will be detailed in the Project Operations Manual.

(iii) Direct contracting with nongovernmental and private sector organizations in support of curative, preventive, and community-based health and nutrition services. While the BSP roll-out is initially focusing on public sector services, it can be expanded to include NGO, church-affiliated, and selected private clinics/hospitals. The MOH has identified several initial priorities for contracting, where private/NGO clinics could expand their services to a wider population. Public-private partnerships could be initially financed by the Project, but later integrated into the MTEF and budget. Contracts would be performance based, particularly to ensure access to the BSP by the poor in exchange for MOH subsidies. Support may be in-kind (essential drugs or equipment), or through direct financing.

(b) *Strengthening community health, nutrition, and reproductive health interventions, as well as outreach services in remote areas*. The importance of strengthening integrated community nutrition and health programs is widely acknowledged, but the mechanisms for doing so need to be further developed. HSSP-SP will therefore support several approaches identified in the HSSP, including:

(i) Direct financing for community-level activities by health districts, including the new Family Health Provider program. The FHP program was developed by MOH with support from EC, and is to rely on community volunteers; about 600 volunteers have been trained, but the mechanisms for supervising and motivating these volunteers need to be further developed;

(ii) Scaling up community-level integrated nutrition and health programs, in the context of the MOH's revised nutrition policy, through financing of contracts for local and international NGOs to support community nutrition and health service in partnership with MOH and districts. The project will support an international advisor to the MOH to further develop nutrition policies and implementation strategies;

(iii) Most health districts have designated sites for visits by mobile clinics, but the visits are irregular due to resource and personnel constraints. The Project will support outreach services by health districts, in the context of their Annual Plans. In addition, the MOH also plans to evaluate the experience with mobile outreach clinics and develop a Remote Areas outreach strategy, given that a significant portion of the population still does not live within an hour of health clinics, but often with population catchment areas too small to justify construction of new clinics.

(c) *Improving hospital care and the referral system*, *including implementation of the Hospital Service Package (HSP).* The HSSP calls for development of a Hospital Service Package, as well as the development of Hospital Master Plans in all referral hospitals by the end of 2008. A EC-finance consultancy contract is undertaking a hospital costing exercise in the latter half of 2007; the MTEF will be updated on the basis of this costing exercise, while keeping within the 40 percent cap on total hospital expenditures. Because strengthening hospital management and quality is a long-term proposition, priority will be given to sustained capacity building arrangements, including "twinning" with referral hospitals in Australia, Indonesia, or other nearby countries. Policy dialogue in the context of annual sector reviews will review progress in implementing hospital reforms and autonomy legislation. Specific priorities identified for financing in the first year include: technical assistance for "commissioning" of the new regional hospitals; support for "twinning" arrangements with hospitals in the sub-regions to strengthen hospital management and key support services (such as hospital pharmacies and laboratories, and biomedical equipment maintenance); and strengthening of hospital information and management systems, including through TA and limited equipment purchases.

(d) *Assuring quality of care throughout the health system, including improvements in infrastructure and equipment at health facilities*. With respect to infrastructure, the focus in the first year will be on upgrading existing Community Health Centers (CHCs) to include maternity rooms and equipment, and ensuring adequate disposal of biomedical waste. Although no new construction is expected to be financed by the project, the MOH will be supported to update its health services coverage plan, taking into account the location of public and private facilities, and assesses the trade-offs of new clinic construction compared to other strategies (such as mobile clinics). With respect to commodities, the MTEF estimates the costs of commodities necessary for BSP implementation, including vaccines, medicines, treated bednets, equipment, etc. Pharmaceuticals and vaccines have been covered by the HSRDP-EC grant as well as UN agencies, but will increasingly being financed by the budget. No direct purchase of pharmaceuticals is forseen in the first year of the Project; the Project will focus instead on strengthening SAMES and the logistics system for pharmaceuticals (see below).

11. In addition, the program will provide flexible support to fill financing gaps in major disease control programs, including for malaria, HIV/AIDS, and avian flu. The ongoing Global Fund HIV/AIDS project is covering most of the financing needs for HIV/AIDS prevention and treatment, particularly with high-risk groups. In addition, the MOH has submitted Global Fund proposals for TB and malaria ($10.3 million and $7 million, respectively over five years, although the full amounts may not be approved and funding for the final three years would be conditioned on performance). If approved, these grants would cover most of the financing needs for these programs. Funding decisions are expected by mid- November 2007. Depending on the outcome of funding decisions and effectiveness dates of these new grants, the Project could help fill any remaining funding gaps. With regard to avian flu preparedness, in light of the few identified human case in nearby Bali, the Project will stand ready to reprogram funds on an emergency basis in the event of a human pandemic.

12. **Component 2 – Support Services, Human Resource Development, and Management (approximately US$ 4m).** Activities under this component will be closely coordinated with the EC technical assistance, which is providing TA for human resource development, as well as the Public Finance and Management Capacity Building Program (PFMCBP), which includes targeted support for the health sector as well as support for capacity building and reforms in central ministries. Particular focus under component 2 will be given to:

(a) *Strengthening 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 the region. The Project may also support possible support for equipment and small civil works; as well as direct support for advanced training for faculty.

(b) *Improving human resource development and management practices*. Based on the updated Health Workforce Plan, the Project will provide direct support for priority local and international training for Timorese staff; support improved human resource development and management practices (in cooperation with EC technical assistance), and support the MOH's efforts to improve the identification, mobilization and management of priority Technical Assistance services. Support will be provided through a mix of analytic work, technical assistance, and direct support for strengthening of HR management system, training institutes (including the Institute of Health Sciences), and direct support for local or overseas training of Timorese staff.

(c) *Improving procurement, distribution and management of essential drugs and supplies* (through SAMES and Department of Pharmacy). Strengthening SAMES as an autonomous entity is a major focus of an EC Trust Fund that will be ongoing through 2009, but significant progress is needed. Possible areas of support could include funding for senior technical advisors to SAMES (continuation of support through an EC trust fund), support for further strengthening of SAMES management and reforms; and analysis and dialogue to support further reforms to improve SAMES performance.

(d) *Strengthening "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 (for Finance, Procurement, and Infrastructure), as well as "contracting out" of certain technical services (such as maintenance of computer equipment). Most civil works and equipment have been financed by projects to date, and overseen by the PMU, but financing will increasingly shift to the budget. The conversion of the PMU to an Infrastructure Support Unit will facilitate execution of the capital expenditure budget and donor-financed civil works and maintenance.

13. **Component 3 – Coordination, Planning and Monitoring (approximately US$2.0m).** Support from this component will include: (a) support for establishment of the Department for Partnership Management to strengthen MOH capacity for donor coordination, including financing a senior advisor for this Department, while ensuring that line departments take the lead in implementation of Project- and donor-financed activities; (b) technical assistance (in collaboration with EC) for strengthening the annual planning and budgeting process at central and district level, including integration of external assistance into annual plans and reporting; (c) further strengthening the MOH Health Management Information System (HMIS), including through technical assistance and support for related hardware and software; (d) direct financing of surveys and other evaluations, including through the national statistics department (DNS) as well through other public, private and nongovernmental organizations; (e) improved policy development and research capacity within MOH, including targeted support for operational research.

14. **Component 4 – Innovation and Program Development (approximately US$2.3m).** **C**omponent 4 provide flexible support to piloting new initiatives or further development of promising approaches, together with technical assistance for implementation, evaluation, and lesson-sharing. Successful initiatives will be scaled up and incorporated into MTEF and annual

plans and budgets, and/or will contribute to revisions in national policies. The following are likely to be priorities: (a) promote community demand for health services, including through the Family Health Promoter Program, and piloting financial incentives for use of key services (e.g., assisted deliveries); (b) provide incentives to service providers, particularly to attract and retain key health personnel in remote/rural areas, including performance-based incentives; (c) establish effective public-private partnership options and contracting mechanisms. The Rapid Results Initiative (RRI) approach[10] will be introduced as a methodology to pilot new initiatives and to build local implementation capacity and strengthen the focus on results, initially in coordination with the roll-out of the BSP. An MOH committee will be established to provide oversight for the fund and vet proposals (see Annex 6). The guidelines for selecting, financing, and evaluating activities under this component will be included in the Project Operational Manual. Monitoring and evaluation will be integrated into the pilot activities, but may be contracted out separately for larger pilots or initiatives of particular policy interest. Annual "lesson sharing" events will be organized to share results and assess priorities for scaling up.

[10] The Rapid Results Initiative (RRI) approach was initially developed by a management consulting firm, and has been used in Bank-financed project in a range of sectors and countries over the past five years, although with most initiatives in the social sectors or in public sector management. In brief, local stakeholders identify a limited number of priority results they would like to achieve (e.g., increase vaccination or assisted deliveries), and set specific targets to be achieved in a limited time (usually 100-120 days), beginning with 1-2 districts. Local teams work with "coaches" to develop implementation and monitoring strategies, and work together to solve problems and wanted to achieve the results. At the end of the time period, a workshop is held to share lessons, draw policy implications, and agree on next steps. While RRIs have been used as high-profile initiatives to "kick-start" slow-moving projects, in the Timor-Leste context a "lower profile" approach would be used to introduce and seek to adapt the methodology to ongoing initiatives and programs, beginning with BSP roll-out.

Annex 5: Project Costs

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

1. This Annex provides the overall indicative allocation of the distribution of the pooled funds over five years. Detailed costs have been agreed for the first year of operation. Subsequent allocations of pooled financing beginning with the year 2009 are indicative, and will be based on the annual planning process. Table 5.2 gives the indicative financing framework for the sector, based on the MTEF, which will be updated in early 2008 on the basis of revised budget allocations for health, and donor funding decisions.

Table 5.1: Indicative Financing Plan for HSSP-SP (US$ millions)

	Year 1 2008	Year 2 2009	Year 3 2010	Year 4 2011	Year 5 2012	**Total**
HSSP-SP Financing	**4.3**	**5**	**5.1**	**5.3**	**0.6***	**20.3**
1. Health service delivery	2.5	3	3	3.2	0.3	**12**
2. Support services, HR, management	0.9	1	1	1	0.1	**4**
3. Coordination, planning, and monitoring	0.4	0.5	0.5	0.5	0.1	**2**
4. Innovation and Program Development	0.5	0.5	0.6	0.6	0.1	**2.3**

* AusAID expects to contribute an additional AUD4 million (US$3.5 million) for year 5, which will be approved following a midterm review after Year 2.

Table 5.2: Projected Health Sector Financing (US$ millions)

	2008	**2009**	**2010**	**2011**	**2012**	**TOTAL**
Health Sector Financing						
Government Budget*	22	21	24.1	27.5	30	**124.6**
HSSP-SP: (AusAID/IDA)	**4.3**	**5**	**5.1**	**5.3**	**0.6**	**20.3**
USAID	4.8	3.3	0	0	0	**8.1**
Multilateral financing						**0**
TFET (incl. EC TFs)	*2*	*0.5*	*0.5*			**3**
EU	*0.6*	*2*	*1.3*	*1.3*		**5.2**
Global Fund (HIV)**	*1.8*	*1.8*	*1.8*	*1.8*	*1.8*	**9**
UN Agencies	*5.2*	*5.2*	*5.2*	*5.2*	*5.2*	**26**
Other bilateral, NGO/private	1	1	1	1	1	**5**
TOTAL	**41.7**	**39.8**	**39**	**42.1**	**38.6**	**201.2**

*Note: The April 2007 MTEF underestimates likely budgetary allocations for health for 2008 onward, and will be updated in January 2008 based on revised health budget allocations and projections.

** Does not include potential Global Fund Grants for TB and malaria; funding decisions expected in mid-November 2007. MTEF will be updated on the basis of approved financing.

Annex 6: Implementation Arrangements

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

Partnership arrangements

1. The HSSP-SP is financed by the World Bank and AusAID. Project legal agreements include: a Grant Agreement between IDA and GoTL; a Grant Agreement between IDA and GoTL regarding Trust Fund arrangements; and a Trust Fund Administrative Agreement (AA) between IDA and AusAID. Although at this time AusAID is the only donor that has made a firm commitment to contribute to the Trust Fund, it will be established as a Multi-Donor Trust Fund (MDTF) to facilitate entry of other donor partners in the future. The GoTL, AusAID and the World Bank have agreed on common technical and financial, as well as project performance indicators. They have also agreed on reporting formats and to rely as much as possible on GoTL monitoring systems, which will be strengthened over the course of the Project. IDA will have primary responsibility for fiduciary oversight of the fund, while IDA and AusAID (and any future participating partners) will engage jointly in policy dialogue and technical supervision of the fund, including decisions on the annual funding allocations.

2. The current practice of twice-yearly Joint Donor Mission (JDM) led by the World Bank will be further consolidated through the establishment of a Joint Annual Sector Review (May), led by the MOH and focused on reviewing overall sector progress determining indicative funding allocations for the subsequent year. A Joint Annual Planning Summit (October/November) will then be convened by MOH to agree on specific programming of donor and budgetary resources. All donors will be encouraged to submit their fully costed annual financing proposals according to the standard MOH budget format and program categories, which will facilitate the compilation of a consolidated Annual Plan. The documentation produced by the MOH and the Aide Memoires for the joint missions will serve as the basis for supervision of pooled financing; parallel reporting requirements will be avoided as much as possible.

3. Consistent with the sector wide approach, other donor partners and technical agencies – including United Nations (UN) agencies, other bilaterals, and NGOs -- will participate in the joint annual sector reviews, and may take a lead role in providing technical or implementation support for certain activities financed by the pooled fund, according to their respective competencies and mandates. For example, WHO will provide technical leadership on disease control, health management information systems, and certain key health systems issues, including rollout of the Basic Service Package; UNICEF will provide leadership and support for immunization, maternal and child health and nutrition; UNFPA will play lead technical role in reproductive health, family planning, and safe motherhood issues; and nutrition interventions will be coordinated with the World Food Program. The Global Fund will likely provide substantial financing for malaria and TB, in addition to HIV/AIDS, and could participate in annual reviews within the context of their grant agreements with GoTL, in which quarterly disbursements are released on the basis of progress toward agreed targets. International and local NGOs and faith-based organizations could contribute based on expertise and experience in technical areas (e.g., maternal and child health, or community health and nutrition activities). A brief “Principles of Engagement” document, which outlines the commitments and accountabilities of MOH and partners in the context of a sector approach, will be drafted for discussion at the first JASR and for eventual signature by partners.

Institutional and implementation arrangements

Implementation and coordination responsibilities

4. *Implementation responsibilities.* The MOH will have responsibility for HSSP-SP implementation, including procurement, disbursement, and financial management. Project policy and execution management will be the responsibility of the Minister, who will serve as Project Director. Responsibility for implementation of Project-financed activities will rest with the various line departments of the MOH. To facilitate integration of external financing with the national budget, the MOH will create a new Directorate of Planning and Financing, and establish within this Directorate a Department for Partnership Management (DPM), staffed by a Program Facilitator and "desk officers" responsible for major donor-financed activities, including this pooled fund (see proposed MOH Organogram[11] below). The Project will finance a senior advisor to support the establishment and operation of this new Department. The Project Management Unit (PMU) currently managing the HSRDP2 and the EC trust funds will be integrated into MOH structures. The current PMU coordinator and civil works contractual staff will form the basis of a new Infrastructure Support Unit (IFU) based in the Logistics Department of the Directorate of Administration, Logistics, and Procurement, which will implement both donor- and budget-financed civil works. Technical advisors will be needed for core fiduciary functions (financial management and procurement) for most of the duration of the Project, but they will be assigned to line unit and their roles will increasingly shift toward capacity building and coaching. They also will assist the DPM in assuring that Project and donor fiduciary and reporting requirements are fulfilled.

5. *Coordination and oversight arrangements***.** Coordination of GoTL and donor partner contributions to HSSP implementation will be led by the MOH, and facilitated through monthly donor Coordination Meetings, and the conduct of a Joint Annual Planning Summit (JAPS) and a Joint Annual Sector Review (JASR). Several Technical Working Groups are active, which include relevant MOH staff and interested donors. A Strategic Plan Working Group of the MOH, which meets weekly, is chaired by the Minister and includes MOH Directors and key heads of department. Although the name may change, this entity will provide policy guidance and facilitate coordination of the HSSP-SP and other donor programs. The World Bank will take the lead role in administering the HSSP-SP Trust Fund and oversight for the financial management, procurement and fiduciary arrangements. Formal supervision missions for the HSSP-SP will be undertaken concurrently with the JAPS and the JASR, although smaller implementation support missions may be undertaken at other times. The Country Coordinating Mechanism (CCM), which was established to provide oversight for Global Fund grants and includes a range of stakeholders, could also become a venue for discussing coordination with other externally financed activities, including this Project. The structure and mandate of the Health Service Support Unit (HSSU), which was established within the Directorate of Health Service to support Global Fund implementation, is expected to remain unchanged initially, however. The workload of this unit will increase substantially if the Timor-Leste malaria and TB proposals for grant funding are approved by the Global Fund Board on mid-November 2007. The HSSU will coordinate closely with the new Department for Partnership Management. It is anticipated that the structures will work toward greater harmonization and integration, taking into account timelines of the Global Fund-financed programs and the evolving nature of the new systems established under the HSSP-SP.

[11] The Proposed MOH Organogram (attached below) is provisional until it has been formally approved by the Ministry of Health.

6. *Coordinating and managing technical assistance.* Given the high cost of expatriate technical assistance, and past experience with inadequate supervision, communication, and performance management of TA in the Health Sector, it is critical that technical assistance be better prioritized and coordinated. The MOH has proposed the establishment of a small TA oversight committee, with support from a senior advisor, which will provide support in the recruitment, supervision, and performance evaluation of international TA, as well as helping to resolve difficulties or misunderstanding that may arise between international advisors and local counterparts. In addition, the MOH would like to pursue the expanded use of Timorese/Tetum-speaking consultants to help translate and adapt the "best practice" strategies and policies generated by international advisors into simple tools and guidelines that can be applied by health districts and hospitals, and to provide "hands-on" support to local staff. The Project will finance international and local technical assistance based on priorities identified in the HSSP and MTEF, and agreed by MOH. While most individual consultants and firms will be directly contracted with Project financing, UN organizations including WHO may be contracted to ensure quality and technical oversight for TA in certain priority areas, including development of the HMIS system, and roll-out of the Basic Service Package.

7. *Strengthening supervision and capacity of districts and hospitals***.** Health districts and hospitals will be responsible for implementing service delivery activities, based on their annual plans, which will be approved and monitored by MOH. Two key challenges highlighted in both the HSSP and the Health Sector Review are the needs to (i) strengthen supervision by central MOH of hospitals and districts, and to improve supervision by districts of health facilities; (ii) strengthen capacity of districts and hospitals for planning, implementation, supervision, and monitoring of health services. Many district officials lack basic management training, and many health workers lack basic technical and mathematical skills (for example, the majority of health workers have difficulty calculating percentages). The proliferation of various tools, policies, guidelines, and donor-financed initiatives further taxes limited management capacity. To address these challenges, the Project will provide flexible support for capacity building priorities identified in the HSSP. Specific priorities for support will include: (i) recruitment of a mobile team (composed of Tetum or Bahasa speakers) to provide technical assistance and training of district teams and hospital managers in BSP and HSP rollout; (ii) strengthening the Institute for Health Sciences (HIS), particularly to expand management training for district and CHC managers, including through a "twinning" arrangements with regional training institute(s); (iii) "twinning" arrangements to strengthen hospital management and upgrade key support functions (laboratory, pharmacy); (iv) development of simple, standardized guidelines and protocols for planning and supervision (at central, district, facility level).

Annual Planning, Budgeting, and Reporting

8. *Annual planning and budgeting.* Within the overall scope of the HSSP and the sector MTEF, annual implementation plans and combined sources budgets will be prepared by the MOH in line with the GoTL's planning and budgeting procedures and calendar (see Annex 7). The Directorate of Policy and Finance will take the lead in preparation of Annual Plans and updating the MTEF. This process will increasingly be driven by the preparation of annual District Health Plans and Budgets, and resources allocated based on demonstrated need and other financial allocation targets specified in the health MTEF. Broader stakeholder involvement in the planning and budgeting process will be facilitated through the JASR and JAPS process. On the basis of the joint annual sector reviews, IDA and AusAID (and any other participating HSSP-SP partners) will announce prior to the beginning of the annual budget process the indicative contribution to the pooled fund for the forthcoming year. The level of annual contributions to pooled account

will vary based on implementation performance, progress on key indicators and agreed sector reforms, and results of annual financial audits. The MOH will prepare an Annual Plan, which will include proposed allocations for the budget, HSSP-SP pooled funds, as well as other donor resources. The draft Annual Plan will be submitted to partners at least two weeks prior to the JAPS, and revised based on agreements reached during the JAPS. The proposed allocation of HSSP-SP funds, together with an updated procurement plan, will then be submitted to IDA and AusAID for approval.

9. *Review and reporting***.** Consistent with current practice, at least two weeks prior to the six-monthly sector review missions, the MOH will submit to the partners a Briefing Document that will summarize sector progress, including implementation of the budget, HSSP-SP, and other donor projects, as well as progress on key performance indicators. The MOH will also submit to IDA and AusAID quarterly Interim Financial Reports (IFRs), which will serve as the basis for replenishment of the Designated Account. Reporting on health sector performance and Project implementation progress will be based primarily on MOH data collection and reporting systems, using standard reporting formats. Nevertheless, some additional data collection work/special studies will be carried out as required, or commissioned as input to the annual joint sector reviews (with financing from the Project as needed). Based on the terms of reference of the annual reviews, donor representatives of the review/supervision missions may be tasked with providing critical insight into sector and institutional performance issues.

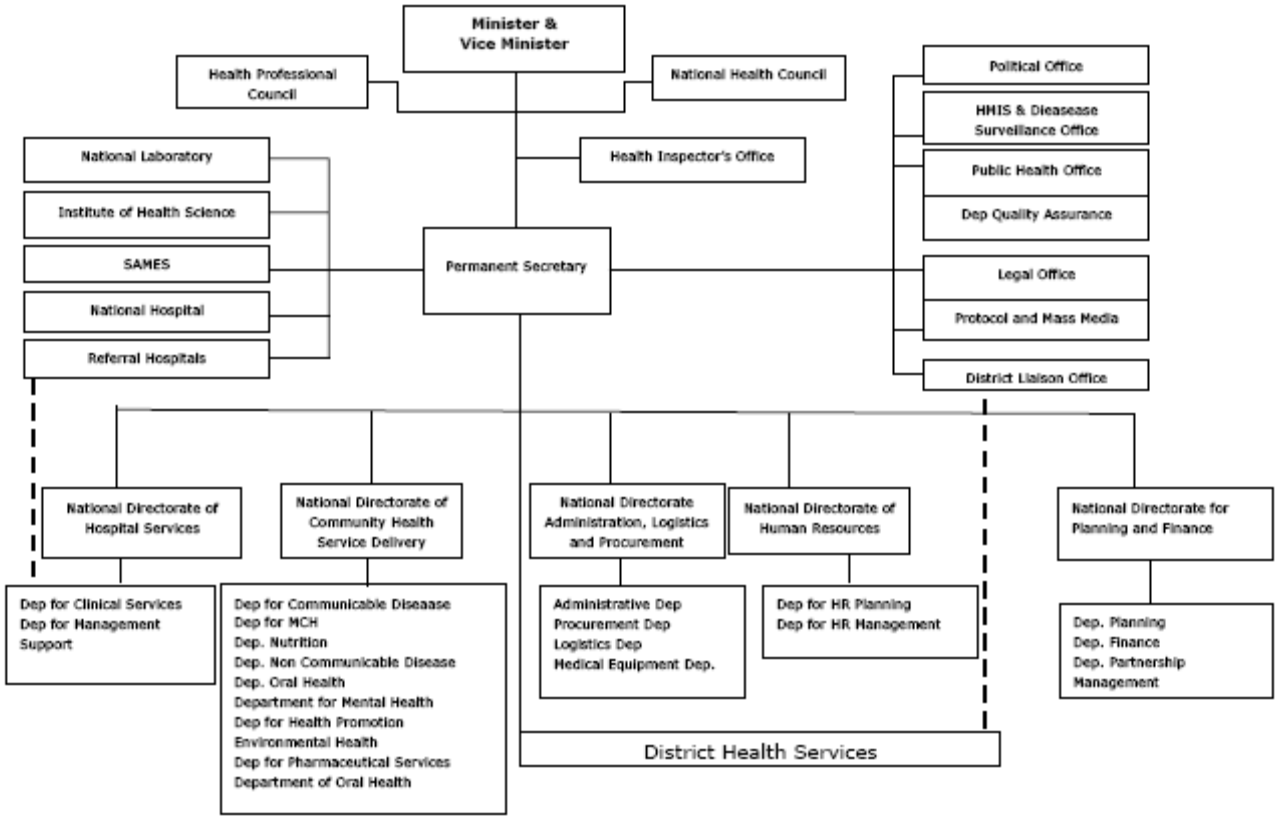
Arrangements for Contracting and Financing Innovations

10. *Innovation and Project Development***.** The Project will finance the piloting of new innovations, as well as adaptation or scaling up of existing pilot experiences. There will be two "windows" for financing. To encourage innovation by health districts teams without cumbersome administrative processes, each district will be allocated up to $5,000 in their annual plans to test new approaches from a menu of agreed priorities (such as strengthening community demand and outreach). The second window will be for larger pilots, which would generally be developed as a partnership between a health district or hospital, and an NGO, research institute, or international organization. Grant applications will be submitted to the MOH Proposal Review Committee, which is currently chaired by the vice minister and includes the Director of Health Services Delivery and the heads of relevant program departments. The proposals will describe which aspects of the pilot will be directly managed by the district/hospital, and which by the partner organization. Donor and NGO representatives may also be included in the review process, provided there is no conflict of interest. Guidelines for selecting, financing, and evaluating activities under this component will be included in the Project Operational Manual, and made available to health districts, NGOs, and other interested organizations. Monitoring arrangements will be kept simple, using routine data where possible, but depending on the activity piloted, evaluation may be built into the contract or contracted to an independent consultant or institute. Annual "lesson sharing" events will be organized to share results and assess priorities for scaling up.

11. *Contracting with NGOs and Private Sector***.** Some project activities, including direct service delivery, technical support for districts, and community health and nutrition activities, will be implemented through NGOs or private sector entities. To expand coverage of integrated community nutrition and health activities, the MOH will contract with international and local NGOs, in partnership with health districts. International NGOs are active in most districts, although not all at community level. While there are some strong local NGOs, their current coverage and capacity is limited, so strengthening local civil society organizations will be among the objectives. NGOs will be invited to submit expressions of interest, and will be selected

(singly or in partnership with another local/international NGO) based on expertise and geographic coverage. NGOs will be expected to adhere to MOH policies, and may be contracted to either expand activities in districts where they are currently working, or to initiate activities in a district that currently receives little NGO support. In terms of clinical services, the MOH is currently expanding an MOU with Café Timor for provision of primary health services, in exchange for essential drugs from MOH. The MOH is also planning to develop MOUs with religious-affiliated clinics to expand service provision and lower the cost of services for the poor. Support may be in-kind (drugs or equipment), but direct payments will also be an option. The MOH will develop standard Memorandum of Understanding (MOUs) and performance contracts, which will specify the obligations of each party and the services to be delivered and performance targets to be achieved by the NGO. Successful contracting will be subsequently integrated into the budget and MTEF.

PROPOSED MOH ORGANOGRAM



Annex 7: Financial Management and Disbursement Arrangements

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

1. The desired result of project and program financial management (FM) arrangements is that program funds will be used for the purposes intended. Financial management risk is the risk that grant proceeds and co-financing proceeds will not be used for the purposes intended and is a combination of country, sector and program-specific risk factors. The overall FM risk for the project is considered as Substantial. Taking into account the risk mitigation measures proposed under the program, the FM risk could however be managed and kept under control.

2. The core FM arrangements for the program will make use of the stand-alone FMIS used by GoTL for development projects; this system has been in use for the HSRDP2 as well as the two European Commission Trust Funds but there is a need to reinstate access to the system and to provide a higher level of support to the MOH. The GoTL financial management and budget systems that apply to development projects have been assessed as reliable and robust enough to cater for the needs of the project provided that MOF fulfill their commitments to maintain the stand-alone FMIS. The MOF have also agreed to facilitate the minor changes required to provide the requisite management information to monitor the project at an activity level. The implementing agency will be MOH with the Directorate of Planning and Finance being responsible for the day to day financial management of the project. The project operational manual (condition of effectiveness) will contain a section on financial management which will provide the details regarding the roles and responsibilities, controls, decision making, and flow of funds and information arrangements. Since many of the controls etc. follow GoTL procedures the operational manual will cross reference these where appropriate.

3. Proceeds from the IDA Grant and AusAID co-financing trust fund will be pooled in a Designated Account which will not form part of the state budget[12]. Expenditure authorization and accounting processes would follow the same procedures as for other recipient executed development projects which are using the stand-alone FMIS. There is a risk that the accuracy of the information contained in the accounting systems will be undermined due to coding errors and measures have been proposed to guard against this risk, primarily the requirement for regular reconciliation of the financial monitoring reports.

4. The mechanism for agreement to the Annual Work Program and the procedures for agreeing on changes to the plan during the year will be included in the legal agreements (A separate legal agreement will be required for the IDA Grant and Trust Fund with signing of the Trust Fund agreement being an effectiveness condition for the IDA Grant). Changes may be required both in terms of deletion/addition of activities and also the resources required to complete activities.

Summary Project Description

5. The overall objective of the program is to improve the quality and coverage of preventive and curative health services, particularly for women and children, in order to accelerate progress

[12] Consideration was given to passing funds through the State Budget. The MOF expressed preference that a project-based financing system be maintained, to avoid additional complications while they seek to roll-out decentralization of budget commitment authority to line ministries in 2008. In addition, government's position has been that Bank Procurement Guidelines could not apply to funds passed through the State Budget. The option of supporting operational costs through the budget system will be considered at the midterm review of the project.

toward the health MDGs. It is proposed that the NHSP would have two parts: (a) direct financial support using the Health Sector Strategic Plan and MTEF framework, including for (i) health service delivery; (ii) support services, human resource development, and management; and (iii) coordination, planning, and monitoring; and (b) addressing remaining challenges and innovations needed for the health sector to be prepared for the next generation of issues. The MOH will be supported to work with the MOF in the development of an expenditure system that will allow tracking of both budgetary and program expenses according to both programmatic and input categories. Project design is intended to be flexible, so costs (Annex 5) are indicative and may be revised based on the rolling MTEF, as well as entry of new partners into the pooled fund.

Implementing Entity

6. The project would be implemented by the MOH through the Directorate of Planning and Finance. An internationally qualified Finance Advisor will be appointed and maintained throughout the duration of the project, based in the Finance Department, to assist the MOH with the annual planning and budgeting process, and further strengthening financial management. The Finance Advisor will also assist the Finance Department and the Services Support Unit (HSSP-SP) in the preparation of Interim Financial Reports (IFRs), replenishment requests for the Designated Accounts, and other reporting requirements. This arrangement is a continuation of existing support under HSRDP2 which has proved effective in ensuring maintenance of project financial management information whilst at the same time has built general capacity in financial management. The international advisor will be supported by a small team of local consultants with specific responsibility for building capacity at the district level and ensuring that acquittal procedures for imprests at the district level are rigorously enforced.

Risk Analysis

The overall financial management risk of the project is considered as substantial. However, taking the proposed mitigating arrangements and actions into consideration, the risk can be contained and managed properly. In general, building the government system's capacity and more frequent supervision, and TA together with leveraging the PFMCBP should ensure that the health sector capacity issues are addressed early on and the risks reduced.

Risk	***Risk Rating***	***Mitigation Measures Proposed***	***Implications for Legal Agreements (non standard requirements)***
1. INHERENT RISKS			
1.1 Country Level			
Country Public Financial Management Systems Recent PEFA assessment indicated significant weaknesses in the PFM system with Bottlenecks proving difficult to overcome – against this core accounting and treasury arrangements are sound.	***High***	Frequency of supervision missions will reflect overall weak environment and the use of a Designated Account addresses some of the concerns over bottlenecks.	None

Risk	*Risk Rating*	*Mitigation Measures Proposed*	*Implications for Legal Agreements (non standard requirements)*
Country Portfolio Indicators Timor-Leste has two portfolio indicators flagged, country environment and country record.	***Moderate***	Frequency of supervision missions will reflect overall weak environment	None
1.2. Entity Level Although the Ministry of Health is familiar with implementation of donor funded projects they are heavily dependent on Technical Assistance and are vulnerable to consultant and staff turnover.	***Substantial***	Allocation of sufficient program resources to provide international FM and local FM advisors	Maintain FM Advisor position for life of program
1. 3. Project Level			
Project Size The total investment is some USD 20 million. Although GoTL is experiencing budget execution difficulties it is unlikely that this will flow through to the activities to be financed by the program given the implementation arrangements proposed	***Moderate***	None specifically for FM although it is noted that adequate resources are set aside for program management.	None
Project Complexity The project intends to support a diverse range of activities in a decentralised environment which will include operation of imprest accounts.	***Substantial***	Capacity building for district officers Local FM Consultants Strict enforcement of acquittal procedures for imprest accounts	None
OVERALL INHERENT RISK	***Substantial***		
2. CONTROL RISKS			
Budget At the time of preparation the GoTL is changing its fiscal year and the timetable for budget preparation is uncertain. However the previous record of GoTL in preparation of budgets and timely approval is a good one and it is expected that a firm budget timetable for FY 2009 will be in place.	***Moderate***	Joint Annual Sector Review (May) Joint Annual Planning Summit (October/November)	None
Capacity of Project Management and FM Staff Local Capacity is generally weak with reliance on international advisors being a feature of past projects. Although the skills required to serve the FM needs of the Bank financed activities are modest the presence of international advisors affords the opportunity to build capacity.	***Substantial***	Appoint international FM advisor for life of the project Recruit local consultants with specific responsibility for district activities	Appoint international FM advisor for life of the project

Risk	*Risk Rating*	*Mitigation Measures Proposed*	*Implications for Legal Agreements (non standard requirements)*
Accounting Systems Although the FMIS used by GoTL for development projects is effective in other Ministries it has fallen into disrepair in the MOH.	***High***	MOF undertakings to properly support the FMIS Requirement for Reconciliations in the quarterly financial reports	Define Financial Management Systems by reference to the stand alone FMIS.
Internal Controls Will follow GoTL standard procedures which are effective (but can lead to bottlenecks)	***Low***	None	None
Funds Flow The arrangements do not rely on cofinancing from GoTL and standard practice. The use of imprest accounts to facilitate activities at the district level adds a level of complication however GoTL is already operating its own imprest accounts and the project will replicate these procedures	***Moderate***	Strict enforcement of acquittal arrangements for imprest accounts (no new advances without acquittals)	None
Financial Reporting The reporting requirements for the project are straightforward – provided that the FMIS functions well	***Moderate***	Agree formats prior to negotiations to allow report based disbursements based on ESSP project – see also comment above on reconciliations	None
Auditing There is an umbrella agreement for all projects in Timor financed directly by GoTL – this project will be added to the agreement	***Low***		None
OVERALL CONTROL RISK	***Substantial***		
OVERALL RISK RATING	***Substantial***		

Budgeting

7. Fundamental to this successful implementation of the program will be the engagement of development partners with the government in the formulation and execution of program activities. And indicative timetable is set out below for this annual process.

Activity	**Responsibility**	**Submitted to**	**Date**
Annual Joint Sector Review will review progress and set program priorities	MOH / Development partners	GoTL	May
Agreed levels of donor funding are communicated	MOH Directorate of Planning and Finance	MoEC	June

Activity	Responsibility	Submitted to	Date
Submission of Budget Guidelines Including Broad Ceilings	MOF	Cabinet	July
Budget guidelines and forms distributed	MOF	All Ministries	July
Annual project/program work plans drafted for the new year	MOH	MOF	August
Financial year submitted Draft revenue and expenditure estimates submitted	MOH	MOF	October
Joint Annual Planning Summit	MOH/ Development Partners	MOH / MOF	October
Consultation with Ministries on first budget submissions	MOF	MOH	November
First (draft) Budget estimates	MOF	Cabinet	December

Funds Flow and Disbursement Arrangements

Separate legal agreements will be established for the IDA Grant and AusAID Trust Fund. Each source of funding is expected to contribute a fixed percentage for all items to be financed as per the table below and this will be reflected in the legal agreements. Since the program seeks to provide flexible financing based on the MTEF and annual workplans, only one disbursement category will be defined in the Financing Agreement with the financial monitoring reports providing the means to monitor expenditures.

	IDA		**AusAID**	
Category	**Amount of the Financing Allocated (US$ million)**	**Percentage of Expenditures to be Financed (inclusive of Taxes)[13]**	**Amount of the Financing Allocated (US$ million)**	**Percentage of Expenditures to be Financed (inclusive of Taxes)**
1. Commodities, equipment, and medicine; technical assistance and consultancy services, and training; civil works.	1.0	5%	19.3	95%

8. The stand-alone FMIS for development projects will provide the necessary information needed to prepare reports for GoTL (which will also satisfy the information needs of Development partners) and will be able to provide the following:

- Reporting against Annual Action Plans (including budgets)
- Multi year Reporting
- Preparation of Statements of Advances Outstanding
- Contract Monitoring
- Reconciliation against Government Accounting Systems (with a verifiable audit trail back to transactions)
- Listing of Payments against Prior Approval contracts
- Cash Forecasting (for use in Report Based Disbursement Withdrawal Applications)

9. Monthly expenditure reports will be prepared and reconciled to the stand-alone FMIS. On a quarterly basis expenditure reports will be incorporated into a summary project progress report – this should be available to Government within 18 days of the quarter end and copied to Development partners so as to facilitate discussion on project progress within 30 days of the quarter end. The inclusion of the financial reports will satisfy the Bank's requirement for the provision of FMR's (Interim Unaudited Financial Statements) and should be in sufficient detail that the reports may be used by the Bank for the purpose of report based disbursement. A draft template for the reports was agreed during negotiations, but the initial disbursement arrangements

[13] Note that the percentage has been rounded so as to make calculations easier in preparation of the Withdrawal Applications

for the project will be on a transaction basis (providing for advances, reimbursement and direct payment). If initial financial management performance is satisfactory, an update to the disbursement letter will be issued once FMR formats have been agreed, which will allow for disbursement on a report basis.

10. The fourth quarterly report in each year will take the form of an annual project progress report and will be prepared for GoTL and shared with Development Partners. The annual report will include financial information, progress and performance data, including progress against agreed performance targets. The financial statements within the annual report will be audited within 6 months of the year end.

11. A separate Bank Account will be opened in a commercial bank (BNU). The designated account would pool advances from the IDA and co-financing Trust Fund – there would be no requirement for MOH to account for each source of funding separately (other than on a summary basis in the source and application of funds statement). A single Withdrawal Application covering both sources of finance will be submitted to the bank which will allocate the expenditure as per the disbursement percentages specified in the legal agreements. The authorized ceiling for the Designated Account will be USD 1.5 million, however, each WA for additional advance will need to be supported by a cash flow forecast so as to provide justification for the amount requested.

12. So as to facilitate operations at the District level cash will be withdrawn from the designated account and provided to districts as an imprest. The MOH already operates an imprest system for State Budget financed expenditure and the intention is to replicate this system for expenses to be financed under the program. The maximum cash to be provided to each district will initially be set at USD 10,000 (with an aggregate maximum of USD 200,000 – this will provide for the possibility of cash being provided to non district level administrative units). Expenditures will become eligible for financing following acquittal – additional cash will not be provided unless an acquittal has been received. Expenses to be paid at the district level will be limited to those that cannot reasonably be paid for directly from the designated account.

13. To assist the MOH in controlling the cash holdings for both the State Budget and the Program it has been agreed that 2 – 3 local consultants will be hired so as to build capacity in the operation of the imprests and to provide the MOH with an effective oversight mechanism. The operation of the imprest accounts will be outlined in the project operational manual.

Auditing

14. The constitution of Timor-Leste allots the function of external audit to the High Administrative, Tax and Audit Court. As this institution remains to be created, the function of external audit is for the time being assigned to the MOF which discharges its responsibilities through the contracting of external audit services. The Government will be required to seek an additional Audit Opinion on the expenditures of the project as presented in the annual project report and this will be submitted to development partners within 6 months of the year end. The Government will fund the costs of the audit through their existing contractual arrangements.

15. Although the Auditor will be recruited and remunerated by Government the Bank will reserve the right to insist on a supplementary audit if the quality and scope of audit services contracted by Government falls short of the required standards. The audit report will include as a minimum the following:

- the audit report will state the purpose of the report and its intended use,

- The audit report will state which/whose generally accepted accounting standards have been applied and indicate the effect of any deviations from those standards.

- The audit report will state that the audit was conducted in accordance with either ISA or INTOSAI audit standards.

- The audit opinion will cover the current period.

- The audit opinion will state whether or not the financial statements present fairly for the project that the funds were utilized for the purposes defined by the funding agreements.

- The audit opinion will cover in all material respects the supporting schedules (e.g. procurement, assets register etc).

- The auditor should provide an opinion on whether the auditee complied with applicable laws, regulations and the Procurement procedures and other provisions of the funding agreements that have a direct and material financial effect on the financial report.

- The auditor should provide an opinion on the effectiveness of internal control over compliance with requirements that could have a direct and material financial effect on the financial statements as well as internal control over financial reporting.

Supervision Plan

16. The overall rating for the project is Substantial and it is envisaged that FM supervision missions would be required on a semi-annual basis or as determined by ongoing risk assessment and supervision results. To minimize costs the missions would be planned to coincide with financial management supervision of other projects in Timor-Leste.

Annex 8: Procurement Arrangements

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

A. General

1. As currently planned, the project would be financed by IDA through a grant of US$1.0 million and by AusAID through a grant of AUD21.9 million (US$19.3 million equivalent). The grant from AusAID would be administered by the Bank, and the Bank's policies shall apply. The Ministry of Health (MOH) of the Government of Timor-Leste (GOTL) will carry out procurement for the proposed project in accordance with the World Bank's *Guidelines: Procurement under IBRD Loans and IDA Credits* dated May 2004, and revised in October 2006; and *Guidelines: Selection and Employment of Consultants by World Bank Borrowers* dated May 2004, and revised in October 2006, and the provisions stipulated in the Financing Agreement. For procurement through National Competitive Bidding, the provisions outlined in the Attachment to this Annex shall be applicable. This Annex describes the general description of various items under different expenditure categories. The Procurement Plan provides detailed description of contracts to be financed by the Grant during the first year of the Project, the different procurement methods or consultant selection methods, estimated costs, prior review requirements, and time frame for such procurement, based on agreement between GOTL and the Bank project team. MOH will update the Procurement Plan at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

2. **Procurement of Works**: Works procured under this project would include: rehabilitation or extension of existing Community Health Centers (CHCs) or Health Posts, construction of housing for medical staff (on the grounds of the clinic), and installation of incinerators at CHCs. As currently defined, the Bank does not anticipate any International Competitive Bidding (ICB) for civil works under the Project and, depending on the estimated value of the contract, procurement would be carried out either through National Competitive Bidding (NCB) or through Shopping (see Section F). The total estimated cost of civil works in the first 12 months of the Project is US$300,000, with total civil works expenditure not expected to exceed US$1.5 million.

3. **Procurement of Goods**: Goods procured under this project would include: vehicles (trucks, cars, motorcycles, and bicycles), medical equipment, medical supplies and commodities, information technology hardware and software, communications equipment. Depending on the estimated value of the contract, procurement of goods and equipment would be carried out through International Competitive Bidding (ICB), National Competitive Bidding (NCB) or through Shopping (see Section F). In addition, MOH may procure vehicles (trucks, cars, and possibly motorcycles) from the United Nations Inter-Agency Procurement Services Office (IAPSO). Although no ICB for equipment is anticipated in the first 12-month procurement plan, ICB is retained as an option for future procurements of goods. The total estimated cost of goods to be procured during the first year is US$650,000, and the total goods to be procured during the life of the project not expected to exceed US$3.0 million.

4. **Selection of Consulting Services - Firms:** The project shall finance (i) "twinning" arrangements between hospitals and training/research institutions in nearby countries, in order to build capacity, improve quality of service delivery, and strengthen vital support functions; (ii) appointment of local and international nongovernmental organizations for the provision of community and clinical health and nutrition services; (iii) contracts with local and international NGOs, research or training institutions, or consulting firms -- in partnership with health districts, hospitals, or other health services providers or national organizations -- for the provision of

technical assistance, evaluation, or other services in support of innovative activities under component 4; (iv) contracts with local and international NGOs, research or training institutions, or consulting firms for health sector surveys, beneficiary assessments, or other evaluation activities; (v) "contracting out" of some core support services for the MOH, including support ICT network maintenance; and (vi) consultancy contracts with UN Agencies for provision of technical assistance to MOH.

5. Specific "twinning" activities would include a "twinning" arrangement between the Institute of Health Sciences (IHS) and a regional training and/or research institution to strengthen IHS capacity and expand programs offerings; "twinning" with hospital(s) in the region to improve management and quality of care at Guido Valadarez National Hospital (GVNH) in Dili and also at the five regional hospitals. Selection of the IHS "twinning" arrangement and any other "twinning" arrangement estimated to cost more than US$200,000 shall be through Quality Based Selection (QBS). For other "twinning" contract arrangements, selection of the partner institutions may be through Selection based on the Consultants' Qualification (CQS) method if the estimated cost is US$200,000 or less. Under exceptional circumstances and with the prior concurrence of the Bank, Single Source Selection may also be used to extend existing, successful partnership programs with international organizations or NGOs. This may include provision of technical support for biomedical equipment maintenance, or strengthening laboratory and pharmacy services at the GVNH hospital and regional hospitals.

6. Subject to Bank's prior approval, MOH may use Single Source Selection (SSS) with local and international nongovernmental organizations for the provision of community and clinical health and nutrition services, or support for innovative activities, if the partner institution: (i) is already active and successful in providing these services in a given health district for over two years; and (ii) has its accounts regularly audited. Otherwise, NGO contracts for supporting community nutrition/health services will be selected based on Consultants' Qualifications (CQS).

7. The size of contracts of other consultants that would provide core support services is expected to be less than US$200,000 each and they may be selected through Consultants' Qualifications.

8. With respect to consultancy contract for UN agencies, the Project may contract with WHO to provide technical assistance to the MOH in key areas consistent with WHO's comparative advantage, including support for the HMIS, and rollout of the BSP and HSP. In addition, the MOH may choose to enter into contracts with other UN agencies for provision of specific technical services, including for implementation support and evaluation of pilot activities. If the criteria outlined in paragraph 3.10 of the Consultant Guidelines can be met, with the prior concurrence of the Bank, these contracts may be awarded through Single-Source Selection and their total value is not expected to exceed $1.2 million.

9. **Selection of Consulting Services -Individuals:** The project will finance both long- and short-term individual consultancies to support capacity building, policy advice and analysis, and line implementation responsibilities for the MOH. This will include financing long-term international advisors in key positions (such as financial management, procurement, nutrition, support for district health services), and other individual consultants, both local and international. These individual consultants shall be selected through a comparison of qualifications of at least three qualified consultants among those who have expressed interest in the assignments or have been approached directly by MOH. In addition, with appropriate justifications, individual consultants may be selected on sole-source basis in exceptional circumstances, such as: tasks that are continuation of previous work that the consultants have carried out and for which the

consultants were selected competitively; assignments lasting less than six months; and when the individual consultant is the only consultant qualified for the assignment.

10. **Procurement Documents**: For procurement of works and goods through ICB, MOH shall use the Bank's latest Standard Bidding Documents (SBDs), while for procurement through NCB, National SBDs, satisfactory to the Bank shall be used. For procurement through Shopping, simplified documents agreed with the Bank may be used. For selection of consulting firms, MOH shall use the Bank's latest Standard Request for Proposals. The Bank's *Standard Bid Evaluation Form: Procurement of Goods and Works* shall be used for preparation of evaluation reports for procurement of works and goods procured through ICB and NCB. In the case of evaluation of proposals from consulting firms, the Bank's *Sample Form of Evaluation Report: Selection of Consultants* shall be used. The Bank's standard documents are available on the Bank's Internet.

11. **Scholarships:** The project will finance overseas scholarships for Timorese, for short-term study as well as degree programs in priority areas identified in the updated Health Workforce Plan of the Ministry of Health. Candidates for overseas study will be chosen through a transparent selection process organized by the Department of Human Resources of the MOH. The proposed annual training plan will be submitted to Bank for approval, as part of the annual planning process. Training included in the approved training plan will not require further approvals from Bank. The training plan may be amended with Bank approval, but no training shall be financed by the Project outside of the plan.

B. Assessment of the agency's capacity to implement procurement

12. Procurement Unit in the National Directorate of Administration, Logistics and Procurement (DALP) in the Ministry for Health, with support from the Department for Partnership Management (DPM), will carry out procurement activities under the Project. MOH will recruit a senior advisor and a locally recruited Desk Officer to support implementation of the Project by the DIC. The procurement function is carried out by two staff in the Procurement and Logistics Division of DALP. Both staff have received preliminary training on World Bank Procurement. MOH has previously hired a Procurement Advisor financed under an EC Grant. The Advisor departed in June, however, and MOH is recruiting a replacement of this Advisor to support implementation ongoing EC grants as well as this Project. The Advisor would be financed by the EC Grant through June 2008, and subsequently by the Project. SAMES has recruited an internationally qualified procurement advisor (who arrived in October 2007) to assist in strengthening capacity for procurement of pharmaceutical equipment and supplies, and will also be available to support MOH procurement as needed.

13. EAPCO carried out an assessment of the capacity of MOH to implement procurement actions for the project in June 2006 and February 2007. The assessment reviewed the organizational structure for implementing the project and the interaction between the project's staff responsible for procurement and the Ministry's relevant central unit for administration and finance. Most of the issues/ risks concerning the procurement component for implementation of the project have been identified and focus on low capacity of MOH generally, and the procurement unit in particular, to carry out procurement following World Bank's procurement policies and procedures, which has caused significant delays in implementation of Bank funded projects at the MOH. The corrective measure which has been discussed is the recruitment of a Procurement Advisor with international experience in World Bank Procurement, who will provide assistance in procurement for Project financed and government financed procurement, as well as provide training staff in the procurement unit in the MOH.

14. The overall project risk for procurement is ***'HIGH'***.

C. Procurement Plan

15. MOH developed a procurement plan for project implementation which provides the basis for the procurement methods. It will be available in the project's database and in the Bank's external website once it is finalized and approved by the Bank. The Procurement Plan will be updated by MOH annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. Such revised Procurement Plans shall be submitted to the Bank for its approval.

D. Frequency of Procurement Supervision

16. In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended an annual procurement supervision to visit the field to carry out post review of procurement actions. Even though the procurement risks are "high", such annual review is considered appropriate considering the low volume of contract that would be subject to post review. Approximately, 20 percent of the contracts awarded shall be post reviewed on a sample basis.

E. Details of the Procurement Arrangements Involving International Competition

1. Goods, Works, and Non Consulting Services

(a) List of contract packages to be procured following ICB and direct contracting in the first 18 months of the Project: None

2. Consulting Services

(a) List of consulting assignments for the first 18 months with short-list of international firms.

1	2	3	4	5	6
Ref. No.	**Description of Assignment**	**Estimated Cost**	**Selection Method**	**Review by Bank (Prior / Post)**	**Expected Proposals Submission Date**
1	WHO technical assistance to MOH	$350,000	SSS	Prior	January 2, 2008
2	"Twinning" for IHS	$200,000	QBS	Prior	February 1,2008
3	"Twinning" for GVNH pharmacy/ Laboratory	$100,000	CQS	Prior	March 1, 2008
4	Support for Commissioning and management of regional hospitals	$100,000	CQS	Prior	March 15, 2008
5	NGO contracts for community nutrition activities (for NGOs already active in the district)	$50,000 (per district/ contract)	SSS	Prior	February 15, 2008

6	NGO contracts for community nutrition activities (for NGOs not active in community nutrition in district)	$50,000 (per district/ contract)	CQS	Post	June 1, 2008

(b) Consultancy services estimated to cost above US$100,000 per contract and single source selection of consultants (firms) will be subject to prior review by the Bank.

F. Bank Prior Review Thresholds

Goods, Works and Non-Consulting Services

No.	**Procurement Method**	**Procurement Method Ceiling**	**Prior Review Threshold**
1.	ICB (Goods)	≥ US$150,000	All
2.	ICB (Works)	≥ US$500,000	All
3.	NCB (Goods)	< US$150,000	1st contract
4.	NCB (Works)	< US$500,000	1st contract
5.	Shopping	< US$50,000	None
6.	Direct Contracting	If justified	All

Consulting Firm

No.	**Selection Method**	**Selection Method Ceiling**	**Prior Review Threshold**
1.	QCBS, QBS, FBS, LCS	No Limit	US$100,000
2.	CQS	< US$200,000	US$100,000
3.	SSS		All

Individual Consultant

No.	**Procurement Method**	**Prior Review Threshold**
1.	Competitive	Only TORs on selective basis. Contracts identified in procurement plan
2.	Sole Source	Only TORs on selective basis. Contracts identified in procurement plan

ICB: International Competitive Bidding
LIB: Limited International Bidding
NCB: National Competitive Bidding

QCBS: Quality and Cost Based Selection
QBS: Quality Based Selection
FBS: Fixed Budget Selection
LCS Least-Cost Selection
CQS: Consultant Qualification Selection
SSS: Single Source Selection

Annex 8
Attachment

National Competitive Bidding Procedures

1. The following provisions shall apply in respect of contracts for goods and works financed out of the proceeds of the Grant and procured according to National Competitive Bidding procedures ("NCB"):

2. Eligibility

The eligibility of bidders shall be as defined under Section I of the Association's Guidelines for Procurement under IBRD Loans and IDA Credits, published by the Association in May 2004 and revised in October 2006; accordingly, no bidder or potential bidder should be declared ineligible for contracts financed by the Association for reasons other than the ones provided by Section I of the Guidelines.

3. Bidders participation

(a) No eligibility restrictions based on nationality of bidder or origin of goods shall apply; therefore, foreign bidders shall be allowed to participate in NCB without restriction.

(b) No limitations shall be imposed on any bidder as to the number of tenders in which he may participate during a given period of time.

(c) Prior registration, obtaining a license or an agreement shall not be a requirement for any bidder to participate in bidding procedures.

4. Advertising, Time for Bid Preparation

Potential bidders shall be allowed adequate time to prepare bids which should not be less than thirty (30) days, except for commodities and small goods contracts.

5. Standard Bidding Documents

Standard Bidding Documents, acceptable to the Association, should be used.

6. Bid Security

Bid security shall not be required for all procurement and shall be capped to a reasonable percentage of the amount of the contract in order not to hinder competition; when required, it shall be in the form of a bank guarantee from a reputable bank.

7. Qualification Criteria and Evaluation Criteria

Qualification criteria shall be clearly specified in the bidding documents, and all criteria so specified, and only criteria so specified, shall be used to determine whether a bidder is qualified. The evaluation of the bidder's qualifications should be conducted separately from the technical and commercial evaluation of the bid.

8. Bid Opening, Evaluation and Award of Contract

Bids shall be opened immediately after the stipulated deadline for submission of bids. Bids received after the deadline for bid submission shall be rejected and returned to the bidders unopened.

(a) Evaluation of bids shall be made in strict adherence to the criteria that shall be clearly specified in the bidding documents and quantified in monetary terms for evaluation criteria other than price; merit points shall not be used in bid evaluation.

(b) A contract shall be awarded to the technically responsive bid that offers the lowest evaluated price and no negotiations shall be permitted.

(c) Bidders shall not be eliminated from detailed evaluation on the basis of minor, non-substantial deviations.

(d) No bidder shall be rejected on the basis of a comparison with the employer's estimate and budget ceiling without the Association's prior concurrence.

9. Preferences

No domestic preference shall be given for domestic bidders and for domestically manufactured goods.

10. Rejection of all bids and re-bidding

All bids shall not be rejected or new bids solicited without the Association's prior written concurrence.

11. Publication of the Award of Contract

Publication of the contract award should include: (a) name of each bidder who submitted a bid; (b) bid prices as read out at bid opening; (c) name and evaluated price of each bid, (d) name of bidders whose bids were rejected; and (e) name of the winning bidder; upon request, the Recipient shall inform unsuccessful bidders of the reasons of their rejection.

12. Complaints by Bidders and Handling of Complaints

The Recipient shall establish an effective and independent protest mechanism allowing bidders to protest and to have their protests handled in a timely manner.

13. Fraud and Corruption

The Association shall declare a firm or individual ineligible, either indefinitely or for a stated period, to be awarded a contract financed by the Association, if it at any time determines that the firm or individual has, directly or through an agent, engaged in corrupt, fraudulent, collusive, or coercive practices in competing for, or in executing, a contract financed by the Association.

14. Right to Inspect/Audit

Each bidding document and contract financed from the proceeds of the Grant shall provide that bidders, suppliers and contractors shall permit the Association, at its request, to inspect their accounts and records relating to the bid submission and performance of the contract and to have said accounts and records audited by auditors appointed by the Association.

Annex 9: Economic and Financial Analysis

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

A. ECONOMIC ANALYSIS OF INVESTMENTS IN HEALTH SERVICES

(i) Benefits of improved primary health care

1. *Basic package of primary health care services*: In a low capacity environment, Timor-Leste has reestablished basic health infrastructure and improved health outcomes, though the latter still remain of concern. The proposed investments under the Health Sector Strategic Plan Support Project (henceforth 'the Project') that support the Government's Health Sector Strategic Plan (HSSP) will address continued improvement in outcomes by addressing the quality and increased utilization of basic health services. Such investments also have a strong economic rationale, as discussed below.

2. *Description of the basic package*: Through transfer of resources and technical assistance from development partners, the proposed Project supports the Government's 'Basic Service Package' (BSP) which targets the health MDGs. The BSP includes interventions to reduce child and maternal mortality, and the spread of prevalent infectious diseases such as HIV/AIDS, STIs, Tuberculosis, and Malaria. The package includes community-level mobilization which is required for preventive education and communication. The HSSP involves a resource commitment from the Medium Term Expenditure Framework for the Health Sector that will ensure that target levels of coverage for the BSP are achieved, and the known issues of inadequate access and disparities in service utilization are addressed. The Joint Donor involvement under the proposed Project focuses on plugging the capacity and resource gaps in the implementation of the HSSP under the MTEF resource envelope.

3. *Spending on the BSP meets public finance criteria*: The financing of the overall BSP from Government revenues meets three public finance criteria. One, the benefits from the vaccination and prevention programs – given wide enough coverage to tackle the entire at-risk population – confers benefits on society rather than the individual by preventing the spread of disease. Two, the Timor-Leste population faces a situation of low health information, especially for women, who make many of the health and nutrition decisions for the household. In this situation, increased community-level mobilization and preventive communication to create behavior change and promote healthy practices has a strong public finance rationale. Three, outcomes, as well as access to and utilization of healthcare services remain inequitable, especially in rural areas[14] and for households with less educated mothers[15]. This means that subsidized basic health services should be provided on equity grounds.

4. *Improved basic/primary health care services are necessary for health outcomes*: There is evidence from international comparative studies that indicates a strong association between primary health care and population health outcomes[16]. An increasingly healthy society across demographic categories is a basic prerequisite for productive and motivated workers, and for reducing social disparities.

---

[14] The IMR and U5MR in rural areas were 95 and 136 respectively, compared to 65 and 89 for urban areas (Timor-Leste MICS, 2002). While 83.4% of children 12-23 months in urban areas received BCG vaccination, the proportions in both rural (center) and rural (east) were 77.1% (Timor-Leste DHS, 2003).

[15] IMR and U5MR for children of mothers with no education were 89 and 119 respectively, compared to 77 and 93 for those whose mothers had completed primary education (Timor-Leste DHS, 2003).

[16] Starfield, B. 1991. Primary Care and Health: A Cross-National Comparison. *Journal of the American Medical Association.* 266:2268-71; Starfield, B. 1994. Is Primary Care Essential? *Lancet* 344:1129-33.

(ii) **Benefits of improved hospital and referral health care**

5. *Hospital package of services*: The Government's Health Sector Strategic Plan (HSSP) intends on improving the healthcare services provided to the population from hospitals and referral services. This involves improving consultation and procedures in the areas of obstetrics and gynecology, neonatal and pediatrics, internal medicine, trauma and surgery, etc., as well as diagnostic and auxiliary services. The MOH in Timor-Leste has already made some substantial investments in hospitals, and the future program will see further infrastructure constructed as well as definition of the institutional roles of the planned hospitals. The investments in the hospital package of services (HSP) also focus on improvements in the equipment at existing facilities, improved access to basic operational supplies, and the monitoring and assurance of quality of care through the entire health system.

6. *Synergy of the HSP with the BSP*: The increased attention paid to the primary health care system should stabilize the referral rate to the hospital and upper-level facilities, reducing the overall load on the referral health care system as extra capacity is added. In parallel, the investments in hospital development and increased efficiency throughout the referral system should provide both better quality of care and higher cure rates without major increases in the cost per admission[17]. The HSSP intention is to achieve this while ensuring that a balance between hospital and primary health care expenditures is maintained at some predetermined threshold[18].

7. *Development and deployment of Timor-Leste health workforce*: Timor-Leste suffered a loss of trained medical professionals during the events of separation from Indonesia and subsequent internal disorder. With recent expansion of the health facility infrastructure and hiring, in general, the country has an adequate number of nurses and allied health-workers[19]. Timor-Leste had till recently only 17 Timorese medical doctors across the health system, of which only 58.8% worked in a permanent capacity for the MOH[20]. A dependence on foreign doctors – about 300 Cuban physicians – has been budgeted for till the return of Timorese doctors from training abroad (potentially by the end of this Project's period in 2012). At that point, the deployment of doctors can be rationalized across districts and facilities as per need, and as per the HSP. In time, an adequately incentivized salary package for health care workers across the public system will need to be designed to ensure that quality of the BSP and HSP are maintained.

(iii) **Benefit analysis**

8. There are well-known problems in quantifying the benefits of health system programs: for example, problems in directly relating the reduction in adverse health outcomes to investments in support services (Component 2 from Section II.D above), or in coordination and monitoring (Component 3 from Section II.D), which are both essential for the smooth and sustainable functioning of the BSP and the HSP components in this Project. Given that benefits to health outcomes will derive from success across all three components, there is an attribution problem that complicates traditional benefit-cost analysis, Therefore, in the analysis below only benefits are computed, and it is assumed that these flow from some scenarios of effectiveness across the entire project. No formal benefit-cost ratios are presented.

[17] The proposed target for improved hospital efficiency is to cap the recurrent cost per admission at US$252 by 2012 (currently US$258), as per the MTEF Indicators & Targets (MTEF for the Health Sector, p. 27).
[18] This threshold is set at <40%, i.e. the percentage of recurrent expenditure on hospital care across the system should be less than half of MoH spending (Ibid. p. 27).
[19] With the exception of midwives, where more may need to be recruited - see Timor-Leste Health Sector Review, p. 84-86 (Draft, The World Bank, October 2006).
[20] As per the MOH personnel database, March 2005.

9. Further, there is the problem of choosing a metric for benefits at the population level for health system improvement programs. The choice of Disability Adjusted Life Years (DALYs) as a measure suggests itself since there is an existing literature on using these for the cost-effectiveness analysis of health programs. However, the measurement of DALYs lost due to cause is difficult, and while estimates exist for a single year (2002) for Timor-Leste, they cannot be taken as authoritative. As a result, the results below in terms of benefits should be taken as indicative. In the analysis below, two scenarios of Project effectiveness are defined associated with differing percentage reduction levels in age-standardized DALYs by cause in Timor-Leste (Table 2) above and beyond what is projected to be achieved in the absence of the Project (i.e., the current baseline).

10. In the absence of repeat measurements of DALYs, it is difficult to establish the baseline rate at which Timor-Leste is reducing these. Instead, Table 1 provides a snapshot of achievements in recent years on some of the health MDGs, on tuberculosis coverage and treatment success, and on the prevalence of some common childhood ailments. The changes are calculated based on the available measurements (which may have a wide margin of error). For the indicators available over multiple years (IMR, U5MR) the reduction across two years, 2003-05, ranges between 13-26%. In contrast, there is a decline in success with tuberculosis detection and treatment. There is no assumed correlation between improvements in MDG outcomes and DALYs. Viewing Table 1 as purely indicative, a very generous assumption of baseline improvements in DALYs by cause is of a 5% reduction from current rates in 2007, in the absence of the Project. It is assumed that the baseline rate of reduction would slacken without further improvement in health services.

Table 1: Recent trends in outcomes and service delivery in Timor-Leste

Indicator					**Change**			
	2002	**2003**	**2004**	**2005**	**02-03**	**03-04**	**04-05**	**03-05**
Infant Mortality Rate per 1000		60	64	52		*6.7%*	-18.8%	-13.3%
U5 Mortality Rate per 1000		83	80	61		-3.6%	-23.8%	-26.5%
Tuberculosis: DOTS case detection rate (%)		49.6	45.7	43.7		*-7.9%*	*-4.4%*	*-11.9%*
Tuberculosis: DOTS treatment success (%)		81	80			*-1.2%*		
Prevalence of ARI among U5 children (%)	14.1	14			-0.7%			
Prevalence of fever among U5 children (%)	27	29.8			*10.4%*			
Prevalence of diarrhea among U5 children (%)	25.4	10.1			-60.2%			

Inimical changes are highlighted with italics. Sources: MICS 2002, DHS 2003, WHO 2007

11. Table 2 below reports two scenarios of Project effectiveness in reducing the DALYs by source over the four years 2008-12, beyond the schedule of slackening baseline reductions. Under the 'pessimistic' scenario, by 2012 the investments in support of the Project reduce DALYs for communicable, maternal, perinatal and nutritional conditions by an additional total reduction of 15%, for noncommunicable diseases by 5%, and for injuries by 10%.

Table 2: Scenarios of effectiveness in reducing DALYs per 100,000 by end of the Project period

	Age-standardized estimated DALYs per 100,000 by cause (2002)*	**Baseline** (2-5%** per year across CD, NCD, INJ)	**Pessimistic**: 15% CD, 5% NCD, 10% INJ	**Optimistic**: 25% CD, 8% NCD, 15% INJ
Communicable, maternal, perinatal and nutritional conditions (CD)	11,805	10,234	8,699	7,675
Noncommunicable diseases (NCD)	6,783	5,880	5,586	5,410
Injuries (INJ)	2,289	1,984	1,786	1,687

* Source: WHO Global burden of disease database 2007, values for Timor-Leste
** 5% in the first year, 4% in the second year, 3% in the third year, and 2% in the fourth year.

12. *Assumptions*: The DALYs averted per 100,000 are expanded to give a population-wide figure using a projected Timorese population of 1.2 million by 2012. Each DALY is valued at the current Timor-Leste per capita income figure, approximately US$ 750. This is as per recent methods of valuing DALYs[21]. The cost per DALY averted is calculated with the assumed total Project cost of US$20 million. The results are displayed in Table 3 and 4 below. Given the fact these are only the direct benefits[22], the analysis is conservative.

Table 3: Scenarios and approximate benefit-cost ratios for HSSP-SP Project

Effectiveness	**Benefit (US $mn.)**
Pessimistic	$18.3
Optimistic	$30

Source: World Bank staff calculations.

Table 4: Cost per DALY averted

Pessimistic	$822
Optimistic	$501

Table 5: Sensitivity analysis: Benefit (US $ million) under different valuations of a DALY

Scenario	DALY valued at $850	DALY valued at $1000
Pessimistic	20.6	24.3
Optimistic	34	40

13. *Analysis*: Even under conservative calculations, the project delivers large benefits, which rise if moderately optimistic assumptions are made on program effectiveness and the valuation of an age-standardized DALY. Given that the Timorese per capita income will grow rapidly in coming years with increased petroleum revenues, the values as in Table 5 may be justified. The cost per DALY averted are comparable to per capita income. The results of the benefit and cost per DALY analysis in this section are for indicative purposes. The Project also has a strong public finance rationale.

[21] See Ch.4. "Cost of Pollution in China – Economic Estimates of Physical Damages" where DALYs are valued at the local per capita GDP of a city.

[22] The indirect benefits of reduced referral rates, improved productivity of the Timorese workforce, greater efficiencies and quality in service delivery, etc., are not quantifiable.

B. SUSTAINABILITY ANALYSIS

(i) Macroeconomic and fiscal situation

14. The key recent development in the Timorese economy is the exploitation of under surface natural resources, specifically petroleum and natural gas. The total petroleum revenues amounted to US$1.4 billion on June 30, 2007, with approximately US$100 million in new revenues each month[23]. These petroleum revenues require careful management such that Timorese national priorities are addressed. The funds are currently deposited in a Petroleum Fund managed by the Banking and Payments Authority. These funds are invested such that the real dollar value of the petroleum earnings can be sustained in the long term, while the interest income from the Petroleum Fund and taxation revenue of petroleum extraction operations pass to the Government Budget. About US$ 300 million is sustainably available for the Budget per annum.

15. *Budget execution and institutional capacity*: Despite abundant revenues, in recent years the Government in Dili has struggled to spend the funds at its disposal due to weak capacity and cumbersome, over-centralized systems. By the end of the third quarter of FY 2006-7, only US$81 million had been spent from a Central Government Budget of US$ 320 million. As in the health sector as or any other, increasing Government capacity to execute its budget is necessary to achieve the fruits of greater resources available to the country.

(ii) Recent trends in health care sector financing

16. *Government health financing vs. other sources of financing*: Out-of-pocket expenditures for households remain low for visits to government facilities, and government facilities are substantially cheaper than the private facilities as per the DHS 2003[24]. However, the data has several discrepancies, for example when compared to the Timor-Leste LSMS data on household expenditure. It can still be claimed that population dependence on Government public health spending remains significant (79% of spending from all sources in 2004) given trends in affordability of and access to other sources of health care. The recent social and economic disruptions in mid 2006 (when a substantial proportion of the coffee crop was lost) have impacted household incomes severely in a country where a majority of the population still derives incomes from the non-petroleum sector. With half the population under 18, and the 15-19 age group suffering unemployment up to 58%[25], the support of subsidized Government health services is necessary for the medium term till the economy and livelihoods recover.

17. *Recent trends in public health expenditures*: Public health expenditures here include those funded from the Government's own budget (i.e., the MOH budget) and the funding from bilateral and multilateral development partners in the form of off-budget grants. The spending in 2005-06 (estimated actual) and 2006-07 (budget estimates) peak compared to other years in the constant prices comparison from Fig. 1 below. This is because of higher off-budget support from development partners in these years. Figure 2 provides a snapshot of the same indicator as a percentage of total Government budget spending per capita. In both figures, the projected spending in 2007/08 and 2008/09 seems to have reduced, but this is because (i) the data includes only 'confirmed' funding support from development partners as known at this time; and (ii) the current MTEF underestimates likely State Budget allocations for health for 2008 and onwards. Therefore, the future spending may be higher, even at constant prices, as funding levels firm up. The data indicates significant levels of funding for health in the country, as compared to other countries in the

[23] Social and Economic Development Brief on Timor-Leste, The World Bank, August 2007
[24] Table 4-3 in the Timor-Leste Health Sector Review, The World Bank (draft, October 2006)
[25] Social and Economic Development Brief on Timor-Leste, The World Bank, August 2007

region. The MoH is one of the better departments in execution of its budgets, but implementing any larger expenditure increases would significantly tax its capacity.

Fig. 1: Public health expenditure in Timor-Leste – all sources, constant prices

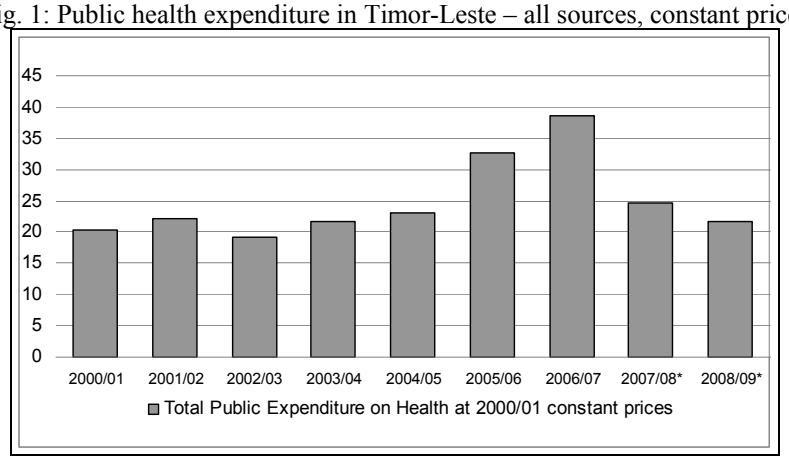
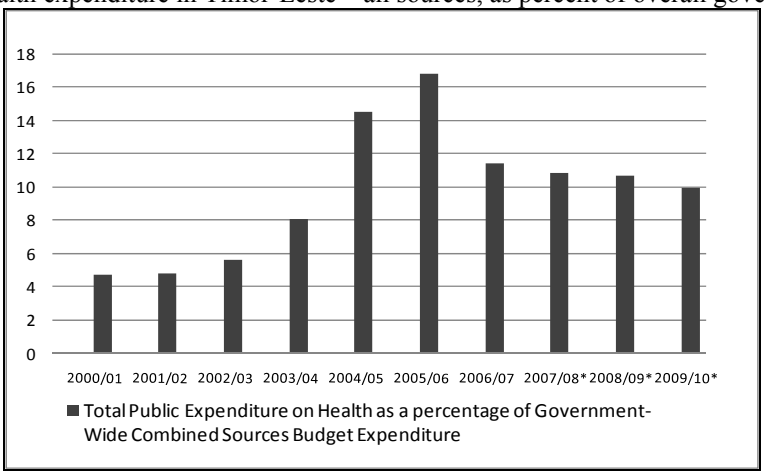


Fig. 2: Public health expenditure in Timor-Leste – all sources, as percent of overall government spending



Source (Fig.1 & 2): Timor-Leste Health Sector Review (World Bank 2006)

Table 7: Current burden of recurrent vs. other spending in MOH expenditures

	2004/05	**2005/06**	**2006/07**
	Actual	Estimated Actual	Budget Estimates
Recurrent Expenses	**93.6%**	**71.8%**	**60.8%**
(i) Salary and Wages	28.8%	21.5%	15.0%
(ii) Goods and Services	60.0%	46.5%	40.8%
(iii) Minor Capital Expenses	4.8%	3.9%	5.0%
Capital Development Expenses (Infrastructure)	**6.4%**	**28.2%**	**39.2%**

Source: Timor-Leste Health Sector Review (World Bank 2006)

18. Table 7 indicates that in recent spending, the share of capital development expenditure has been rising as facilities were constructed or rehabilitated to account for the previous destruction of the country's infrastructure, and equipment was replaced. The MTEF expects that in the future the

infrastructure development costs will be rationalized[26] since the physical state of the health system is now broadly sufficient for coming needs under the HSSP, though incentives for the human capital in the health sector need attention. This implies that recurrent expenses may rise in the future, even if all recurrent expenses for the hospital sector are capped at below 40% of the MOH budget, while salaries specifically (districts and hospitals) will be capped at 30% of the overall recurring portion of the budget.

(iii) **Fiscal sustainability analysis**

19. The rise in the international price of oil in 2005 and 2006 and expanded production levels have raised the estimates of what is a sustainable level of on-budget expenditure across sectors. The health sector is a priority declared under the sector MTEF, but future availability of funds under the overall budget will be negotiated between the MOF and the MOH.

Table 8: Projected fiscal situation and the sustainability of health sector spending

	2007/08	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Total Budget Revenues	515.50	499.40	501.90	515.74	547.35
Petroleum %	77.6%	84.1%	85.7%	85.3%	85.9%
Donor sources %	12.5%	4.9%	2.7%	2.6%	2.0%
Taxes %	8.3%	9.2%	9.7%	10.1%	10.1%
Total Budget Expenditure	319.70	288.30	270.20	263.90	264.20
Fiscal Balance	195.80	211.10	231.70	251.84	283.14
Total Public Expenditure on Health*	42.92	40.16	35.35	38.33	41.19
Total Public Expenditure on Health as a percentage of Total Budget Revenues	8.3%	8.0%	7.0%	7.4%	7.5%
Total Public Expenditure on Health as a percentage of Total Budget Expenditure	13.4%	13.9%	13.1%	14.5%	15.6%

* Values from 2007/08 onwards are the proposed expenditures from the MTEF
Sources: Health MTEF (2006), World Bank calculations, Timor-Leste Health Sector Review (World Bank, 2006)

20. The HSSP-SP funding is in support the overall HSSP, and imposes very modest additional recurrent costs, and no major new infrastructure is expected to be financed by the Project. Therefore, the sustainability analysis can be performed entirely on the proposed expenditure on health as per the sectoral MTEF, which is in line with the Government's HSSP. Table 8 above projects the fiscal situation over the Project's timeline, and provides two indicators of sustainability: total public expenditure on health as a percentage of budget revenues (associated with the availability of funds, or the overall resource envelope); and as a percentage of budget expenditures (executability of funds in the MOH). Two major assumptions are used in the calculations for Table 8. First, funds from the petroleum sector (interest on the Petroleum Fund and taxes) will be available at modestly rising rates from the current levels (US$492 million in FY 2006, estimated). This schedule of funds starts at US$ 400 million for FY 2007, rising to US $470 million in FY 2011. Second, it is assumed that direct budget support from development partners will continue to drop, reaching zero in 2008-09 (as per current projections), and this will continue till 2011-12. The off-budget donor support in the health sector has been added – as per the estimates in the MTEF[27] – to get overall Government funds available. This underestimates Government funds available if off-budget donor support will be available in other sectors.

[26] The target proportion for physical investment within total capital expenditure is set at 30% in the MTEF.
[27] Medium Term Expenditure Framework, see Table 4, p. 44. (Ministry of Health, Timor-Leste, May 2007)

21. Table 8 indicates that the proposed spending under the HSSP are sustainable at the conservatively projected future revenues, both in terms of funds available and for executability in the MOH (given some development partner support in planning and prioritizing). Further discussion of executability is provided below under 'Institutional sustainability'.

(iv) **Institutional sustainability**

22. Implementation capacity remains an important constraint throughout the government and health system, and reliance on international technical advisors remains high. The program will seek to strengthen the likelihood of institutional sustainability through several approaches.

23. First, consolidating and strengthening approaches for capacity development, including (i) rationalization of the selection and oversight of technical assistance, and ensuring that TA contributes to building local capacity, and better linking TA to training of local staff; (ii) establishing innovative arrangements for capacity building, including twinning arrangements with institutions in nearby countries.

24. Second, making use of national policy, planning, budgeting, and reporting procedures to the extent possible, and avoiding the creation of parallel implementation units. Third, the program will support pilots of institutional innovations (demand- and health worker incentives, contracting out of services, etc.) that could be integrated into the national budget if proven successful. Fourth, coordinating with other institutional reform efforts at the national and sector levels (e.g., PFMCBP, CSP) to implement policy and institutional reforms that will improve budget execution and service delivery performance.

C. ALLOCATIVE EFFICIENCY OF PROPOSED INVESTMENTS

25. *Population groups*: The extension and improvement of primary health care services under the BSP supported by this Project is pro-poor, based on international experience with similar extension services as well as the proposed design of this investment. The HSSP as envisaged by the Timorese MOH uses the principle of equity that the population should have equal access to health services on the basis of need. The access to care and the utilization of essential services are both expected to improve among the underserved sections of the population. This is as per the stated objectives of the HSSP. The Project monitoring will track these objectives.

27. *Geographical coverage*: In recent years, there has been an attempt to move away from resource allocations to districts in an incremental fashion (which resulted in widely differing allocations by facility) towards an allocation based on the needs of the different facilities. This method will need to be adjusted for further considerations of providing adequate staff incentives, improve efficiency, and the changes in the needs of the various populations served by the facilities.

Annex 10: Safeguard Policy Issues

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

Environmental Impacts and Management

Civil Works

1. The Project will not finance major construction of new hospitals, but may support maintenance and rehabilitation, as well as building and/or rehabilitation of some health posts. As such, it is envisaged that civil works and the corresponding environmental impacts, if any, will be minimal and temporary, which will include noise, air emissions and generation of construction wastes. Procedures to address these impacts will be included in civil works contracts, where contractors will be required to formulate and implement proper housekeeping measures to address the issues. The HSSP-SP will also seek to strengthen planning, supervision, and maintenance of civil works, which will be primarily financed through the consolidated budget

Health Care Waste Characterization and Management

2. *Waste characterization*. A waste characterization in Timor-Leste health care facilities undertaken under the first Health Sector Rehabilitation and Development Project (HSRDP1) indicated that about 80% of the total waste generated by healthcare activities can be classified as general waste. The remaining 20% of the total waste can be classified as hazardous materials, with the majority (15%) considered as infectious or anatomic waste; about 3% chemical and pharmaceutical waste and 1% genotoxic and radioactive wastes. An analysis of the types of healthcare waste generated in Timor-Leste showed that genotoxic waste and radioactive wastes are not produced in the country.

3. *Health care waste management*. A Health Care Waste Management Plan was prepared during HSSP-SP preparation, and has been disclosed locally in Timor-Leste and through the World Bank's InfoShop. In the past, community health care centers and hospitals in Timor-Leste only burnt in the open or buried in the open health care wastes as a way of disposing them. Neither method is satisfactory as the waste could not be completely burnt and would produce highly toxic substances such as dioxins and furans or, if buried, could be dug up by animals and either way could remain toxic or dangerous for long periods. Some hospitals had been provided with diesel powered incinerators that were large, expensive to run and not appropriate to the needs of small rural facilities.

4. The alternative to disposal on site is collection and disposal at a central location. This however was not considered to be a practical solution in Timor-Leste, due to the bad state of the roads, the remote location of many health facilities, heavy rainfall during the rainy season and the relatively high cost of vehicles, fuel and maintenance.

5. What is therefore practical health care waste management at the community health care facilities is a small efficient incinerator (or gasifier) that could be easily managed, use locally available fuel, produce no toxic gases and reduce the waste to a small amount of harmless ash that could be safely disposed of by burial on the site.

6. Under HSRDP1, all community health care centers were equipped with clinical waste gasifiers to be used for the safe disposal of clinical wastes, 13 of which have been supplied under HSRDP1 or one per district. For the four hospitals being constructed under the second Health Sector Rehabilitation and Development Project (HSRDP2), similar but larger gasifiers were provided to these hospitals. The use of gasifiers in managing health care wastes will continue under the project.

7. The gasifiers are designed to operate using easily obtainable and cheap biomass fuels such as wood or coconut shells and they require no additional fuel such as diesel or gas or any electrical connections. The gasifiers have two chambers: the fuel and small bags of clinical waste are placed in alternating layers in the first of the chambers and when lit, the fuel in the lowest layer begins to convert to charcoal while the temperature rises rapidly to 900 degrees centigrade. As the hydrocarbons contained in the waste material, particularly fats and plastics, begin to volatilise, the temperature rises to 1000 degrees centigrade. These volatile gases pass through the hot charcoal where they further react to form hydrogen methane and carbon monoxide. These gases pass into the second chamber where a process of combustion converts them into benign carbon dioxide and water vapor which is discharged through a flue at the top. Meanwhile in the first chamber the process begins again with the second layer of fuel and the second bag of waste. Once the burning process is complete the gasifier is left to cool down and then the ash door is opened and the sterile ash can be removed.

8. The gasifier is easy to load and ignite and once lit requires no further attendance. The waste is reduced to small quantities of ash, toxic volatile substances are turned into harmless gases, sharps are reduced in size and strength and rendered safe to handle and the small quantities of ash can be safely buried. If managed properly there should be no visible smoke coming from the flue and no measurable hydrocarbons.

Asbestos Generation and Management

9. The main activities of the Project that could have implications for asbestos generation and management are the rehabilitation of some health posts and hospitals.

10. Asbestos is found in Timor-Leste mainly as part of a variety of asbestos-cement building materials. These are mainly corrugated roofing sheets and flat sheets that have been used for walling or ceiling panels. Samples of corrugated roofing sheets and flat sheets were taken to UK for testing during the implementation of HSRDP1 and roof sheets were found to contain white and brown asbestos and the flat sheets white asbestos only. These materials are considered safe if they are left in position and not damaged, cut or abraded.

11. In response to the need to reduce any potential health risks from asbestos resulting from reconstruction activities in Timor-Leste, the East Timor Transition Administration (ETTA) produced "Guidelines on Maintenance, Handling and Disposal of Asbestos Materials and Asbestos Waste" in September 2000, in cooperation with AusAid. This document contains: (i) guidelines on the maintenance of asbestos-cement products; (ii) guidelines on the handling of building rubble and other material containing asbestos; and (iii) guidance for the siting and management of asbestos disposal sites.

12. The project documentation will specify that all civil works activities will be in full compliance with the guidelines described above and all civil works contracts will provide for the safe handling and disposal of asbestos in accordance with the guidelines. These guidelines will be attached to the bidding documents as they were in the HSRDP1 and HSRDP2 bidding documents and the Project will ensure that the guidelines are followed wherever the contractors encounter any asbestos.

Institutional Arrangements

13. **Ministry of Health**. The MOH will ensure that all health posts and hospitals that will be supported under the project have their respective gasifiers (if not yet provided under HSRDP1 and HSRDP2) for managing health care wastes. Those that do not have the gasifiers either will be required to

purchase them charged against the project or will be required to bring their wastes to the nearest community health care facility or health post or hospital for treatment prior to disposal.

14. **Health Care Facility**. Each health care facility (health posts and hospitals) will ensure that civil works contracts will contain clause on good environmental practice and proper housekeeping measures, including adherence by the contractors to the "Guidelines on Maintenance, Handling and Disposal of Asbestos Materials and Asbestos Waste". The facility will ensure the proper management of health care wastes that will be generated through the use of gasifiers to treatment prior to final disposal.

Social Safeguards and Other Issues

15. The HSSP-SP will not bring any adverse social impacts to local communities, as this is a health sector project which seeks to improve community health services. No land acquisition and/or resettlement is likely to take place. Regarding social issues, one concern is to avoid the exclusion of vulnerable groups from Project benefits. The "vulnerable" include, among others, indigenous people, isolated people, the poor, women, and in Timor-Leste (as a post-conflict region), Internally Displaced Persons (IDPs). The Health Sector Strategy Plan (HSSP) has provided strategies targeted to the vulnerable groups, including improved coverage and access to health services for the poor, reaching remote and other vulnerable groups through appropriate location of health facilities and the strengthening of outreach services. With regard to gender equity, the HSSP calls for promoting gender mainstreaming in the MOH, improving awareness of gender issues throughout the health workforce and providing affirmative action opportunities for women. This will provide basic guidance for the project for safeguarding the inclusion of the vulnerable groups. Since gender influences of seeking behavior, decisions regarding family planning, and transmission of knowledge, the design of interventions should be informed by gender analysis, and the monitoring and evaluation system should allow disaggregated monitoring of key indicators according to gender where possible.

Land acquisition and relocation

16. The project will not be financing any large civil works. The work will be mostly rehabilitation or upgrading the existing health facilities. There is still a possibility to build new clinics or health centers, but it is confirmed that the new buildings will be built in government-owned lands or next to the clinics had been burned down previously. No land acquisition is anticipated in this project.

17. With respect to relocation, concern have been raised regarding the Internally Displaced Persons (IDP) camp on the grounds of the national hospital (GVNH, Dili), which is obstructing the contractor access to carry out the repair work (financing from the HSRDP2 and the HSRDP-EC Grant). The hospital administration and Ministry of Health have sought to relocate IDPs within the hospital grounds, in order to access in hospital buildings under renovations. The presence of IDPs on the grounds of the national hospital also poses a health and safety risk for hospital patients, IDPs, and hospital staff. While the government is seeking appropriate relocation options for all IDPs living in temporary camps, finding alternatives for IDPs on hospital grounds should be prioritized. Care will need to be taken with the relocation, in particular when this is not the preference of the IDPs themselves. If the relocation will take place, then the government will need to ensure that:

- Consultation regarding the relocation plan with all IDPs (or representatives) will be conducted, with separate meeting for women to ensure their voices are heard;
- Site selection and time for moving will be agreed among them; and
- The IDPs will not become worse-off (socially, economically and in relation to their security) in their new locations, and be assisted in restoring their livelihood.

Indigenous people (IP)

18. The project does not target IP specifically, but seeing IP as part of vulnerable people in general. Indigenous people, as part of vulnerable groups, can easily be adversely affected by development projects because of their special characteristics. This project should not negatively affect IP, but some conditions may cause them to be left out from the project. Most of IP occupy subordinate positions within local social structure. Some tribes rejected any modern systems, some have deeply hierarchical village structure, and their unique identities may exclude them from development planning process and benefit of the project. Therefore the project should be adaptive for specific condition where IPs are present, through:

- Involvement of NGOs who are familiar working with them to get useful way for effective consultation with the IP;
- Direct consultation with the IP about their opinion of the project, and to get their specific needs in terms of health programs to suit their culture;
- Improvement in information dissemination through better facilitation and local language material

19. It is likely that safeguarding indigenous people – who has specific characteristics as defined on the Bank's policy – is not an issue in this project, since the majority of Timor-Leste's population is considered indigenous. If necessary, further examination will be done through a Social Assessment to find out whether indigenous groups with distinct culture from the majority are present in Timor-Leste, and who need specific strategies to benefit from the project.

Other vulnerable groups

20. People who live in remote areas are often marginalized from development programs. In the health sector, their access to services is typically poor. The project, through component 1, will try to strengthen community health services, as well as outreach services in remote areas, and through component 4 will provide incentives to service providers, particularly to attract and retain key health personnel in remote/rural areas. It will be important to ensure the sustainability of the initiatives, for example, maintaining health posts or community health centers (according to their needs) and daily or routine presence of health personnel. Community-based strategies will need to adapt to the medical pluralism which usually exists widely in remote areas. Consultations with the community in isolated areas and other relevant stakeholders are required to know the real needs.

21. The ongoing social tensions in Timor-Leste initially resulted in an Internally Displaced Person (IDP) population estimated at 150,000; currently an estimated 70,000 are still living in IDP camps, although some reside there only temporarily. IDPs require health services and other until they feel safe to return and/or their houses are rebuilt: living in the temporary shelters with poor tents and inadequate clean water and sanitation can make them vulnerable to disease. While IDPs often are at risk being excluded from any development programs, MOH and NGOs have organized mobile clinics and other health services that reach most of the IDP camps. At appraisal, financing for health services to IDP camps was considered adequate, with MOH suggesting a shift toward provision of community services-based to encourage IDPs to return home. In the case of further unrest or emergence of financing gaps for IDPs, the project will consider their vulnerabilities intervention design and to ensure their inclusion in program benefits.

Social Assessment

22. As proposed by the Safeguard Review Meeting, a Social Assessment will be carried prior to or soon after Project effectiveness, to ensure that no group of community will be marginalized from project benefits. The Social Assessment will review the needs of indigenous people, people who live in remote

areas, the poor and women are some of the groups of community who are vulnerable of being marginalized from any development initiatives, as well as Internally Displaced Persons (IDPs). The SA will further examine which groups are considered to be vulnerable and why they are vulnerable, and will propose strategies to ensure their inclusion in the whole cycle of the project. The SA will also propose measures to empower stakeholders (government, NGOs, beneficiaries/vulnerable groups, and others) through their participation in the project design and implementation. Gender issues, perception and beliefs regarding health and disease and issues related to "medical pluralism" will also be covered in the SA.

23. In 2005, as part of a broader Health Sector Review in Timor-Leste, the study of "Health Service Delivery and Utilization in Timor-Leste: A Qualitative Study" was undertaken, which addressed two themes: i) health seeking behavior and especially the determinants of low levels of utilization of health care; and ii) human resources issues, including factors affecting health workers' job motivation, satisfaction and performance. The study provides a qualitative description regarding reasons of the low demand to health services, which will inform the Social Assessment as well as strategies for promoting community demand to health services. In addition, AusAID is financing a Health Seeking Behavior Study, which is expected to be completed in 2008 and will provide further analysis of these issues.

24. Through this project, the government is interested in piloting innovative mechanisms to generate increased demand for key services, such as strengthening health promotion and community participation and increasing demand for health services, and public private partnership. Whatever mechanisms to be applied, like Conditional Cash Transfer (CCT), Public Private Partnership or others, the project should ensure that they will not marginalize the vulnerable groups. For instance, CCT will work effectively if health facilities are distributed equally in all regions and/or people in particular the poorest are used to such modern and formal health facilities. If not, then the program may not benefit the poorest or those in remote areas. Public-Private partnerships will seek to lower the cost of health services for the poor, but the quality and cost of these services will need to be monitored during implementation.

25. The findings of the SA will become main inputs to the project design in dealing with the vulnerable groups to meet the project objectives.

Annex 11: Project Preparation and Supervision

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

	Planned	Actual
	Planned	Actual
PCN review	01/30/2007	02/12/2007
Initial PID to PIC		03/29/2007
Initial ISDS to PIC		08/30/2007
Appraisal	09/11/2007	09/11/2007
Negotiations	10/01/2007	11/05/2007
Board/RVP approval	12/13/2007	
Planned date of effectiveness	01/15/2008	
Planned date of mid-term review	01/15/2010	
Planned closing date	06/30/2013	

Key institutions responsible for preparation of the project: Ministry of Health

World Bank and AusAID staff and consultants who worked on the project included:

Name	Title	Unit
Timothy Johnston	Sr. Health Specialist/ Team Leader	EASHD
Natasha Beschorner	Senior ICT Policy Specialist	CITPO
Rosario Aristorenas	Program Assistant	EASHD
Junxue Chu	Sr. Finance Officer	LOAFC
Kishor Uprety	Sr. Counsel	LEGES
Roch Levesque	Sr. Counsel	LEGES
Nurul Alam	Sr. Procurement Specialist	EAPCO
Bisma Husen	Procurement Specialist	EAPCO
David Michael Chandler	Sr. Financial Management Specialist	EAPCO
Olivio Euclides Dos Santos	Team Assistant	EACDF
Joao Jose Augusto Gomes	Operations Officer	EACDF
Cristiano Costa e Silva Nunes	Procurement Specialist	EAPCO
Josefo Tuyor	Environmental Specialist	EASRE
Ninin Dewey	Social Development Specialist	EASIS
Isono Sadako	Social Development Specialist	EASIS
Christopher Scarf	Hospital Management / Consultant	Consultant
Nigel Wakeham	Architect/ Consultant	Consultant
AusAID Team		
Natalie McKelleher/ Colin Wiltshire	Policy Officer (Canberra)	ETB
Dan Heldon	Country Program Manager (Canberra)	ETB

David Hook	First Secretary, Development (Dili)	
Armandina Amaral	Program Officer (Dili)	
Jim Tulloch	Principal Health Adviser (Canberra)	AG
Chris Hoban	Principal Adviser Operations	AG
Jonathan Hampshire	Project Design Specialist	Consultant/AusAID
Mark Minford	Project Design Specialist	Consultant/AusAID
Ross Naylor	Public Health Specialist	Consultant/AusAID

Bank funds expended to date on project preparation:

1. Bank resources: $44,035
2. Trust funds: 0
3. Total: $44,035

Estimated Approval and Supervision costs:

1. Remaining costs to approval: $20,965
2. Estimated annual supervision cost: $140,000

Annex 12: Documents in the Project File

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

AusAID, *Timor-Leste: Health Sector Resilience and Performance in a Time of Instability,* AusAID, 2007

AusAID, Country Strategy for Timor-Leste

AusAID, *Australian Government's Overseas Aid Program* ("White Paper"), 2006.

Demographic and Health Survey (2003),

Ministry of Health (2007), *Basic Service Package for Primary Health Care and Hospitals: Achieving the MDGs by Improved Service Delivery.*

Ministry of Health (2007), *Health Sector Strategic Plan*, Timor-Leste, September 2007

Ministry of Health (2007), *Medium Term Expenditure Framework*, Timor-Leste, May 2007.

International Monetary Fund (2005). "Article IV Consultation with the Democratic Republic of Timor-Leste." Public Information Notice, July 20, 2005.

Planning Commission Dili (May 2002). *East Timor National Development Plan*.

The United Nations World Food Programme. VAM Unit. Food Insecurity and Vulnerability Analysis (Timor-Leste - April 2005).

UNICEF (2003). "Multiple Indicator Cluster Survey (MICS - 2002)." Prepared for the Government of the Republic of Timor-Leste, May 2003.

World Bank (2007), *Timor-Leste Health Sector Review: Meeting Health Challenges and Improving Health Outcomes*, World Bank (Washington, DC) and Ministry of Health (Timor-Leste), June 2007.

World Bank (2006). "Background Paper for the Timor-Leste and Development Partners Meeting," 3-4 April, 2006.

World Bank (2005). "Country Assistance Strategy for Timor-Leste FY06-08."

World Bank (2005). "Joint Staff Advisory Note on the Poverty Reduction Strategy Paper, Volume 1." EASPR, April 29, 2005.

World Bank (2005). *World Development Report 2006: The Case for Equity.*

World Bank (2006). *World Development Report 2007: Development and the Next Generation*

World Bank (2003). "Timor-Leste, Poverty in a New Nation: Analysis for Action," May 2003.

World Bank (2000). *World Development Report 2000/2001: Attacking Poverty.*

Annex 13: Statement of Loans and Credits

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

			Original Amount in US$ Millions						Difference between expected and actual disbursements	
Project ID	FY	Purpose	IBRD	IDA	SF	GEF	Cancel.	Undisb.	Orig.	Frm. Rev'd
P092484	2006	Planning & Fin Mgt Capacity Building	0.00	0.00	0.00	0.00	0.00	6.55	-0.71	0.00
P087801	2005	TP-POWER SECTOR PRIORITY INVESTMENTS	0.00	0.00	1.39	0.00	0.00	0.26	1.39	0.00
P079320	2004	TP-Third Agric.Rehabilitation Proj.	0.00	0.00	3.00	0.00	0.00	0.43	3.00	0.00
P072654	2002	TP-Small Enterprises Project II	0.00	0.00	7.50	0.00	0.00	1.93	7.50	7.50
P072648	2001	TP-2ND HEALTH SECTOR REHAB	0.00	0.00	12.60	0.00	0.00	2.15	12.60	11.67
		Total:	0.00	0.00	24.49	0.00	0.00	11.32	23.78	19.17

TIMOR-LESTE
STATEMENT OF IFC's
Held and Disbursed Portfolio
In Millions of US Dollars

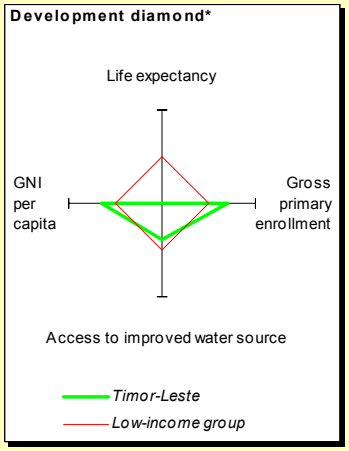
		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
	Total portfolio:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

		Approvals Pending Commitment			
FY Approval	Company	Loan	Equity	Quasi	Partic.
	Total pending commitment:	0.00	0.00	0.00	0.00

Annex 14: Country at a Glance

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

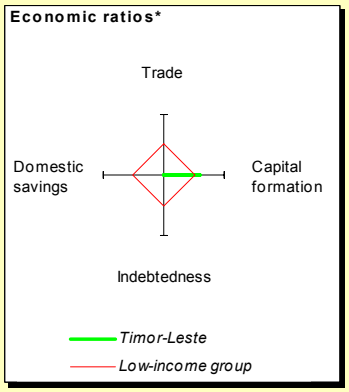
POVERTY and SOCIAL	Timor-Leste	East Asia & Pacific	Low-income
2005			
Population, mid-year *(millions)*	0.98	1,885	2,353
GNI per capita *(Atlas method, US$)*	750	1,627	580
GNI *(Atlas method, US$ billions)*	0.73	3,067	1,364
Average annual growth, 1999-05			
Population *(%)*	3.7	0.9	1.9
Labor force *(%)*	6.6	1.3	2.3
Most recent estimate (latest year available, 1999-05)			
Poverty *(% of population below national poverty line)*	..	..	..
Urban population *(% of total population)*	27	41	30
Life expectancy at birth *(years)*	..	70	59
Infant mortality *(per 1,000 live births)*	64	29	80
Child malnutrition *(% of children under 5)*	46	15	39
Access to an improved water source *(% of population)*	58	79	75
Literacy *(% of population age 15+)*	..	91	62
Gross primary enrollment *(% of school-age population)*	146	115	104
Male	..	116	110
Female	..	114	99



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

	1985	1995	2004	2005
GDP *(US$ billions)*	..	..	0.34	0.35
Gross capital formation/GDP	..	..	28.5	32.0
Exports of goods and services/GDP	..	..	..	..
Gross domestic savings/GDP	..	..	-12.8	..
Gross national savings/GDP	..	..	123.5	6.0
Current account balance/GDP	..	..	35.2	42.7
Interest payments/GDP	..	..	..	..
Total debt/GDP	..	..	..	..
Total debt service/exports	..	..	..	..
Present value of debt/GDP	..	..	..	..
Present value of debt/exports	..	..	..	..

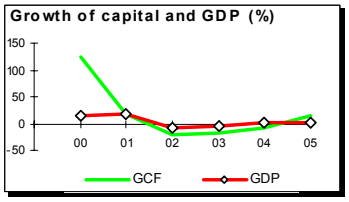
	1985-95	1995-05	2004	2005	2005-09
(average annual growth)					
GDP	..	1.5	0.4	1.8	4.3
GDP per capita	..	-2.4	-4.8	-3.5	1.1
Exports of goods and services	..	..	..	..	..



STRUCTURE of the ECONOMY

	1985	1995	2004	2005
(% of GDP)				
Agriculture	..	..	31.7	..
Industry	..	..	14.9	..
Manufacturing	..	..	3.7	..
Services	..	..	53.7	..
Household final consumption expenditure	..	..	61.5	..
General gov't final consumption expenditure	..	..	51.3	..
Imports of goods and services	..	..	..	..

	1985-95	1995-05	2004	2005
(average annual growth)				
Agriculture	..	2.5	10.1	..
Industry	..	-2.8	2.0	..
Manufacturing	..	7.3	1.8	..
Services	..	4.1	-2.3	..
Household final consumption expenditure	..	-5.1	3.7	..
General gov't final consumption expenditure	..	22.3	-10.4	..
Gross capital formation	..	2.4	-8.5	14.3
Imports of goods and services	..	..	..	..



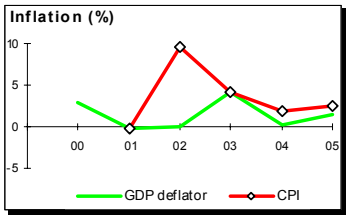
Note: 2005 data are preliminary estimates.

This table was produced from the Development Economics LDB database.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

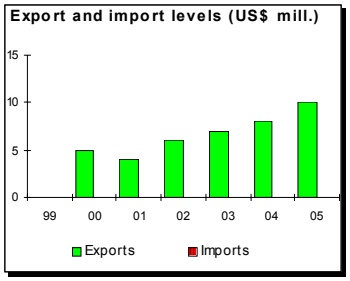
PRICES and GOVERNMENT FINANCE

	1985	1995	2004	2005
Domestic prices				
(% change)				
Consumer prices	..	..	1.8	2.5
Implicit GDP deflator	..	..	0.3	1.4
Government finance				
(% of GDP, includes current grants)				
Current revenue	..	..	91.0	58.3
Current budget balance	..	..	71.4	37.3
Overall surplus/deficit	..	..	69.0	27.5



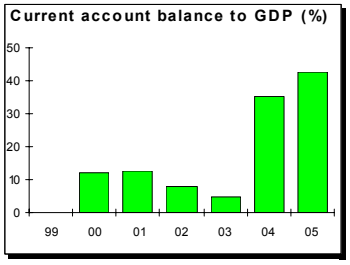
TRADE

	1985	1995	2004	2005
(US$ millions)				
Total exports (fob)	..	..	8	10
Commodity 1	..	..	7	8
Commodity 2	..	..	..	..
Manufactures	..	..	..	..
Total imports (cif)	..	..	-202	-241
Food	..	..	..	..
Fuel and energy	..	..	..	..
Capital goods	..	..	..	..
Export price index *(2000=100)*	..	..	..	..
Import price index *(2000=100)*	..	..	..	..
Terms of trade *(2000=100)*	..	..	..	..



BALANCE of PAYMENTS

	1985	1995	2004	2005
(US$ millions)				
Exports of goods and services	..	..	..	..
Imports of goods and services	..	..	..	..
Resource balance	..	..	-228	-231
Net income	..	..	30	54
Net current transfers	..	..	317	326
Current account balance	..	..	119	149
Financing items (net)	..	..	3	67
Changes in net reserves	..	..	-122	-216
Memo:				
Reserves including gold *(US$ millions)*	..	..	..	..
Conversion rate *(DEC, local/US$)*	..	..	1.0	1.0



EXTERNAL DEBT and RESOURCE FLOWS

	1985	1995	2004	2005
(US$ millions)				
Total debt outstanding and disbursed	..	..	..	..
IBRD	..	..	..	..
IDA	..	..	..	..
Total debt service	..	..	..	..
IBRD	..	..	..	..
IDA	..	..	..	..
Composition of net resource flows				
Official grants	..	..	..	..
Official creditors	..	..	..	..
Private creditors	..	..	..	..
Foreign direct investment (net inflows)	..	..	..	..
Portfolio equity (net inflows)	..	..	..	..
World Bank program				
Commitments	..	..	..	..
Disbursements	..	..	..	..
Principal repayments	..	..	..	..
Net flows	..	..	..	..
Interest payments	..	..	..	..
Net transfers	..	..	..	..

Note: This table was produced from the Development Economics LDB database. 8/13/06

Annex 15: Maps

TIMOR-LESTE: HEALTH SECTOR STRATEGIC PLAN SUPPORT PROJECT

IBRD 33496