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The World Bank

Report No: ICR0000971

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(TF-29888 TF-51363)

ON

GRANTS

IN THE AMOUNT OF US$12.6 MILLION (TF-29888) AND

EURO 16.2 MILLION (TF-51363)

TO

TIMOR-LESTE

FOR A

SECOND HEALTH SECTOR REHABILITATION AND DEVELOPMENT PROJECT

February 12, 2009

Health, Nutrition and Population
Human Development Sector Unit
East Asia and Pacific Region

CURRENCY EQUIVALENTS

Currency Unit = US Dollar
US$1.00 = US$1.00

FISCAL YEAR

July 1 – June 30

ABBREVIATIONS AND ACRONYMS

AusAID	Australian Agency for International Development	INTEFET	International Force for Timor-Leste
BSP	Basic Service Package	MDTF	Multi-donor Trust Fund
CFET	Consolidated Fund for Timor-Leste	MOH	Ministry of Health
CHC	Community Health Center	MOPF	Ministry of Planning and Finance
DHS1	Division of Health Services	MOU	Memorandum of Understanding
DHS2	Demographic and Health Survey	MTEF	Medium-Term Expenditure Framework
DPs	Development Partners	MTR	Mid-Term Review
EC	European Commission	NGO	Non-governmental Organization
ECHO	European Commission Humanitarian Office	PAD	Project Appraisal Document
GDP	Gross Domestic Product	PDO	Project Development Objective
GoTL	Government of Timor-Leste	PMU	Project Management Unit
GVNH	Guido Valadarez National Hospital	RACs	Royal Australian College of Physicians
HMIS	Health Management Information System	SAMES	Servico Autonomo de Medicamentos e Equipmentos de Saude
HSP	Hospital Strategic Plan	TB	Tuberculosis
HSRDP I	Health Sector Rehabilitation and Development Project	TF	Trust Fund
HSRDP II	Second Health Sector and Rehabilitation Development Project	TFET	Trust Fund for Timor-Leste
HSSP-SP	Health Sector Strategic Plan Support Project	TFR	Total Fertility Rate
ICR	Implementation Completion and Results Report	TLSLS	Timor-Leste Standards of Living Survey
IDA	International Development Association	UN	United Nations
IDP	Internally Displaced Persons	UNICEF	United Nations Children's Fund
IHA	Interim Health Authority	WHO	World Health Organization

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TIMOR-LESTE
Second Health Sector Rehabilitation and Development Project

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MAP IBRD 33496

A. Basic Information

Country:	Timor-Leste	Project Name:	Second Health Sector Rehabilitation and Development Project
Project ID:	P072648	L/C/TF Number(s):	TF-29888,TF-51363
ICR Date:	02/24/2009	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	E. TIMOR
Original Total Commitment:	USD 12.6M	Disbursed Amount:	USD 12.6M
Environmental Category: C			
Implementing Agencies: Ministry of Health			
Cofinanciers and Other External Partners:			

B. Key Dates

Process	Date	Process	Original Date	Revised / Actual Date(s)
Concept Review:		Effectiveness:	12/03/2001	12/03/2001
Appraisal:	04/16/2001	Restructuring(s):		
Approval:	06/29/2001	Mid-term Review:		
		Closing:	03/31/2004	07/31/2008

C. Ratings Summary

C.1 Performance Rating by ICR

Outcomes:	Moderately Satisfactory
Risk to Development Outcome:	Moderate
Bank Performance:	Moderately Satisfactory
Borrower Performance:	Moderately Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)

Bank	Ratings	Borrower	Ratings
Quality at Entry:	Moderately Satisfactory	Government:	Moderately Satisfactory
Quality of Supervision:	Moderately Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	Moderately Satisfactory	**Overall Borrower Performance:**	Moderately Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators

Implementation Performance	Indicators	QAG Assessments (if any)	Rating
Potential Problem Project	Yes	Quality at Entry	None

at any time (Yes/No):		(QEA):	
Problem Project at any time (Yes/No):	No	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Moderately Satisfactory		

D. Sector and Theme Codes		
	Original	Actual
Sector Code (as % of total Bank financing)		
Central government administration	15	15
Health	85	85

Theme Code (Primary/Secondary)		
Conflict prevention and post-conflict reconstruction	Secondary	Primary
Health system performance	Primary	Primary
Other communicable diseases	Secondary	Secondary
Participation and civic engagement	Secondary	Secondary
Population and reproductive health	Secondary	Secondary

E. Bank Staff		
Positions	At ICR	At Approval
Vice President:	James W. Adams	Jemal-ud-din Kassum
Country Director:	Kanthan Shankar	Klaus Rohland
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Project Team Leader:	Timothy A. Johnston	Ian P. Morris
ICR Team Leader:	Timothy A. Johnston	
ICR Primary Author:	Betty Hanan	
	Peter F. B. A. Lafere	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)
The overall objective of the health program is to rehabilitate and develop a cost-effective and financially sustainable health system in East Timor to be responsive to the immediate basic health needs of the population and, within a well integrated and sustainable policy framework, to prepare the health system to meet future needs.

The project has three components:

Component 1: Support On-going Service Delivery, will assist continued service delivery through the provision of (a) technical assistance to the new district health management teams in the development and implementation of the district health plans, and by drawing on the support of the specialized technical agencies, and (b) pharmaceuticals to health facilities, including hospitals. The component ensures basic services, selected high priority activities, pharmaceuticals and essential hospital care.

Component 2: Improve the Range and Quality of Services, and Develop and Implement Supporting Systems, will support improvements in the quality of services with a) particular emphasis on standardizing and enhancing the quality of delivery of the basic package of services; b) strengthening referral systems and a rational hospital plan. through assistance to the rehabilitation/reconstruction, refurbishing and equipping of hospitals, an urban commuity health center, the Central Medical Laboratory and communications and transport and c) technical assistance to the building up of supporting systems such as laboratory services, and pharmaceuticals and medical supply systems.

Component 3: Develop and Implement Health Sector Policy and Management Systems, will support policy development, including conducting a Demographic and Health Survey, and capacity building for policy formulation, promulgation and implementation . An important subcomponent will relate to development and implementation of a Human Resource Management Strategy, including training. Systems management will be strengthened by the development of a health and management information system, by the re-establishment of administrative infrastructure and processes at central and district level, and by management training and capacity building. The component also provides for audits. It will also support the Health Program Management Unit's running costs, including training for East Timorese staff in financial management and procurement.

Donor assistance to the health sector will be coordinated, as in the first project, within an overall framework, or sector wide program.

Revised Project Development Objectives (as approved by original approving authority)
PDO was not revised.

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Percentage of children under one year of age immunized in each district (a) DPT3 - (b) Measles (a) DPT3 - (b) Measles			
Value quantitative or Qualitative)	20% in each district	50% in each district -- original target in PAD for 6/30/03		(a) 70% (b) 63%

Date achieved	06/01/2001	06/30/2003		12/31/2007
Comments (incl. % achievement)	The baseline coverage was estimated. Actual 2007 values above are from HMIS data. Comparison of 2001 and 2007 household survey data (TLSLS) show marked improvements in coverage, from 25% to 74% for DPT3, and from 18% to 65% for measles.			
Indicator 2 :	Percentage of births with skilled attendance: (a) Nationality (b) in each district (for lowest coverage district)			
Value quantitative or Qualitative)	(a) 20% (note: baselines were overestimated) (b) 4%	(a) 35% (b) 20% (lowest district)		(a) 37.3% (b) 61.4% (highest district, 15% lowest)
Date achieved	06/01/2001	06/30/2003		12/31/2007
Comments (incl. % achievement)	The highest percentage coverage is in Manatuto District. The lowest is 15.2% in Ainaro District. Skilled attendance was not measured in 2001 TLSLS, but was found to be 41% in 2007 TLSLS (which is comparable to HMIS data).			
Indicator 3 :	Percentage of population with access to: (a) basic health services within two hours from home (b) in-patient services within two hours from a source of basic health services			
Value quantitative or Qualitative)	(a) 60% (b) 40%	(a) 95% (B) 80%		(a) n.a. (b) n.a.
Date achieved	06/30/2001	06/30/2003		12/31/2007
Comments (incl. % achievement)	The percentage of population with access within two hours is no longer collected by the MOH because it was deemed unreliable. However, the TLSLS (2007) puts the travel time to the nearest clinic at 54 minutes one way on average nationally.			
Indicator 4 :	Number of outpatient visits per person per year at each health facility.			
Value quantitative or Qualitative)	1	2.5		1.9
Date achieved	06/30/2001	06/30/2002		12/31/2007
Comments (incl. % achievement)	Baseline data were overestimated, and the original target of 2.5 OPD was probably overoptimistic. "Cleaning" of HMIS data in 2006 resulted in downward revision of OPD data, but utilization clearly increased during the project.			
Indicator 5 :	Percentage of health facilities reporting no stock outs of essential drugs lasting more than two weeks in the previous quarter.			
Value quantitative or Qualitative)	60%	90%		87% at SAMES, N.A. at facility level
Date achieved	06/01/2001	03/30/2003		12/31/2007
Comments (incl. % achievement)	While essential drug stock data for SAMES central warehouse has been regularly monitored, MOH has not yet put in place a system to regularly monitor drug availability at facility level. A facility-level survey is underway.			
Indicator 6 :	Draft health sector policy paper discussed with stakeholders			
Value		Health Policy		Health Policy

quantitative or Qualitative)		Completed by June 2002		Completed by June 2002
Date achieved		06/30/2002		06/30/2002
Comments (incl. % achievement)	The MOH subsequently completed in 2007 a Health Sector Strategic Plan, which is being updated by the new government.			
Indicator 7 :	Revised pharmaceuticals regulations: (a) Draft prepared (b) Regulations issued			
Value quantitative or Qualitative)	NA	(a) Draft prepared by June 2002 (b) Regulations issued by June 2003		(a) Draft prepared by June 2002 (b) Regulations issued by June 2003
Date achieved	06/30/2001	06/30/2003		06/30/2003
Comments (incl. % achievement)	Updating of the essential drug list and standard treatment guidelines is currently underway.			
Indicator 8 :	Human resource management and development plan adopted			
Value quantitative or Qualitative)	N.A.	HR Strategy Adopted by June 2002		HR Strategy Adopted by June 2002
Date achieved	06/03/2002	06/30/2002		06/30/2002
Comments (incl. % achievement)	HR strategy was updated in 2008 to reflect changing HR situation, including arrival of 300 Cuban doctors and sending 600 Timorese for medical training in Cuba.			

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	N/A			
Value (quantitative or Qualitative)				
Date achieved				
Comments (incl. % achievement)				

G. Ratings of Project Performance in ISRs

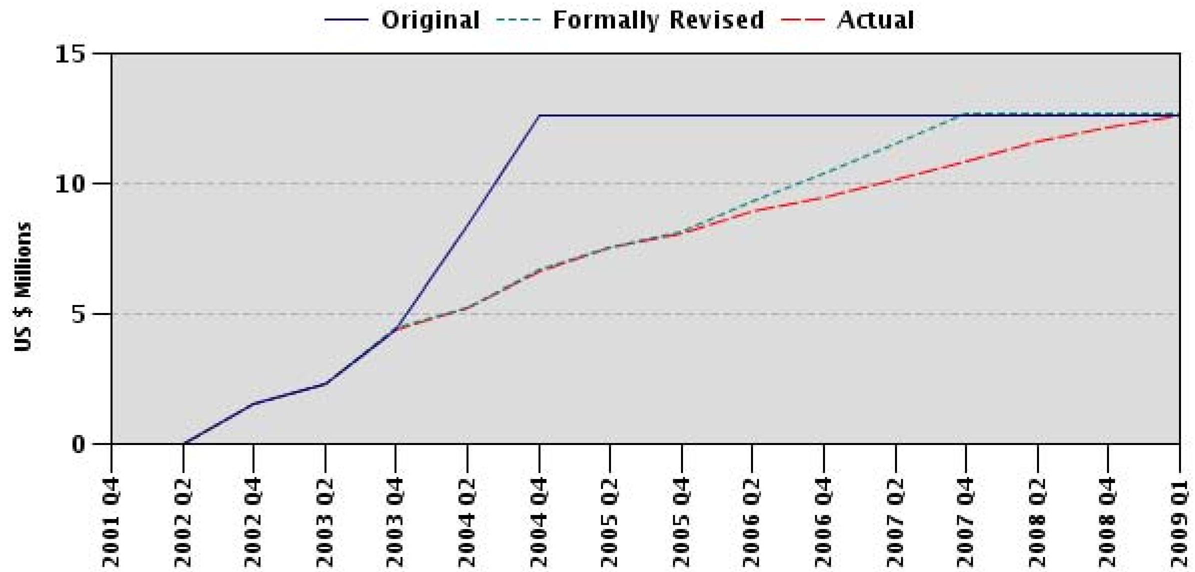
No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	12/27/2001	Satisfactory	Satisfactory	0.00

2	06/25/2002	Satisfactory	Satisfactory	1.51
3	12/19/2002	Satisfactory	Satisfactory	2.15
4	05/14/2003	Satisfactory	Satisfactory	3.46
5	06/30/2003	Satisfactory	Satisfactory	4.42
6	06/30/2003	Satisfactory	Satisfactory	4.42
7	12/15/2003	Satisfactory	Satisfactory	5.23
8	03/26/2004	Satisfactory	Satisfactory	5.74
9	12/23/2004	Satisfactory	Satisfactory	7.51
10	06/02/2005	Satisfactory	Satisfactory	7.88
11	12/20/2005	Satisfactory	Satisfactory	8.96
12	12/22/2006	Satisfactory	Moderately Satisfactory	10.17
13	06/20/2007	Satisfactory	Satisfactory	10.86
14	04/18/2008	Moderately Satisfactory	Moderately Satisfactory	12.05

H. Restructuring (if any)

Not Applicable

I. Disbursement Profile



1. Project Context, Development Objectives and Design

The **Second Health Sector Rehabilitation and Development Project (HSRDP II) was approved on June 29, 2001 and launched in August 2001.** The project constituted the second phase of a multi-donor program. It aimed to restore health service provision after the country's violent separation from Indonesia and the resulting collapse of state structures, widespread destruction of infrastructure and institutions, and disruption of livelihoods. The Project was financed by the multi-donor Trust Fund for Timor-Leste (TFET)[1] administered by the World Bank (TF-029888 for US$12.6 million) and an EC Trust Fund (TF-051363 for Euro 16.17 million, US$20.36 million equivalent).

1.1 Context at Appraisal

Timor-Leste was one of the poorest provinces in Indonesia at the time of its separation under United Nations Administration in 1999. In the violence that followed the 1999 referendum for independence, about 75 percent of health infrastructure was destroyed or badly damaged, two thirds of the population was displaced, and virtually all middle- and higher-level civil servants (mostly Indonesians), including health managers and doctors, left the country. Timor-Leste had a rapid and peaceful political transition, however, and did not go through a prolonged civil war as many other post-conflict countries. Many NGOs that had arrived to provide rapid intervention and services left the country following the initial post-conflict phase; those that remained were assigned to each district by the Interim Health Authority (IHA) to manage and deliver health services.

In 1999, the under-five mortality rate was 105 per 1000 and average life expectancy at birth 54 years. By 2003 infant and child mortality rates estimates had improved, but they were still high -- 60 and 83 per thousand live births respectively (DHS 2003). Data from a 2002 survey showed that 56 percent of children under the age of five had experienced some form of illness in the two weeks preceding the survey, with malaria, acute respiratory infections, and diarrhea being the leading diseases in this age group (MICS 2002).

The Grant for the first Health Sector Rehabilitation and Development Project (HSRDP I) became effective in July 2000. It had two broad objectives: (i) to facilitate in the short-term access to basic healthcare services in the aftermath of conflict, and (b) to build the foundations for the development of health policies and a system appropriate to the new country for the medium-term. In addition to supporting reconstruction of basic health infrastructure, HSRDP I sought to strengthen district capacity by supporting a transition from reliance on international NGOs to establishment of district health teams led by Timorese. The outcome of HSRDP I was rated Satisfactory by the ICR of June 27, 2005.

[1] TFET was a multi-donor Trust Fund (MDTF) established in 1999 with grant funds from 12 bilateral donors, the European Commission, and the World Bank to support reconstruction and development of Timor-Leste. The World Bank serves as the Trustee. HSRDP I and II were established as 'child' accounts under the 'parent' MDTF.

Until the discovery of oil and the establishment of the petroleum fund in 2005, the general expectation by the government and the international community was that Timor-Leste would remain a resource-poor and cash-strapped country for many years.

1.2 Original Project Development Objectives (PDO) and Key Indicators

The overall objective of the health program was to rehabilitate and develop a cost-effective and financially sustainable health system in Timor-Leste, responsive to the immediate basic health needs of the population and, within an integrated and sustainable policy framework, to prepare the health system to meet future needs.

The PAD listed the following key performance indictors for the health program over the next two years of implementation. They included several indicators established for the HSRDP I -- in some cases refined -- as well as indicators of progress under the HSRDP II. The baseline indicators were estimates, pending completion of the 2001 Timor-Leste Standards of Living Survey (TLSLS) and the subsequent Demographic and Health Survey (DHS2) in 2003. However, when these surveys were undertaken, neither the baseline nor targets were changed. The indicators and targets were:

		June 01	June 02	June 03
1.	Children under 1 year immunized (in each district) more than:			
	(a) DPT3	20%	30%	50%
	(b) Measles	20%	30%	50%
2.	Births with skilled attendance at birth more than:			
	(a) nationally	20%	25%	35%
	(b) in each district	4%	10%	20%
3.	Population with access to:			
	(a) basic health services within 2 hours from home more than:	60%	90%	95%
	(b) inpatient services within two hours from a source of basic Health services more than:	40%	70%	80%
4.	Health facilities in district health plans appropriately utilized: Number of outpatient visits per capita per annum more than:	1	2	2.5
5.	Health facilities reporting no stock outs of essential drugs lasting more than 2 weeks in the previous quarter	60%	90%	90%

6. Draft health sector policy paper discussed with stakeholders and completed by June 2002

7. Revised regulations on pharmaceuticals:
(a) draft prepared by June 2002
(b) regulations issued by June 2003

8. Human resource management and development plan adopted by June 2002.

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification

The PDO was not revised, nor were the indicators. The original closing date of the Grant was March 31, 2004. The project implementation period was known to be insufficient at the time of appraisal, but the Grant could not be extended until an extension of the "parent" trust fund was approved (see below). Both the TFET and the EC Grants were extended several times (see 1.7 for details). While the initial indicator targets (for June 2003) were clearly optimistic, the targets were not formally updated when the Grants were extended.

1.4 Main Beneficiaries

The restoration of health services and the development of a sustainable, efficient and accessible health system were to benefit the entire population of Timor-Leste (787,000 in 2001). Women of reproductive age (15 to 49), and children under 5, who represented 23 percent and 15 percent of the population respectively, were to benefit significantly from maternity care and child health (immunization and IMCI).

1.5 Original Components

The project had three components:[2]

Component 1: Support On-going Service Delivery (US$8.73 million) through the provision of: (a) technical assistance to the new district health management teams in the development and implementation of the district health plans, and by drawing on the support of the specialized technical agencies, and (b) pharmaceuticals for hospitals and other health facilities.

Component 2: Improve the Range and Quality of Services, and Develop and Implement Supporting Systems (US$19.50 million) through: (a) standardizing and enhancing the quality of delivery of the basic service package (BSP); (b) strengthening referral systems and establishing a rational hospital plan through assistance to the rehabilitation/reconstruction, refurbishing and equipping of hospitals, the Central Medical Laboratory, and communications and transport; and (c) provision of technical assistance to help build supporting systems, such as laboratory services, and pharmaceuticals and medical supply systems.

Component 3: Develop and Implement Health Sector Policy and Management Systems (US$4.23 million) to support policy development, including conducting a Demographic and Health Survey (DHS2)[3], and capacity building for policy formulation, promulgation and implementation. An important sub-component was to develop and implement a Human Resource Management Strategy, including extensive training for

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[2] Amounts per component relate to both grants. The amounts included in the PAD were revised at the time of the signing of the EC Grant Agreement.

[3] In this document, DHS1 is the Division of Health Services and DHS2 is the Demographic Health Survey.

Timorese in a wide range of professions, including nursing, midwifery, public health, pharmacy, health policy, etc. Systems management was to be strengthened by: (i) development of a Health and Management Information System (HMIS); (ii) re-establishing the administrative infrastructure and processes at central and district levels; and (iii) management training and capacity building, including through provision of technical assistance. The component also financed audits, and the Health Project Management Unit's (PMU) running costs, including staff training in financial management and procurement. As in the HSRDP I, donor assistance to the health sector was coordinated within the framework of an overall sector-wide program.

Because HSRDP I focused primarily on rehabilitating Community Health Centers (CHCs) and health posts, an important emphasis of the HSRDP II was secondary health care. The MOH adopted a hospital rationalization strategy, in which the Guido Valadarez National Hospital (GVNH) in Dili was designated the national referral hospital to be supported by five regional hospitals. The Dili, Maubisse, Oecussi and Maliana hospitals were prioritized for rehabilitation by the Project. The government agreed to provide $2.5 million in cofinancing for GVNH, as well as to finance construction/rehabilitation of the other two regional hospitals (Bacau and Suai) using the designs developed for the project, with supervision from the Project Management Unit (PMU). Significant attention was given during appraisal to ensure that hospitals were efficiently designed and that the number of beds and staff could be sustained within the projected government budget. In addition, to ensure adequate funding for primary care, MOH agreed to allocate no more than 40 percent of its annual recurrent budget to hospitals.

While it was recognized that the construction of hospitals under Component 1 would take more than two years to construct, the extension of the TFET "parent" fund had not yet been approved at the time of HSRDP II approval. Thus the closing date for HSRDP II could not be beyond the closing date for TFET. While it was understood by the Government (GoTL) and DPs that the Grant closing date would be extended as soon as the overall TFET extension was approved, this was never noted in the PAD.

1.6 Revised Components

Components were not revised.

1.7 Other significant changes

The Project Development Objectives (PDOs) and components did not change. However, the original implementation timetable proved ambitious. The scale, emphasis, and timing of individual activities within the components also evolved in response to technical assistance under the project, which suggested an increasing emphasis in some areas, including: (i) development and implementation of the district health plans, and (ii) strengthening capacity of the Servico Autonomo de Medicamentos e Equipamentos de Saude (SAMES). While hospital design and construction encountered considerable delays, the extensions enabled completion of construction of the four hospitals, contracting and delivery of some medical equipment, and additional training and capacity building activities.

However, due to problems with the procurement of medical equipment, the extensions did not allow time for contracting and delivery of about US$2 million worth of medical equipment before the closing dates. Instead, that Bank reached an agreement with GoTL that US$2 million originally programmed for hospital equipment under the project would be used to finance additional works at GVNH, and that the GoTL budget would finance the remaining hospital equipment (see more details later in the ICR).

Closing Date Extensions. The closing date for the Grant under the Trust Fund for Timor-Leste administered by the World Bank (TFET – TF-29888) was extended 3 times with a total extension of 4 years and three months: (i) June 30, 2005, (ii) June 30, 2007, and (iii) July 31, 2008[4]. The Administration Agreement with the European Commission (EC) was extended from August 31, 2006 until December 31, 2007, and subsequently until October 31, 2008 (reflecting a final closing date for the EC Grant Agreement of July 31, 2008).[5]

2. Key Factors Affecting Implementation and Outcomes

When troops from the International Force for Timor-Leste (INTEFET) arrived in 1999, the health situation in the country was precarious. The health system under Indonesia had not performed well; the territory's health indicators were among the poorest in the archipelago and other countries in the region. The health services: (i) were chronically under-funded; (ii) public subsidies were not allocated in a pro-poor basis; (iii) supported overcapacity infrastructure and staff without essential quality enhancing inputs (drugs, equipment, etc); (iv) provided in many cases poor quality services; and (iv) were unresponsive to the needs of beneficiaries. In addition, the quality assurance systems and regulatory framework did not produce adequate information for planning and evaluation purposes.

Implementation of activities, including construction of the hospitals, was disrupted due to the political crisis in April-July 2006. Contractors and key personnel left the country for several months; internally displaced persons (IDPs) installed themselves on Dili hospital grounds, as well as SAMES, and import of essential materials halted. The IDP camp remained on the Dili hospital grounds through most of the remaining construction phase, until IDPs were relocated by mutual agreement with government in May 2008[6].

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[4] Although the last extension was until June 30, 2008, it was subsequently extended "retroactively" to July 31, 2008 to ensure delivery of hospital equipment procured through "shopping" and completion of the Dili hospital rehabilitation.

[5] According to the Framework Agreement between the EC and the World Bank, a two-month grace period is required between the closing date of Administrative Agreement (between World Bank and EC) and end disbursement date of Grant Agreement. Normally, a four-month grace period is required between the Grant closing date and the grant's end-disbursement date, but on an exceptional basis this was shortened to just one month.

[6] The ICR Mission confirmed that IDPs relocated from the hospital grounds received financial compensation following Government's guidelines.

The European Commission (EC) financed an additional grant to the MOH of 3.8 million through a World Bank trust fund arrangement (TF-054512), which was approved in October 2005, to support: (i) further strengthening of SAMES; (ii) implementation of the human resources development plan; and (iii) ongoing service delivery, including rehabilitation of clinics and health posts. In parallel, the EC financed a technical assistance contract (Support to the Implementation of the Health Sector Investment Program (SIHSIP)), which supports the MOH in the development and implementation of health policies, services and programs to enhance health status -- including support for development of the Health Sector Strategic Plan (HSSP), and updating of the human resources strategy. The Grant is scheduled to close August 2009, but is likely to be extended another year.

Through a bilateral agreement between GoTL and Cuba, about 300 Cuban doctors have been working in Timor-Leste since 2006, and over 600 Timorese have been sent for medical training in Cuba. While the availability of the Cuban doctors increased human resource availability, it led to a need to revisit the Human Resource Management Strategy. It also brought challenges in standardizing treatment practices and contributed to a significant increase in drug prescriptions and difficulties in projecting drug needs. The MOH has made progress in addressing these concerns, and is currently updating the standard treatment guidelines and essential drug list (with support from the ongoing EC grant (TF-054512)).

2.1 Project Preparation, Design and Quality at Entry

Project Design and Preparation. The HSRDP II was prepared and appraised in May 2001. The team led by the Bank comprised the EC, AusAID, JICA, Portugal, and Brazil. Mission members were knowledgeable on both the technical issues and the on-ground situation in the health sector. The Bank's Sector Manager, who had been the team leader at the time of preparation of the HSRDP I, provided continued strategic guidance and active support to the team. **The project design was appropriate** and grounded in technical, institutional, and social analyses; however, for reasons explained later in this section, the project had an unrealistic implementation schedule. The project focus and scope had high ownership by DHS1 and the district authorities. An important feature of its commitment at the design stage was the preparation by DHS1 staff of a work program, which became the basis of a program management plan and budget.

Three key decisions arising from the dialogue between Government and DPs were critical for project design. *First,* agreement on the rationale for activities to be supported by the project and acknowledgement that there was a critical need to invest in the construction and equipping of selected hospitals. *Second,* agreement on promoting a more integrated system approach to the definition and implementation of health sector policy and on the need for the project to support system development in a few key areas, rather than attempting to address the full range of health problems. *Third,* recognition that Timor-Leste management should lead the district health planning process, while ensuring that the process was supported by management advisers in the central DHS1, which main function would be district management support.

During conception of HSRDP I, it was intended that the first operation would concentrate on basic health services while hospital issues were to take place under the

expected second and third tranches of TFET. By the time the HSRDP II was prepared, it was decided to have only two projects necessitating a focus on hospital construction and equipment under HSRDP II. While it was acknowledged that construction of hospitals was to take longer than the implementation period established for the project, the closing date of the parent TF did not allow for establishing a realistic implementation period for a project of this nature, i.e. 5 years.

Lessons incorporated into the Project design were well documented in the PAD. They took account of: (i) other post-conflict countries, (ii) health sector development programs in other countries, and (iii) the ongoing HSRDP I.

Safeguards. The project components and activities were designed explicitly to deal with potential environmental and social concerns. The design followed recommendations made at the Environmental Meeting on May 29, 2001. Environmental concerns that were addressed at the design stage related to: (i) land issues, (ii) environmentally sustainable construction, and (iii) waste management.

Risk Assessment. For the most part, the risk assessment assumptions made at appraisal reflected a good understanding of operating in an environment of limited institutional capacity and the ratings recognized this accordingly. In general, adequate mitigation measures were identified and, in practice, they worked. The exception was the rating of “M” for adhering to the rehabilitation schedule for hospitals, which was substantially underestimated. The assumption that this risk was mitigated by the fact that the hospital planning study had been mobilized and the RFP for the design work was under preparation was wrong. It should have been anticipated that the construction program would encounter problems along the way. That said, the supervision team recognized this shortcoming shortly after the Grant became effective and raised the risk rating of this activity to “Substantial”.

Provision was made for considerable technical assistance, on-the job training, seminars, workshops, study tours and operational research, at all levels to create and underpin internal dialogue on the best way forward. Training funded by the project, including support to UN agencies to provide guidance in the implementation of activities, assisted sustainability and capacity development. Adequate attention was given to preempt possible environmental issues during project implementation. However, a clearer focus on realistic implementation schedules, given the institutional limitations, post-conflict situation, and the complexities of procurement in the health sector in general, would have been more appropriate. There was no quality-at-entry review by the Quality Assurance Group (QAG).

2.2 Implementation

The ICR mission rates implementation as ***Moderately Satisfactory***. The project suffered from delays in implementation related to: (i) political tensions and civil unrest, (ii) complex design/contracting/construction issues, (iii) medical equipment procurement delays, (iv) SAMES weaknesses, (v) limitations with quality collection and analysis, (vi) lack of

mid-term review to guide latter years of implementation. The shortcomings directed related to implementation are discussed in more detail later in this section.

The project was implemented during periods of political tensions and discontent among urban youth. Beginning in April 2006, a major political crisis led to confrontations between the police and armed forces, which exacerbated regional tensions. Dozens of people were killed, thousands of homes were burned and up to 150,000 became internally displaced in a cycle of violence and retribution that lasted several months. MOH continued to function throughout the crisis, one of the few government ministries to do so. Despite heightened political tensions and regional divisions, MOH senior officials and health professionals remained neutral, maintained their professional standards, and ensured service delivery in the country throughout the crisis. While most of the violence was concentrated in Dili between April-August 2006, instability and clashes continued well into 2007 and culminated with the assassination attempt on the President and the Prime Minister in February 2008.

Not withstanding the political and civil unrest, Timor-Leste has accomplished a great deal in the health sector since the country's separation from Indonesia. Important accomplishments include the: (i) formulation of policies and strategy development for the health sector, giving priority to primary health care; (ii) development of district health planning, budgeting, and management; (iii) allocation of substantial resources for the health sector[7], while maintaining hospital expenditures at 40% or less of allocated budget resources; (iv) rehabilitation and rationalization of health care infrastructure, including hospitals and community health centers; (v) significant improvement in health indicators, including deliveries attended by health personnel, immunization coverage; (vi) development and adjustment of the health workforce; (vii) development and adoption of the basic service package (BSP), and Hospital Services Package (HSP); (viii) development of MOH organization and its planning and implementation capacities; and (ix) development of a comprehensive, needs-based, Strategic Health Plan covering the period July 2007 to June 2012, and related Medium-Term Expenditure Framework (MTEF). In mid-2008, MOH approved a new organic plan, which resulted in a major reorganization, the creation of new departments, and appointments of new directors and heads of departments. Development partners, in particular the EC-funded technical assistance and the Bank, have made an important contribution to these accomplishments. More specifically, it is clear that both HSRDPs and complementary EC technical assistance have made a strong contribution to the development of the health sector.

The project was successful in delivering most of the outputs under the three components. Some exceptions are summarized above, with details in Annex 2 – Outputs by Component. As expected, implementation has been challenging given: (i) that local capacity at the working level is severely constrained, and to a great extent dependent on foreign

[7] The discovery of oil and establishment of the Petroleum Fund has significantly increased budgetary resources. However, GoTL has committed to remain within annual sustainable expenditure limits. The MOH requested a budget of US$33 million equivalent for 2008, which was subsequently reduced to US$23 million. An additional US$8 million was allocated to MOH during the mid-term budget review, which created a challenge for MOH to commit these funds before the end of the calendar year.

advisors and professionals, and (ii) the fragile environment where there have been periods of civil unrest and internal displacement. The discovery of oil and the establishment of the petroleum fund resulted in a major change in the fiscal and economic outlook, creating fiscal space for more ambitious expansion of health coverage, but also placing a greater premium on the need to strengthen capacity to execute the national budget as well as externally-financed projects. Details on outputs are presented in Annex 2.

The project supported rehabilitation of referral hospitals, which together with the support under the HSRDP I for the reconstruction of community health centers and health posts, have gone a long way to re-establish the infrastructure destroyed after the separation from Indonesia and, thus, a functioning health service. While the hospital construction was substantially delayed, the hospitals were constructed to a good quality standard. Reasons for the delay included: (i) problems with the preparation of the RFP for the hospital design and supervision contracts and (ii) delays with the selection of construction companies and subsequent delays in the actual construction, partially caused by the civil unrest of mid-2006. The three regional hospitals were finally completed by October 2007, and rehabilitation of GVNH was completed by July 2008. While various missions noted the delays in the construction program, they also recognized the importance of getting the program "right".

In terms of the first component – **Supporting ongoing service delivery,** all planned outputs were completed, albeit with varying degrees of efficiency and timeliness. Problems remain with the procurement and provision of pharmaceuticals through SAMES and the overall operations of SAMES. Most activities under Component 2 – **Range and quality of services and develop/implement support systems** were implemented, with the notable exception of the procurement of a large portion of medical equipment for the refurbished hospitals and central lab. All activities planned under Component 3 – **Develop/implement health sector policy and management systems** were implemented. Several of those are of a continuing nature and are being supported by the new AusAID-World Bank financed project (the Health Sector Strategic Plan Support Project (HSSP-SP)) approved on December 13, 2007.

The ICR team noted four main shortcomings in the implementation of the project: (i) weak SAMES institutionalization, (ii) inadequate quality of health information data, (iii) significant delays in procurement of hospital equipment, and (iv) lack of Mid-Term Review.

Establishing a well-functioning central medical stores has proven challenging in a post-conflict environment. **SAMES** was initially managed through a project-financed contract with a consulting firm (Crown Agents), but MOH was concerned that this contracting arrangement did not contribute to development of local capacity. By 2005, management responsibility was transferred to Timorese staff, supported by international technical advisors who were financed directly by the project. Despite the substantial investments in international technical advisors, SAMES has continued to experience problems related to weak management and oversight arrangements for drug management, procurement, logistics, and supply system. Although progress has been made in establishing stock management, the computerized warehouse management system (WMS) has suffered from weaknesses and broke down in late 2007. With support from the supplier, it is now

operating. Equally, while improvements were made in financial management, its financial management and accounting software is not integrated with the WMS. Given the difficulties in estimating needs at the district level, SAMES is not able to make realistic projections in which to base its requirements.

The project provided direct financing for purchase of pharmaceuticals (through both TFET and the EC Grant) using International Competitive Bidding (ICB) procedures. Pharmaceutical procurement was initially undertaken by the PMU, but by 2007 was delegated to SAMES. The transfer of procurement responsibility was, however, made without evaluating the capacity of SAMES to take over this task. Persistent difficulties were encountered throughout the project, including long lead times for ICB (often taking up to a year), delays in deliveries by suppliers, difficulties in processing payments to suppliers (including Letters of Credit). While some of these problems highlight the need for further strengthening of procurement capacity at SAMES, in retrospect the ICB process for pharmaceutical procurement was not well-adapted to the Timor-Leste context. The Bank and SAMES are considering other approaches for future, including piloting long-term "frame contracts" with pre-qualified suppliers.

A fundamental problem has been that key SAMES managers did not have the requisite training and experience to effectively take on the responsibilities being carried out by the international advisor. Improvements are apparent since the new Director General took office in February 2008, but SAMES needs more qualified personnel and further strengthening of basic systems, including its human resources systems and strategies to ensure effective operations.

NGOs had taken a lead role in the development and maintenance of **health information** generation, analysis and reporting, including logistical support for collection of data from health facilities. Upon their departure and assumption of management by local district management teams, the quality of the information collected and analyzed suffered. With technical assistance under the Project, including support from WHO, efforts have been put in place to strengthen capacity at the district level to collate, interpret and report on health information. These efforts, however, have not been uniform and improvements are still needed. They will continue to be supported under the new project. (Please also see Section 2.3).

The most serious shortcoming of the project was the delays and problems in the **procurement of medical equipment** for the reconstructed regional hospitals, Dili Hospital, and the Central Lab. Even though MOH is widely recognized as one of the more effective government agencies, the procurement of hospital equipment encountered a number of difficulties. Delays were precipitated by the lack of sound procurement expertise in the PMU due to the high turnover and quality of technical assistance in this important area. The procurement delays resulted in hospitals still not able to perform all procedures eight months after their official opening. Senior political leaders on several occasions publicly voiced his concerns regarding delays in procurement of hospital equipment.

Although the initial process for identifying hospital equipment needs was initiated in 2004, the procurement for an estimated US$2.5 in hospital equipment (using ICB) was launched in mid-2006. In April 2007, MOH declared bid failure due to lack of responsive bidders. The Bank asked the MOH to revise the bidding documents and also provided a special waiver to allow the equipment to be purchased through "shopping" procedures, which are more flexible and rapid than ICB. MOH opted to use shopping for about US$0.6 million, however, while continuing with ICB processes for the rest of the equipment. Although the Grants' closing dates were extended to allow completion of this procurement, the process proved taxing on MOH. In particular, MOH was without a full-time procurement advisor or biomedical equipment specialist through most of the critical period for this procurement.[8] A new procurement advisor arrived in February 2008, however, the Bid Evaluation Reports for the ICB were only sent to the Bank for review in April 2008 and the Bank was unable to provide a No Objection because the evaluations were not done in conformity with the original bidding documents.

Because the EC had clearly stated in approving the final extension that no further extensions could be considered, the project team made arrangements with MOF for: (i) the EC Grant to finance instead US$2 million of additional construction on the Dili hospital, and (ii) the Government's budget to allocate up to US$2 million in additional funds to purchase the remaining hospital equipment.[9] Contracts were signed with six suppliers and the medical equipment has now been delivered. Because of availability of additional funds from the EC Grant due to the strengthening of the Euro in relation to the dollar, in fact, US$2.5 million equivalent (instead of US$2 million) was used from the EC grant to support Phase 3 of the Dili Hospital.[10]

Last, but not least, a shortcoming in implementation was the **lack of a Mid-Term Review** to: (i) take stock of project progress and sector performance thus far; (ii) make necessary adjustments, including in the indicator targets; (iii) agree on more realistic implementation schedules; and (iv) provide overall direction for the remaining of the implementation period. The task team at the time considered a formal MTR not to be necessary, given that the Aide Memoires from the joint donor missions provided comprehensive reviews of sector performance, and the design of the second EC grant (TF-

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[8] A biomedical equipment consultant was contracted sporadically during the procurement cycle (initially by the supervising architecture firm for the GVNH construction, and later directly by MOH), but the lack of continuous engagement contributed to the difficulties and delays encountered. A full-time biomedical equipment advisor finally arrived in mid-2008 (financed by EC TF 054512) to help establish a maintenance system for the equipment.

[9] In completing the procurement of the remaining hospital equipment, the GoTL revised the bid evaluation reports on the basis of World Bank comments, which resulted in a substantial reduction of the total cost (by nearly US$800,000).

[10] In the EC's Administrative Agreement with the World Bank, "hospital construction and equipment" are listed on the same budget line. With limited time before project closing and based on consultation with Legal Department, it was agreed that the Bank could approve a reallocation from equipment to hospital construction without awaiting formal approval from the EC. The Grant Agreement was amended accordingly, and the EC was informed in writing of this decision. After the project closing date, the EC expressed concern that they had not approved the reallocation. Such approval was not required by the Administrative Agreement, and waiting for approval would have resulted in the Dili hospital not being completed, all four hospital remaining unequipped, and more than $2.5 million cancelled from the EC grant. The Bank team stands by its decision.

054512) in 2005 provided a further opportunity for stocktaking of project and sector performance. Notwithstanding, in the view of the ICR team, the absence of a formal MTR was a weakness of supervision.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

The results framework in Annex 1 of the PAD included many **key sector performance indicators,** some of which were not reported systematically. However, MOH and the project team did monitor and reported systematically in Aide Memoires on the **Project Performance Indicators** as per the Grant Agreement, which were the same for the PDO listed in the PAD (Section 1.2).

The end-of-project targets in the PAD were for June 30, 2003; most were surpassed. Information regarding in-patient services within two hours from a source of basic health services is not available. The Grants' closing dates were extended several times. However, the targets' dates, were never changed.

Progress in establishing a reliable HMIS has been hindered by inadequately coordinated technical support, due in part to a high turnover of technical assistance. A series of international consultants have supported these efforts over the past several years, adopting different approaches. With technical assistance under the Project and support from WHO, efforts have been put in place to strengthen capacity at the district level to collate, interpret and report on health information. These efforts, however, have not been uniform and improvements are still needed. They will continue to be supported under the Health Sector Strategic Plan Support Project (HSSP-SP). Although HMIS data should be viewed with caution, it is notable that coverage estimates from 2007 HMIS data are comparable to those obtained from the 2007 TLSLS household survey. This suggests that despite continuing issues with quality and timeliness, the HMIS has become an important tool for monitoring coverage trends and performance.

2.4 Safeguard and Fiduciary Compliance

Activities under the project complied with environmental safeguards as follows:

Land Issues. There was no land acquisition or resettlement under the project. IDPs in the Dili Hospital compound (see Section 2.2) were resettled in 2008 and compensated in line with government procedures. In Maubisse, former communal lands were added to the hospital grounds and families cultivating the land were compensated through a satisfactory consultative process.

Environmental Sustainable Construction. All buildings constructed or renovated under the project – hospitals, warehouse, laboratory — make the maximum use of cross-ventilation and have large roofs overhangs to minimize solar penetration into rooms. All rooms are well ventilated and cool and are naturally lit to make limited use of electricity.

Waste Management. Two tools were funded under the project. *First,* the project financed the design and installation of incinerators (larger versions of the incinerators

approved for the health centers and hospitals under the first project). *Second,* all sanitary waste from hospitals and other health facilities constructed under the project are being treated in septic tanks with the overflow taken to soak ways.

In terms of fiduciary safeguards:

Financial management. Overall financial management is rated Satisfactory. An experienced long-term financial advisor was in place for four years, for most of the project's life. Although "mapped" to the PMU, the FM advisor not only contributed to effective FM oversight and management of the project, but was also effective in training Timorese counterparts, establishing financial management systems, and mainstreaming the FM function into the MOH. FM performance declined temporarily for a few months between the departure of this advisor in February 2008 and the hiring of a new advisor in May 2008, but subsequently improved prior to project closing.

Procurement. The project financed a series of procurement advisors in the PMU, but high turnover of this position, the absence of a procurement advisor from June 2007 to February 2008, and the poor performance of the advisor hired in February 2008, contributed to shortcomings in procurement management and limited capacity building for MOH. It also contributed to the problems in hospital equipment procurement cited above. Procurement performance was downgraded to Moderately Unsatisfactory in the final year of the project. Civil works oversight remained satisfactory overall, however, in part because civil works were directly supervised by the PMU coordinator (a civil engineer) and by the project engineer, who also had procurement background. A new procurement advisor was appointed after project closing. It is expected that the HSSP-SP project and the multi-sectoral Public Sector Financial Management Capacity Building Project (PFMCBP) will continue to strengthen procurement performance of MOH.

2.5 Post-completion Operation/Next Phase

Support to the sector will continue through the ongoing EC grant (TF-054512), which is expected to be extended through August 2010, as well as the HSSP-SP, which was approved in December 2007. The HSSP-SP is being financed through an AusAID Grant of AUD 21.9 million managed by IDA through a trust fund arrangement[11] and an IDA Grant of US$1.0 million. The overall objective of the project is to improve the quality and coverage of preventive and curative health services, particularly for women and children, to accelerate progress toward the health MDGs. The HSSP-SP has two parts: (i) direct financial support using the health sector Strategic Plan and the MTEF framework, and (ii) addressing challenges and innovations needed for the health sector to be prepared for the next generation of issues. The elements addressed under the HSSP-SP are a logical continuation of the support provided under the HSRDPs, following the gains achieved in the sector since 1999. It addresses "second generation" challenges to further help develop the health system and improve health outcomes.

[11] AusAID and the Bank have agreed to establish a Multidonor Trust Fund to facilitate the entry of other development partners in the future.

Following the improvement of the fiscal situation on the basis of the discovery of oil and the establishment of the petroleum fund, GoTL decided to increase the budget for health in nominal and real terms (not in percentage of total) and to place more medical doctors in the districts. This has raised expectations with the population in terms of the level and quality of health care and may have had an impact on health seeking behavior. The Health Seeking Behavior Study being finalized with funding from AusAID should provide further insights into these issues.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

The project's development objectives and design were of **high overall relevance** to the development of the health sector. The development objectives were and continue to be integral to the Government and Bank's strategies in the sector. The Bank's implementation assistance remains important to achieving the current Bank's Country Assistance Strategy (FY06-08), which 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 project aimed at supporting the delivery of sustainable services, while creating productive employment through the construction/rehabilitation of facilities, both of which are main pillars of the current CAS.

3.2 Achievements of Project Development Objectives

The project was **successful** in meeting its development objectives and key performance indicators, with moderate shortcomings explained elsewhere in this ICR. While some of the performance targets should have been updated to reflect grant extensions, this shortcoming is reflected in the project supervision rating rather than in rating the DO. The risk at the time of the CIR that development outcomes (or expected outcomes) will not be maintained are rated **Moderate**. Given that the original development objectives were broad,[12] the discussion below addresses the various aspects of the DO and associated indicators in turn.

Rehabilitation and development of the health system. The project made a substantial contribution to rehabilitation and development of a health system that had been largely destroyed in 1999. This includes construction and equipment of the tertiary and three referral hospitals (albeit completed behind schedule); substantial investments in technical assistance and training for Timorese health staff and managers; and establishment of basic support services (such as the central medical stores).

*Financial sustainability and cost-effectiveness***.**

[12] "Support the rehabilitation and development of a cost-effective and financially sustainable health system responsive to the immediate basic health needs of the population within a well integrated and sustainable policy framework to prepare the health system to meet future needs."

- The hospital rationalization plan and design and construction of the hospitals contributed to a more cost-effective use of sector resources than would have likely occurred in the absence of the project. The major concern is ensuring adequate institutional arrangements and financial allocations for maintenance of hospital infrastructure and equipment. The ongoing EC grant and HSSP-SP are supporting establishment of a medical equipment maintenance system, and recruitment of an infrastructure maintenance advisor is underway. The sectoral MTEF estimated requirements for maintenance, but the 2009 GoTL budget did not provide adequate financing. This will be a focus for ongoing dialogue.
- Timor-Leste has continued its policy of allocating no more than 40% of resources to hospitals, which avoided the problem in many developing countries where a much higher percentage of resources go to the hospital sector.
- Financial sustainability will be likely assured by the continuing efforts of the Government and DPs to address issues in a sector-wide manner and MOF's commitment to take advantage of additional government's resources through the Petroleum Fund, which has created fiscal space for sustaining existing investments and more ambitious expansion of health coverage.
- While SAMES has not yet fully realized its potential as an efficient supplier of high-quality, cost-effective essential drugs for the population, its performance had improved by the end of the project and is on a path toward reaching this goal.

*Development of a well integrated and sustainable policy framework***.** Reconstruction took place in the context of the formulation of policies and strategies to guide the development of the sector. Specific contributions included:

- Strengthening the policy and institutional framework for the sector, including support for development of the initial health policy document, the human resources development strategy, and the initial pharmaceutical policy. EC technical assistance provided complementary support for TA financed by the project.
- Establishing key performance indicators to assessing sector performance, and undertaking regular reviews of sector performance as part of joint donor missions.
- Supporting establishment of a functioning Timorese administrative structure for the sector, and improving the functioning district health management teams through technical assistance, training, and "learning by doing."
- Establishing the framework for donor coordination through the establishment of a sector wide trust fund arrangement for international assistance. This has been effective in mobilizing substantial resources and has reduced transaction costs.

The project *responded to the immediate basic health needs of the population* by helping to re-establish a functioning health service, including through rehabilitation and rationalization of health care infrastructure, human resource development, procurement and distribution of essential medicines, and strengthened district planning and implementation. Delivery of health services in general has improved significantly from 1999, as evidenced by the HMIS and household surveys. While general concerns surrounding data quality continue, the data show an improving trend for immunization coverage and deliveries attended by health personnel. The tables below present a snapshot of trends in vaccination data in 2007/second quarter 2008 relative to 2006. From a state of utter devastation in late 1999, by

2007: (i) between 70-85% of the population has a health facility within 2-hours travel time from their home; (ii) an estimated 37% of births were attended by a skilled health worker, (iii) an estimated 63% of children under 1 year of age had been immunized for measles, and 70% for DPT3, and (iv) utilization of health facilities has increased from about 0.5 visits per year to 1.9 visits per year per capita.

Table 1: Key Indicators and trends from HMIS data (% coverage)

Qrtr.	Measles			DPT3			Cumulative % of deliveries attended by health personnel		
	2006	**2007**	**2008**	**2006**	**2007**	**2008**	**2006**	**2007**	**2008**
1st	13.8	14.9	26.7	14.5	16.5	28.3	8.2	8.6	8.5
2nd	30.9	30.2	32.0	32.2	32.3	33.0	15.2	18.5	18.0
3rd	46.4	46.8		47.2	50.0		20.1	27.4	
4th	61.0	62.5		63.5	69.8		27.2	37.3	

Source: MOH Annual Statistical Book and MOH tables (January-June 2008). Note: HMIS data prior to 2006 overestimated coverage, and are therefore not included in this table.

Table 2: Key Indicators and trends from 2001 and 2007 TLSLS data (% coverage)

Qrtr.	Measles	DPT3	Deliveries attended by health personnel
2001	17	25	N.A.
2007	59	74	37

Source: 2001 and 2007 Timor-Leste Standards of Living Survey (TLSLS).

As with any sector-wide program, establishing causal linkages between project activities and overall sector performance is difficult. The majority of project financing was devoted to upgrading and equipping referral hospitals. These hospitals were completed a year before project closing and fully equipped after project closing; as such, while they are expected to generate substantial benefits for the population in the coming years, improvements in sector indicators during implementation (such as skilled attendance of deliveries) cannot be attributed to these investments. A strong case can be made, however, that the project contributed to improved performance in coverage of primary health care, because:

- The project was engaged in nearly all aspects of the health sector, including through direct investment (in infrastructure and essential commodities), technical assistance and training, including strengthening of district-level planning and implementation;
- The project supported the development and adoption of the basic service package and hospital services package, which complemented the investments in rehabilitation of health clinics and health posts made under HSRDP1;
- The project and joint donor supervision missions provided the framework for sector coordination and annual review of sector performance, which maintained a collective focus on the need to continue coverage and quality of basic services.

3.3 Efficiency

In the absence of sufficient indicators and evidence to rate efficiency rigorously, efficiency is considered to be **modest** overall. The PAD included a cost-benefit analysis that was necessarily limited in terms of availability and reliability of baseline data. Some of the efficiencies discussed have not been realized, and for others available data are inadequate to undertake a robust analysis. In terms of *technical efficiency*, for the civil works component (which represented the majority of project financing), the hospitals plans and technical designs were cost-effective, and were implemented mostly within budget (most of additional financing at GVNH were for additional works, rather than cost overruns, although the civil unrest and presence of IDPs at GVNH contributed to modest cost overruns and contract variances). The delays in construction and equipment delivery meant the hospitals began generating the anticipated benefits at least two years later than anticipated, however.

The PAD also anticipated improved efficiency and reduction of waste as a result of an increase in drug procurement and distribution. While cost efficiencies may have been achieved through ICB procurement of drugs, continued problems with delayed deliveries and distribution suggest that the anticipated efficiencies were not fully achieved. The project also supported development of a basic service package for primary care, focusing on cost-effective interventions. In terms of *allocative efficiency,* the Credit Agreement included a covenant to limit hospital expenditures at less than 40 percent of the MOH recurrent budget. MOH adhered to this agreement, which meant that the majority of GoTL resources focused on basic health services (which address the majority of the burden of disease in Timor-Leste).

3.4 Justification of Overall Outcome Rating

The project design was highly relevant, achieved the majority of its development objectives with modest shortcomings (despite a difficult post-conflict context), and contributed to improvement in overall coordination and performance of the health sector. On this basis, the ICR rates the overall outcome of the project as ***Moderately Satisfactory*** (consistent with the last ISR ratings). Project objectives and design were appropriate to the challenges of the sector and were consistent with the program approach agreed by DHS1 with joint missions as part of the design of the HSRDP I. However, the implementation schedule at the design stage was unrealistic as it was linked to the closing date of the Umbrella EC Grant. Flexibility was exercised during implementation and some activities initially planned for the HSRDP II, i.e. construction of additional community health centers, the Centro Clinico in Dili, procurement of communication equipment, were implemented under HSRDP I. This level of flexibility was possible because of the nature of the sector wide program approach.

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

Available household survey data suggest that the poor, rural population remains the most vulnerable to losing income-earning potential due to morbidity, but the situation has improved since the launch of the project. Adult morbidity – largely a consequence of malaria

and TB -- can best be addressed through an effective and broadly accessible primary health care system. According to the 2007 TLSLS, 74.6% of people surveyed (71% of the rural population) who reported health complaints in the month prior sought treatment, a significant increase from 51% in 2001. In 2001, 14% of the population had visited a health care provider or facility in the month prior to the survey, which increased by 2007 to 17% of the population. One-way travel time to the nearest facility reduced from 62 minutes in 2001 to 47 minutes in 2007. Nevertheless, in spite of these indicators, the number of days in which activities were disrupted due to illness increased from 4.4 to 5.1 over the same period. Fertility and malnutrition have seen the least improvement, however -- the total fertility rate remains among the highest in the world, and over half of children are malnourished.

(b) Institutional Change/Strengthening

A key problem faced by the health system has been the low capacity of the staff in managerial positions at district levels. As a short-term strategy for capacity development, WHO funded basic training in health management for district health management teams. For longer term managerial support, a mentoring program was introduced through the recruitment of five international public health specialists (based in the districts and covering 2-3 districts each) with field experience in the area of district health management. The rationale for part-time support was that it would stimulate assumption of responsibilities by the district management teams as the presence of NGOs was seen as a form of disempowerment over the performance of the health staff. Increased capacity and the development of a radio information system helped to improve this area. While this type of support to the district health management teams was discontinued for a period, MOH has recognized the importance of continuing technical support and has recently engaged four district management advisors to further strengthen district planning, budgeting and service delivery. Some strong district managers have emerged as evidenced by the significant increases in key indicators in some districts.

The project provided a great deal of training in all aspects of health education, health care delivery, systems and policy development, and in management. The project has financed a number of scholarships and fellowships, including short-term training abroad to update and extend clinical skills and management competences, and longer-term training for doctors, generally for students, who have had their training disrupted (See Annex 7). However, concerted efforts are still needed in this area, including improving hospital management, an area which is seen as weak and is hindering the provision of good health hospital care.

An important outcome of both HSRDPs has been the initiation of a sector wide approach to development assistance, which success should not be underestimated. This approach has reduced duplication of efforts, minimized transactions costs, and facilitated targeting of funding towards priority health sector interventions. The projects have provided a successful mechanism for donor coordination. The bi-annual Joint Donor Missions have been a good forum to monitor progress across the sector and to discuss and agree on strategic decisions on health issues. The decision by MOH to establish a Health Steering Committee

to be supported by thematic groups with plans to meet quarterly will further enhance development assistance coordination.

(c) Other Unintended Outcomes and Impacts (positive or negative)

A complementary benefit of the project was that the construction of hospitals and employment of staff for construction projects were to contribute to the recovery of the economy as a whole. Added groups of beneficiaries, which were not fully recognized in the PAD, have been: (i) local communities, as the project has promoted community and stakeholders participation in the planning and decision making of district health plans, (ii) Internally Displaced Persons (IDPs), who found both refuge and cash-for-work incentives on Dili hospital grounds, even though their presence complicated hospital rehabilitation. No unintended negative outcomes or impacts were identified.

The effectiveness of the health sector response during and following the 2006 political crisis (see "Timor-Leste Health Sector Resilience and Performance in Times of Instability," 2008) reflects well on the leadership and coordination provided by MOH, with the active support and encouragement of NGOs and key UN agencies. MOH leadership displayed strong efforts to encourage health workers to be professional and avoid getting drawn into the conflict. They successfully did so. The MOH is recognized as one of the most effective ministries, both by civil society and by the international community. Its response to the emergency has contributed to state, peace and nation building efforts.

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops

No Beneficiary Survey conducted.

4. Assessment of Risk to Development Outcome

The ICR team rates the risk to development outcomes as ***Moderate*****.** The achievements of the sector are robust and the benefits gained from many elements of the projects are institutionalized. The system is forward-looking and will continue to be supported by MOH with funding from the AusAID-World Bank financed project, the EC, and UN agencies.

5. Assessment of Bank and Recipient Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry

The ICR team rates the Quality at Entry as *Moderately Satisfactory*. The project team had a good skill mix. Mission members were knowledgeable on both the technical issues and the on-ground situation in the health sector. **The project design was appropriate** and grounded in technical, institutional, and social analyses. However, for reasons explained elsewhere in this document, the project had an unrealistic implementation schedule (see also Section 2.1). The requirements for preparing a full PAD despite Emergency Procedures helped ensure due diligence. The strong element of the project was that it was part of a sector-wide program conceived at the time of the HSRDP I, thereby ensuring a comprehensive ongoing approach to sector development. The focus was on reconstruction while at the same time helping Timor to develop a framework for longer-term health policy and systems development; the sector-wide program focus also ensured donor coordination.

(b) Quality of Supervision

The ICR team rates the quality of supervision as *Moderately Satisfactory.* Generally there were two supervision missions annually (sometimes 3), conducted jointly with other donors – including EC, AusAID; the skill mix was adequate. Positive points and shortcomings of supervision can be summarized as follow:

Positive Aspects:

- Missions were effective in reviewing the sector development and project specific progress. The project team focused on looking at the sector as "an integrated whole".
- The bi-annual Joint Donor Missions have been a good forum to monitor progress across the sector and to discuss and agree on strategic decisions on health issues.
- Significant budget resources were allocated to Timor-Leste by the Bank to ensure systematic follow-up.
- An extended-term consultant was hired in 2007 in the Bank's Dili Country Office responsible for health and education, to help provide more on-site guidance to counterparts. After the ICR mission a full-time ETC has been assigned to health.
- There has been relatively good continuity in the team, both among Bank staff/consultants and the development partners (three Team Leaders since its inception).
- The overall focus on micro issues, combined with analytical work conducted by the Bank and local counterparts, helped ensure that the sector performance continued to improve.
- The focus on the PDOs and systematic reporting on indicators in Aide Memoires is exemplary.
- Emphasis and support during missions to district health planners was effective.

In terms of less positive aspects:

- Aide Memoires were lengthy and because of the complexity of issues addressed, do not appear to have been "fully understood" by MOH's staff. While some Aide Memoires were presented together with short 2-3 summaries translated into Tetun, this should have been done routinely to ensure that main findings and recommendations were fully understood by management and staff.
- The supervision process, including managers accepted that the overall IP and DOs be consistently rated Satisfactory. They were only downgraded to MS in late 2005, despite the fact that before 2005 there were serious delays with the construction program. Equally, despite serious procurement management issues, procurement continued to be rated Satisfactory until almost the end of project implementation.
- Guidance on realistic implementation schedules, particularly for the construction of hospitals and on procurement of medical equipment could have been stronger. Supervision guidance should have emphasized the need to start procurement of medical equipment earlier. An attempt could have been made to proceed with procurement processing much earlier, allowing for a phased-delivery of equipment once the construction was completed.
- The lack of Mid-Term Review (MTR). No MTR was conducted despite the fact that this was a requirement under both the IDA and EC Grant Agreements. Although the task team at the time did not judge an MTR to be necessary, the review would have addressed emerging problems and provided an opportunity to update key performance indicators and targets.
- Given the capacity constraints, establishing a stronger presence in the Bank's Dili Country Office – both in terms of sector specialists and operational/procurement support – could have provided better ongoing support and more timely resolution of implementation difficulties. While procurement is the responsibility of the client, the absence of a full-time sector specialist or procurement specialist in the World Bank Dili Country Office (a Procurement Specialist was posted to the Bank's Dili Office in the early stages of implementation of HSRDP I), was a constraint to the timely identification and resolution of the various problems that arose during this complex procurement process. While supervision missions routinely included a consultant architect to supervise civil works, in retrospect, a biomedical equipment specialist should similarly have participated in some supervision missions to be available to provide timely advice to the task team and MOH throughout the procurement cycle.

(c) Justification of Rating for Overall Bank Performance

The ICR team rates the Overall bank Performance as ***Moderately Satisfactory*** for reasons elaborated above.

5.2 Recipient Performance

(a) Government Performance

The ICR team rates Government Performance as ***Moderately Satisfactory***. The performance overall of DHS1/MOH in establishing a policy framework and re-establishing services, has been acknowledged by the government and donors alike as strong.

Recognizing the importance of re-establishing health services, MOF has increased steadily its budget allocations to the health sector since 1999 (see also Section 2.2). Policy development has progressed apace with a large number of policies and/or strategies developed. Starting with the 2005/06 budget, MOH provided a detailed budget for each of the 13 districts, replacing a consolidated estimate for all districts. Although improvements are still necessary in this regard, this was the first step towards decentralized budget preparation at the district level. It laid the groundwork for a more effective central-level monitoring of each district's health activities and financial performance. Procurement of medical equipment and shortcomings by MOH and MOF in acting upon agreements reached on ways to resolve them delayed project implementation. The performance of the Government is rated MS, mainly because of the problems with procurement, especially the procurement of medical equipment.

(b) Implementing Agency or Agencies Performance

Moderately Satisfactory. While policy development was central to the overall re-establishment of services, DHS1/MOH sought to prioritize policies and strategies rather than just respond to the availability of donor-funded technical assistance. MOH and district health management teams moved decisively to prepare district health plans and budgets, experiencing initial teething problems as district offices became used to developing their own proposals. Much effort was made to translate plans into action through reviews of district health planning processes and outcomes and assessment of capacity development needs. Despite some delays, MOH successfully implemented a complex construction program, but the procurement of medical equipment, pharmaceuticals and supplies encountered greater difficulties. Equally, MOH has had big challenges regarding the quality of data partially due to the high turnover of technical assistance for HMIS. The Project Management Unit has been over-stretched and has suffered from a high turnover of staff, especially for procurement management, which has hindered its ability for timely procurement processes. In addition, the progress with the institutionalization of SAMES, discussed in other parts of this report, has been slower than expected.

(c) Justification of Rating for Overall Recipient Performance

The ICR rates Recipient Performance as ***Moderately Satisfactory***. This rating reflects the considerable problems encountered with procurement and overall operations of SAMES.

6. Lessons learned can be categorized into the following major headings:

Coordination

- Close coordination with development partners was critical. Complementary technical assistance provided by the EC was crucial to the development of the sector.

- The capacity to mobilize financial resources through one funding mechanism ensured good donor coordination and reduced transaction costs.

Government ownership and capacity development

- The health strategy in Timor-Leste gives evidence of a balanced choice between visible results in terms of reconstruction and service delivery and the development of a customized policy framework and medium-term planning.
- In the reconstruction phase, there must be a clear focus on the broader sector strategy. Because MOH and its development partners had sector development as the final objective, the actions taken during the reconstruction phase avoided harmful mistakes.

Implementation guidance by the Bank

- Providing continuous guidance in the context of a limited institutional capacity is essential. The Bank should make all efforts to post the TL or a sector staff in the field to provide day-to-day guidance and help resolve bottlenecks. Bank supervision must be continuous and intensive. Adequate supervision resources must be allocated.
- Aide memoires should be written keeping the audience in mind. In an institutionally-constrained environment, attempts should be made to simplify the Aide Memoires, addressing key issues and recommendations in an executive summary. Given the language constraints, Aide Memoires or at least the Executive Summary should be translated into Tetun and/or Portuguese.
- There should have been a Mid-term evaluation by the World Bank, as Trustee, of the interim achievements with a view to addressing emerging problems.

Procurement Challenges

- For planned civil works/medical equipment procurement, it is important to begin the process early, especially in small countries where competition and capacity is limited.
- Given the complexities of procurement in the health sector and the weak institutional capacity, it is recommended that the Procurement Specialist be posted in the Country Office to help resolve day-to-day issues and help expedite procurement processes.

7. Comments on Issues Raised by Recipient/Implementing Agencies/Partners

(a) Recipient/implementing agencies

See Annex 7 for Government's Contribution

(b) Cofinanciers

The ICR team held discussions with several development partners, including: (i) EC, (ii) AusAID, (iii) WHO, and (iv) UNICEF. To the extent possible, their comments are reflected in this document. The draft ICR was made available for comments from EC. EC's comments were incorporated in the final version of the ICR.

(c) Other partners and stakeholders

The ICR team met with International Health Alliance who from their perspective confirmed the progress achieved in the health sector in Timor-Leste over the last 8 years.

Annex 1. Project Costs and Financing

(a) Project Cost by Component (in USD Million equivalent)

Components	Appraisal Estimate (USD millions)		Actual Estimate (USD millions)		Percentage of Appraisal	
	TFET	EC	TFET	EC	TFET	EC
Support Ongoing Service Delivery	3.52	5.21	3.70	5.10	105%	98%
Improve range/quality of services, and develop/implement supporting systems	5.95	13.55	5.34	12.96	90%	96%
Develop and Implement health Sector Policy and Management Systems	2.73	1.60	3.54	1.47	130%	92%
Total Baseline Cost	**12.20**	**20.36**	**12.58**	**19.53**	**100%**	**96%**
Physical Contingencies	0.40	-				
Price Contingencies	-	-				
Total Project Costs	**12.60**	**20.36**	**12.58**	**19.53**	**100%**	**96%**
Total Financing	**12.60**	**20.36**[13]	**12.58**	**19.53**	**100%**	**96%**

(b) Financing

Source of Funds	Type of Cofinancing	Appraisal Estimate (USD millions)	Actual Estimate (USD millions)	Percentage of Appraisal
Recipient		0.00	2.00[14]	-
EC: European Commission		20.36	19.53	96%
Special Financing (TFET)		12.60	12.58	100%

[13] The PAD noted US$8.83 million equivalent as co-financing from the EC. However, by the time the EC Grant Agreement was signed, the EC had increased its grant to US$20.36 million equivalent

[14] GoTL financed US$2 million of medical equipment and it contributed to rental of offices and salaries of staff, which are significant considering that GoTL is financing accommodation of Cuban and other international medical personnel.

(c) Project Cost by Category (in USD Million equivalent)

Categories	Appraisal Estimate (USD millions)		Actual Disbursement (USD millions)		Percentage of Appraisal	
	TFET	**EC**	**TFET**	**EC**	**TFET**	**EC**
(1) Consultant Services	6.12	0.46	7.47	0.32	122 %	70 %
(2) Goods	2.50	7.22	1.80	5.25	72 %	73 %
(3) Training and fellowships	0.80	1.63	0.13	1.64	16 %	101 %
(4) Civil Works	2.50	11.0	2.48	11.82	99 %	107 %
(5) Incremental Operating Costs	0.28	0.05	0.43	0.05	154 %	100 %
(6) Unallocated Funds	0.40		-			
Total Project Costs	**12.60**	**20.36**	**12.6**	**19.53**	**100 %**	**96 %**

Annex 2. Outputs by Component

Component	Planned outputs at Appraisal	Actual outputs at ICR	Comments
Component 1 - Supporting Ongoing Service Delivery (i) District Health Planning	Provision of technical assistance at the DHS1 and district levels for: (i) HR management, (ii) district health management, (iii) hospital management, and (iv) assets management	Technical assistance was provided at the center and district levels to support all aspects of the project. The project financed US$7.80 million in technical assistance.	Initially, NGOs were contracted as service providers following the departure of Indonesian doctors. Later local staff under the guidance of district health advisors took over the responsibility for district planning and management.
(ii) Service Delivery at District level	(a) establishment of Timorese District Health Management Teams (DHMT) (b) work with the community to establish mechanisms for community participation (c) hiring of expatriate doctors (d) provision of selected high priority services	(a) By end of 2001, DHMT were established in each of the 12 districts (not including Dili, which has always been treated separately) (b) Project-financed TA supported DHMTs in preparing district health plans, which included some community consultation. The 2006 budget was decentralized to district level laying the groundwork for more effective district planning. MOH has piloted a community Family Health Promoter program, which will be further strengthened and scaled up with support from HSSP-SP. (c) By the end of 2006, over 300 additional doctors from Cuba had been recruited and 600 medical students were sent to Cuba for training. (d) strengthened planning and implementation at district level has	Through a bilateral agreement between GoTL and Cuba, about 300 Cuban doctors have been working in Timor-Leste since 2006, and over 600 Timorese have been sent for medical training in Cuba. While the availability of the Cuban doctors has increased human resource availability, it led to a need to revisit the HRH strategy, and it also contributed to a significant increase in drug prescriptions and difficulties in projecting drug needs.

		contributed to improved coverage of key services.	
(iii) Pharmaceuticals	(a) provision of pharmaceuticals for one year	(a) TFET financed US$1.3 million and the EC Grant financed US$5.5 million for the provision of pharmaceuticals and medical supplies. The project financed all ICB procurements of medical supplies from 2003-2007. Drug availability was clearly better than would have been without project, but fell short of 90% target.	Continued high levels of drug stock outs due to continued procurement difficulties at SAMES.
(iv) Special Services	(a) support to immunization, the national TB program, nutrition and health promotion	(a) All these areas were supported by the project and their implementation coordinated with relevant UN agencies.	Coverage of community health and nutrition services remains limited, and will be scaled up with support from HSSP-SP.
(v) Basic Services	(a) Maternal and child health	(a) These services have been supported through the project and implemented in collaboration with relevant UN agencies. All key MCH indicators have improved.	
Component 2 - Improve Range and Quality of Services and Develop & Implement Support Systems (i) Improvement of quality of basic health services	Strengthen: (a) health promotion activities (b) communicable disease surveillance, and (c) reproductive health	Range and quality of services have improved considerably since 1999. The project has provided technical assistance and extensive training in a variety of areas to improve technical and clinical skills. Through both TA and training, the project supported health promotion, CD surveillance and reproductive health in close collaboration with UN agencies.	Total fertility rates in Timor remain among the highest in the world, an average of 7.1 children per mother. This contributes in turn to high maternal and infant mortality.
(ii) Hospital rationalization and	(a) Strengthening of referral systems (b) Design and construction of	(a) Legislation was enacted to enable hospitals to become semi-autonomous	Good progress with respect to improved coverage for PHC, including ANC, skilled deliveries, and immunization

strengthening of referral system	four hospitals and other bedded facilities as agreed by DHS1 (c) Equipping of hospitals (d) Establishment of a communications network (e) Support for driving training and vehicle maintenance	(b) Construction of the 4 regional hospitals supported by the Project were completed albeit considerable delays. The project financed US$14.70 for civil works, including the construction of the hospitals and the Dili Lab. (c) There were significant delays in completing procurement procedures for medical equipment. The project financed US$0.6 million for medical equipment. In addition, US$2 million for medical equipment was financed by GOTL. (d) Communications network was established through the provision of radios for every Community Health Center. (e) The project supported these activities; more work is needed.	coverage. There is a lot of room for improvement for vehicle maintenance.
(iii) Central Laboratory and Community Health Centers	(a) rehabilitation of the Central Laboratory and Centro Clinic in Dili (b) equipping of the Lab	(a) The central lab was constructed/equipped albeit delays. (b) Rehabilitation of the Centro Clinic took place under HSRDP I.	
(iv) Autonomous Medical Supply Entity (SAMES)	(a) Enactment of legislation to establish SAMES as an autonomous entity. (b) Provision of TA to institutionalize SAMES.	(a) Legislation was enacted to enable SAMES to become semi-autonomous. (b) The project provided technical assistance to improve the overall operations of SAMES, including pharmaceuticals planning and medical supply systems. The project financed US$7.80 million in technical assistance to support all aspects of implementation,	The sector has suffered from shortages of essential drugs and continued problems in operation of SAMES. Shortages of essential drugs and continued problems in operation of SAMES have remained a major concern. Despite attempts to expedite the procurement of emergency drugs, finalization of orders has been subject to a myriad of delays and miscommunication among SAMES,

		including SAMES operations.	MOH, WB and suppliers.
(v) The Basis Package of Services	Standardization and enhancement of the Basic Service Package (BSP).	(a) The BSP roll-out was piloted in Aileu District from September 2007. Several of the larger facilities are already totally BSP-compliant. Several districts are still partially complaint; the target date is 2010 for 100% BSP-compliance.	
Component 3 - Develop/Implement Health Sector Policy and Management Systems (i) Policy and Systems	(a) Preparation of health policy studies and consultations with stakeholders. (b) Conduct a Demographic and Health Survey (DHS2). (c) Development and implementation of a Human Resource Management Strategy.	(a) The project has supported the development of a number of policy papers, including the Health Sector Strategic Plan with support from EC-financed consultants and the development of the MTEF. (b) DHS2 was conducted (c) HR strategy was developed, but needs to be revisited in view of additional foreign doctors recruited and a great number of Timorese attending medical school in Cuba.	Consultation with stakeholders has been effective through a number of for a, including bi-annual Joint Health Sector Reviews.
(ii) Management Systems	(a) Develop a Health and Management Information System (HMIS) (b) Conduct data analysis for planning and monitoring (c) Project Monitoring and Reporting (d) Provision of fellowships and study tours to managers of DHS1, health professionals and NGOs (e) Provision of fellowships to medical students and health professional to improve clinical skills.	(a) The HMIS was established and progressively there have been improvements in the quality of data entry/analysis and reporting. (b) and (c) Timeliness, reliability and use of data have been a constant challenge. (d) and (e) A great number of fellowships and other training have been made available through the TFET and EC Grants . The project financed US$1.98 million in training activities. One hundred and thirty seven (137) staff have received training: (i) 16 - post	WHO financed a consultant to work with MOH since January 2007 to help "clean" the HMIS data for 2006 and to improve the overall HMIS system. This resulted in a downward revision of some indicators (notably outpatient attendance), but gives more confidence on data for immunization coverage and skilled deliveries.

		graduate degrees, (ii) 87 medical undergraduate courses , (iii) 35 general medicine, (iv) 11 specialist areas, (v) 41 public health, and (vi) 7 courses on economics.	
(iii) Health Program Management Unit (PMU)	(a) Strengthening of the Unit through TA, equipment, furniture and supplies. (b) Capacity building for training of trainers. (c) Development and implementation of a training program for health system trainers, DHS1/MOH managers, members of health professional associations and health sector NGOs. (d) Planning and design of a cost-effective health system including organization structure and administrative procedures.	(a) The PMU was strengthened, and is now being integrated into MOH structures. However, the quality of the technical assistance has varied considerably. The project has financed US$0.5 million for operating costs. (b) Efforts have been displayed to improve capacity for training of trainers. Support in this regard will continue through the new AusAID/WB-financed project. (c) Training programs for health system trainers have been implemented, it will need continued support. (d) The operations of a cost-effective system are a continuous effort.	Capacity building is a process that needs to continue with or without support from external funding. The project has made great efforts in building considerable capacity for planning, management, coordination, and financial management. This capability is being utilized in the implementation of the new AusAID-WB-financed project and ultimately in the improvement of the government system.

Annex 3. Economic and Financial Analysis

N/A

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit	Responsibility/ Specialty
Lending			
Supervision/ICR			
Joseph J. Capuno	Consultant	EASHD	
David Michael Chandler	Sr. Financial Management Special	EAPCO	Fin. Management
Hugo Diaz-Etchevehere	Consultant	QAG	Operations
Olivio Euclides Dos Santos	Program Assistant	EACDF-DIV	Operations
Elke Frieda Ender	ETC Consultant	EASHD	Operations
Joao Jose Augusto Gomes	Operations Officer	EACDF-DIV	Operations
Stephen Paul Hartung	Financial Management Specialist	EAPCO	Fin. Management
Bisma Husen	Procurement Specialist	EAPCO	Procurement
Magnus Lindelow	Senior Economist	EASHD	Economics
Rekha Menon	Senior Economist	ECSHD	Economics
Janet Nassim	Sr. Operations Off.	HDNHE	Operations
Cristiano Costa e Silva Nunes	Procurement Spec.	EAPCO	Procurement
Christopher Scarf	Consultant	EASHD	Hospital Management
Christopher James Smith	Consultant	EASHD	Implementation
Nigel William Wakeham	Consultant	AFTH2	Architect
Rui Paulo de Jesus	E T Consultant	EASHD	
Ina da Silva dos Santos	Consultant	EASHD	
Betty Hanan	Consultant	EASHD	Implementation Specialist
Peter Lafere	Economist/Conflict Specialist	OPCFC	ICR

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY01	13	63.33
FY02		0.86
FY03		0.00
FY04		0.00
FY05		0.00

FY06		0.00
FY07		0.00
FY08		0.00
Total:	13	64.19
Supervision/ICR		
FY01		0.00
FY02	9	49.78
FY03	5	38.53
FY04	3	49.36
FY05	3	27.34
FY06	5	58.40
FY07	10	57.82
FY08	6	65.27
FY09	1	0.00
Total:	42	346.50

Annex 5. Beneficiary Survey Results

Not conducted

Annex 6. Stakeholder Workshop Report and Results

Not conducted

Annex 7. Summary of Recipient's ICR and/or Comments on Draft ICR

A. Background information

TFET implemented a two-phase program financed with TFET funds. The EC contribution has been through a three-phase program estimated at U$$38 million since year 2000. The project was designed as the second phrase financing commencing in Feb. 2004 (EC) and 2002 (TFET) respectively.

The health program was fully consistent with the objectives of the Transition Strategy. The program's policy framework addressed two key cross-cutting issues of risk pooling and cost containment by:

(a) Supporting the continuing operation of secondary and tertiary care facilities which do not at present charge fees, and
(b) Focusing on basic health care services that include health promotion and other components of the "best-buy" basic health service packages.

B. Sector's priorities:

- Restoration of primary health care services at the sub-district level.
- Re-establishment of inpatient services
- Re-establishment of a central health authority – MOH
- Health manpower capacity building.

C. Health service infrastructure in Timor-Leste

Primary health care is the major focus of MOH and all other components of the health systems are gear to support it. The family health promoter (FHP) is a community based initiative implemented in 4 districts, supported by UNICEF, HAI and TAIS. It is to be rolled out to all districts once the strategies are tested workable. Outside Dili, an estimated 30% of the population lives beyond two (2) hours walk from health facilities. Currently, there are four levels of health services, - Level 1 to Level 4.

Level 1 – Health Posts and Mobile clinics

This the basic health services also entry point into the public health services, and situated within sub-districts, serving 1,000 – 2,000 people. The services provided include provided include curative consultation, antenatal and postnatal care, immunization, growth monitoring, health education and health promotion activities. These facilities are plan within 4-8 km from the population. Health post provide link up to higher level of referral and emergency services through radio communication systems. The FPH program through community committee.

Mobile clinics are done at other sites (e.g. schools, markets, community structures), it is an outreach services. Services are conducted by health post and health centre staff on a routine schedule and budgeted basis. There are motorcycle mobile clinics and vehicle mobile clinics.

Level 2 – Community health center (Sub-district centers)

Located in every sub-district, a community health centre provides promotive, preventive and curative services. These include external consultations supported with a simple laboratory, maternity (including antenatal and postnatal care) to preventive (including immunization) and promotive services.

Sub-district health centers are usually situated at sub-district level and provide care for 5,000 – 15,000 people. They house a wide range of staff (usually include a doctor) and provide technical and managerial support to FHPs and health posts in the sub-districts. Sub-district health centers provide a higher range of services than health posts, including basic emergency obstetric care facilities, observation beds for 24 hours, basic laboratory, pharmaceutical services, and regular outreach at health posts to provide clinical and preventive services. The sub-district manager has the responsibility for coordinating all services at health posts.

Level 3 – District facility

District health centers (DHCs) are situated at the 5 districts that do not have a hospital.
They serve the entire district and are responsible for providing outreach and referral services to all facilities, and mobile services to remote areas.

District facilities provide higher level of services than health posts, as well as complicated curative cases requiring referral or inpatient treatment, beds, newborn resuscitation using oxygen, eye care, disability services (with support from NGOS working in the district), pharmacy, dental care, vehicle based mobile services to remote/rural areas, laboratory services, including microscopy, HIV testing.

These facilities are located in districts bordering Dili, like Aileu and Liquica. Atauro, island in Dili also have an observation unit. Minor surgical procedures like stitching, drainage of abscesses or any other surgical procedure not requiring general anesthesia are available there. Other surgical cases requiring general anesthesia are referred to referral hospitals, which are located within two hours' driving time.

Level 4 - Referral hospital

These hospitals are the second level of referral and offer a comprehensive level of services for patients referred in from the district Primary Health Care facilities.

The hospital services package supports and complements the BSP and provides referral services as part of the overall continuum of care starting in the community. While all referral hospitals provide similar services, there are slight variations in the scope governed by the differences in size, scope and environment.

These types of facility are available in Lautem, Viqueque, Manufahi, Ermera and Manatuto Districts. Now with TFET funding, four referral hospitals were built – Maubisse, Maliana, Oecussi and rehabilitation of GVNH, Dili Hospital. The procedures to be done at referral hospitals depend to a large degree on the level of skill of the medical personnel and equipment available. Where there are specialist surgeons, obstetricians or pediatricians, more complex services can be provided and more responsibility can be taken at hospital level.

Referral hospital facilities include an inpatient department, with beds where medical cases can be diagnosed, treated and referred to higher levels if needed. Complete laboratory services and other diagnostic means are available.

GVNH National Hospital

This hospital acts as the national referral hospital. It should attend only referral cases from other hospitals or health centers. Currently, GVNH services – 80% of outpatient services are primary health care. GVNH past statistics indicated it did not provide for equipment maintenance routinely and the status of medical equipment was of poor quality. The weakness on equipment, equipment maintenance were identified and measures were taken with support from TFET and EC grants to provide medical equipment to the hospitals including the hospitals at Maliana, Maubisse, Oecussi.

D. Key policy and institutional reforms supported by the project:

- Ensured that health system development is guided by clear policy.
- Ensured that the medium-term health expenditure program is financially and institutionally sustainable, including development and implementation of a program to rehabilitate the hospital sector that meets core health needs.
- Ensure public expenditure on health are targeted to:

  (i) improved access to the poor particularly rural areas.
  (ii) health services which have strong "public good" and "high positive externalities".

- Instituted mechanisms for community participation in the choices about their health care and information.
- Assisted in the creation of capacity to maintain oversight over policies in other sectors that affect health outcomes.
- Continuous support for SAMES, responsible to government, but run on commercial lines by non – government employees.
- Supported the continuation of the Sector Wide Approach.
- Specialized support to district health management and service delivery.

E. Project Components

Component 1: Support on-going service delivery

The component supported a continued service delivery through the provision of technical assistance to the new district health management teams, provision of pharmaceuticals to health facilities, including hospitals.

For two consecutive years (FY 04 and FY05), all health facilities of the country were supplied with good quality essentials pharmaceuticals and medical supplies, in order to ensure delivery of a Basic Health Package.

Supply of good quality essentials pharmaceuticals and medical supplies:

(a) Supply of pharmaceuticals:

TF-51363 disbursed a total of US$ 1,766,499 during the period 7.1.2004 to 30.06.2005
TF-51363 disbursed a total of US$ 596,044 during the period 1.07.2005 to 30.06.2006
TF- 51363 disbursed a total of US$ 418,859 during the period 1.07.2006 to 30.06.2007
TF-51363 disbursed a total of US$ 2,723,863 during the period 1/7/2007 to 30.08.2008

Total disbursed US$ 5,505,265 from 2004 to 30.08.2008 funded by TF-51363

TF-29888 disbursed US$ 1,272,718 for procurement of pharmaceutical during the period 06.2003 to 06.2004.

Total fund disbursed from TF-29888 for drugs was US$ 1,272,718.

Operational procedures - SAMES

The grants provided technical assistance for SAMES, which have contributed to the development of the following organizational capacity:

- SAMES had taken over the responsibilities of pharmaceuticals procurement starting at the end of 2005. Health commodities information system (WMS) was installed, improved and or modified into a web based window, which allows easy modification and problem fixing by a remote technical centre (Broadline Company). The system has improved stock management and allows a proactive replenishment of stocks. The system integrates procurement and asset management and allows adjustments to correct data if required.
- The verification of incoming goods has been improved with direct observation of all goods. Consultation with necessary officers/Technical Assistance was done immediately and any problem identified are reported and communicated to senior management and when necessary to suppliers.

- SAMES has gradually taken the responsibility of financial reporting and management. It is managing its operational funds from year 2006. In the last quarter of 2007, SAMES started to receive funds directly from GoTL for the procurement of pharmaceuticals.
- SAMES has developed an Accounting Manual and is using MYOB accounting software.

Challenges:

- **Planning** – longer term planning is lacking, no PSM plan, no figures on estimated annual budget for replenishing all stock items, when and how often to procure, funding of the plan, communication and coordination with donors. SAMES is now addressing these matters.
- **Long lead times** – this significantly affects the ability of SAMES/MoH to respond to routine as well as urgent requirements. The bureaucratic procedures for placing and receiving orders are long and often delayed. This is a major cause of stock-outs at SAMES.
- **Inadequate use of the Standard Treatment Guidelines and Essential Drugs List** (STG and EML) – unwillingness and or ignorance of the clinician to adhere to STG and EDL has resulted into duplication of dosage forms for the same product and unnecessary requisition of products that are not in line with the STG/EDL.
- **Poor quality of data form health facilities** – difficulties in health commodities record keeping of consumption data resulting into inability of health facility store keepers to correctly estimate requirements.
- **Slow customs clearance** – customs clearance delays have an additional impact on the products availability, which in turn affects the whole procurement cycle and efforts to prevent stock-outs.
- **Information system** – more requires to be done for SAMES to inform its customers. The integration of Warehouse and Accounting system is being contemplated.
- **Limited warehousing storage capacity.** There is congestion of health commodities due to lack of storage space, however efforts are being undertaken to address the problem.
- **Inadequate health commodities distribution facility**. SAMES has got one old truck, however efforts have been undertaken to address this problem.
- **Lack of quality testing facilities.**
- **Lack of Computer technical personnel at SAMES.** Although great strides have been made in the training of the staff, in the use of important programs, i.e. word, excel, spreadsheet, and database, more needs to be done.
- **Delay in payments** due to unavailability of funds resulting in delays in deliveries

The grants have provided good quality essential pharmaceuticals and medical supplies. SAMES has received a total amount of US$ 6,777,983 for pharmaceuticals and medical supplies from the two grants. The number of facilities that SAMES had provided services had increased by about 64% from year 2005 (261) to year 2006 (428).

Components 2: Improve the range and quality of services, and develop and implement supporting systems

The component supported improvements in the quality of services with particular emphasis on standardizing and enhancing the quality of delivery of the basic package of services, including reproductive health, and strengthening referral systems through the rehabilitation of four hospitals.

Main Component Outputs:

- Output – Up to six "hospital" units constructed/rehabilitated and equipped of which 1 or 2 will provide elective surgical care, while 4 to 5 were to provide emergency surgery only.

- **Operation's design and implementation.** The activities financed under the Trust Fund for the "European Community Health Program for Timor-Leste is an integral part of Timor-Leste's Health Sector Rehabilitation and Development Program.

  The specific objectives of the European Communities (EC) contribution were to:

1. To co-fund the infrastructure/referral system components.
2. To fund the supply of quality pharmaceuticals and medical supplies through SAMES.
3. To fund a substantial part of the Training program.

The hospitals construction expenditure was the largest component of the project. Construction of 4 hospitals – Dili GVNH, Maliana, Oecussi, Maubisse, and the Central Laboratory in Dili.

Construction Status

1. Central laboratory Dili

Construction started on 1 September 2005, contractor was given an extension of 35 days due to site access problem due to IDPs. Phrase 1 (Main laboratory building and the visitor's area) completed on October 20, 2007; handed over in November 2007. The laboratory has been fitted out by St John of God and is now in operation. Phase 2 – is completed and handed over. The EC Grant funded 100% on the project cost.

2. GVNH Hospital Dili

Final phase of the Project was completed in the 1st week August 2008 and handed over to hospital authority. Population at Dili (District) – latest data 240,521.

MOH budget for Dili hospital for Fiscal Year 08 at US$ 2,610,000 and (09) US$ 1,782,719.

The EC Grant financed US$2.5 million of Phase 3.

3. Oecusse Hospital

Building started on 9 December 2005 and practical completion on 5 October 2007. The population at Oecusse - latest data 68,639 population.

MOH budget for Oecusse hospital for Fiscal Year (08) US$ 729,000 and (09) at US$ 643,190.

4. Maliana Hospital

Construction work started on 8 November 2005 and completed on 20 October 2007. Supervision and monitoring of defective liability is on going.

Population at Maliana (latest data) - 164,828
MOH budget at Maliana district for Fiscal Year (08) USD 631,000 and (09) USD 883,893

5. Maubisse Hospital

Construction work started on 11 January 2006 and completed on 10 October 2007. Supervision and monitoring of defective liability is on going. Population at Maubisse - latest data 163,639.

MOH budget at Maubisse for Fiscal Year (08)USD 772,000 and (09) USD 807,900.

The construction of referral hospitals for Maliana, Oecussi, Maubisee took place during the Timor-Leste 2006 crisis period. The construction started on 8th November 2005. At the time, the Project management Unit was operated by a skeleton dedicated staff, coordinating, directing, supervising the project under unstable political environment. The project was granted an extension and practical completion on 20 October 2007, 12 months later than the original plan completion date (i.e. 7 August 2006)

TFET and EC grants components on construction enabled the districts' population at Oecussi, Maliana, Maubissee, access to Level 4 referral hospital and better quality of services.

The TFET and EC grants to rehabilitate GVNH and the central laboratory provided the opportunity to best cater for the needs of RDTL in the capital city, Dili. Besides TFET and EC grants support, GVNH also received grants, contributions in-kind, and other technical assistance from other external donors. This support enabled GVNH to provide improved health services. The grants enabled Level 4 infrastructure catering health access for the population at the district level.

Supply of goods – Hospital equipments – US$ 559,960.41

RFQ goods procured funded jointly by TF-51363 and TF-29888 in the composition 82%:18%.

Medical Equipment for Referral Hospitals:

RFQ06D-K and ICB 06B (Oceano Pty. Global Holdings, Abbot Diagnostics/Bes Technology. Contract and An Hui Co.) amounting to US$ 559,960.59 was delivered by the suppliers and eventually delivered to the hospitals namely: Guido Valadares National Hospital, Oecussi Referral Hospital, Maliana and Maubisse.

Exceptional events: on contract arrangement during grant closure in July 2008:

- ICB 06A, 06B & 06C amounting to $2,074,033.20 has been processed for procurement funded by the Government. CPV (CFET) No. 8PR 992792 amounting to US$2,1 million - approved September 5, 2008.
- Central Procurement administered all the documentation and contract preparations with the assistance of Procurement Assistant in PMU. Contracts were signed with six suppliers; equipment was delivered at the end of 2008.

Operation experience and lesson learned (Medical equipment)

- There is significant level of government commitment in ensuring the hospitals are properly equipped with necessary hospital equipments. The needs are still huge and current fiscal year 2009 budget, donors from UNFPA and RACs have express their interest in contributing medical equipments for CHCs and district health services, trying to address the gaps.

- There is a need for fast respond rate, tight monitoring on project progress to ensure all supplies are delivered on time, payment disbursed before grant closure dateline.

- Timor-Leste is a new nation, it is recovering from post-war and conflict. From 1999 to today, the government is in the process to improve/upgrade/restore the country's infrastructure, energy, agriculture sector, education and health services.

Health service coverage

MOH has developed a Basic Service Package (BSP) that consist of basic reasonable range of appropriate services and programmes for inpatients and to individuals and communities on an outreach basis via mobile clinics;

Most recently, through a locally-generated and centrally-supported health promoter programme, BSP is scheduled to be rolled out in 2008 (a process that is scheduled to

conclude at the end of 2010). BSP also set out MDG goals to attain at the target time-line; BSP goal is based on good practice to reduce mortality and morbidity.

Several of the larger facilities are already totally BSP-compliant, with capacity to target the major priority areas of maternal and child health (through neonatal care, IMCI, immunization, skilled birth attendance and basic emergency obstetric care, STI, and tuberculosis). Many of the districts are still partially compliant. The BSP coverage target date is 2010 for 100% health care facilities access.

Components of BSP:

- Child Health – (MDG 4)
- Maternal Health – (MDG 5)
- Communicable Diseases – (MDG 6)
- Non communicable diseases (Non MDG)
- Health promotion
- Environment Health
- Management and infra-structure

MOH Finance expenditure at DHS level (consolidating figures)

	2008-DHS	2008-total		2009-DHS	2009-total	
Salaries	3187000	5854000	54.4	4933634	10011315	49.3
Goods and services	4935000	18653000	26.5	5937123	18354087	32.3
Operational Material and supplies	**1529000**	**5072000**		**2516225**	**55,42,427**	
Minor Capital	681000	3524000	19.3	971785	1322404	73.5
Capital development	971000	2768000	35.1	2065000	2065000	100.0
Total	9774000	30799000	31.7	13907542	31752806	43.8
	9774000	30799000		13907542	31752806	
Operational % of salaries and goods	31.0	27.2		42.4	30.2	

Expenditure on DHS as % of total expenditure

MOH Finance expenditure at DHS level (consolidated figures)

Among the goods and services of US$ 1,865,300 for the year 2008, TFET and EC drug procurement contributed a certain percentage in the form of medicine, drugs available to DHS and the entire Health structure. SAMES drug distribution statistics provide the percentage supported by TFET and EC contributions.

Lesson learned and difficulties encountered (BSP)

SAMES reported difficulties in obtaining drug distribution data from the MOH systems. Information cycle and data collection are weak

There is a great need for MOH to report its commodities and drugs procurement, usage report per cost centers. These commodities utilized would need to be supported by medical statistics to improve health performance. Reports on drug provided and funding sources per district levels and from donor sources are not easily accessible, retrievable.

Components 3: Develop and Implement Health Sector Policy and Management Systems

Health policy development included: (i) conducting a Demographic and Health Survey (DHS) to provide information on which to base policy; and (ii) assistance to capacity development in the formulation and promulgation of policy, and its implementation. An important sub-component supported the development of a Human Resource Management Strategy, which included training and all other aspects of human resources management.

Components 3 – Training expenditure

EC contribution supported greatly needed training in all aspects of health care delivery, systems and policy development, and in management. The first priority was the development of a program that approached training within the framework of manpower development appropriate to the needs and resources of the country.

Scholarship and fellowships have allowed for: (a) short term training abroad to update and extend clinical skills and management competence, and (b) longer term training for doctors, generally for students, who have had their training disrupted. Training programs also catered for maintenance of new machines and instruments.

A total of US$ 1,770,732 was spent on training funded by TF-51363.

Operation results:

A total number of 137 students were sent abroad, 103 students completed their studies with 34 numbers on going in their courses, a brief summary as below :

	Total numbers			
Description of courses	Total number	Completed	On going	
General Medicine	35	25	10	
Public Health	41	41	0	
Master Public Health	16	7	9	
Radiographer	5	2	3	
Nurse	1	1	0	
Midwife	1	1	0	
Economic degrec	7	7	0	
Doctor specialist	11	7	4	
Electro Medic	6	6	0	
Physioterapy	3	3	0	
Anatesdic Nurse	3	3	0	
Laboratory	5	0	5	
Others	3	0	3	
Total numbers supported	137	103	34	

Results 3 – Health Sector Policy and Management Systems developed.

Operation results

Training components funded by TF-51363:

137 numbers of people trained, with 16 undertaking master studies, 87 pursuing medical undergraduate courses with 35 on general medicines, 11 in specialist areas, 41 on public health, 7 pursuing economic courses.

Output – 103 health staff trained and more than 15 scholarships funded.

The students, who completed the studies and are currently working in hospitals and health care systems is summarized as follows:

- General Medicine – 35 students serving in Dili Hospital.
- Public Health – 41 students, 2 per each of the 13 districts, remaining in Dili Hospitals.
- Midwife – 1 serving at Dili Hospital.
- Radiographer – one for each in Bacau, Saui districts, remaining numbers at Dili Hospital. Now only two remain to graduate.
- Specialist doctors – 7 all at Dili Hospital
- Electro Medic – 1 at Bacau, 1 at Suai, 4 at Dili
- Laboratory – all 5 undergoing studies.

Management Systems:

The PMU has administered the project funding since HSSP I. The PMU has experienced many challenges working in an unstable political environment during the 2006-2007 crisis and functioning with inadequate staffing and a manual system environment.

The current financial management system is manual, working on excel worksheet on all data. The PMU uses Free balances for project expenditures from 2003 until June 2007. There was some system problem with Treasury and access at MOH for Project finance to free balance was not available. The previous Finance Advisor – served for four (4) years and left in January 2008. The finance administration, including payment, replenishment and financial management reporting to the World Bank was managed by the Assistant Accountant since July 2007 until now. Staff are working single-handedly for all functions including replenishment procedures.

F. Ratings

Recipient:

- At design – Satisfactory
- During Implementation – Satisfactory

Bank:

- At design – Satisfactory
- During Implementation – Satisfactory

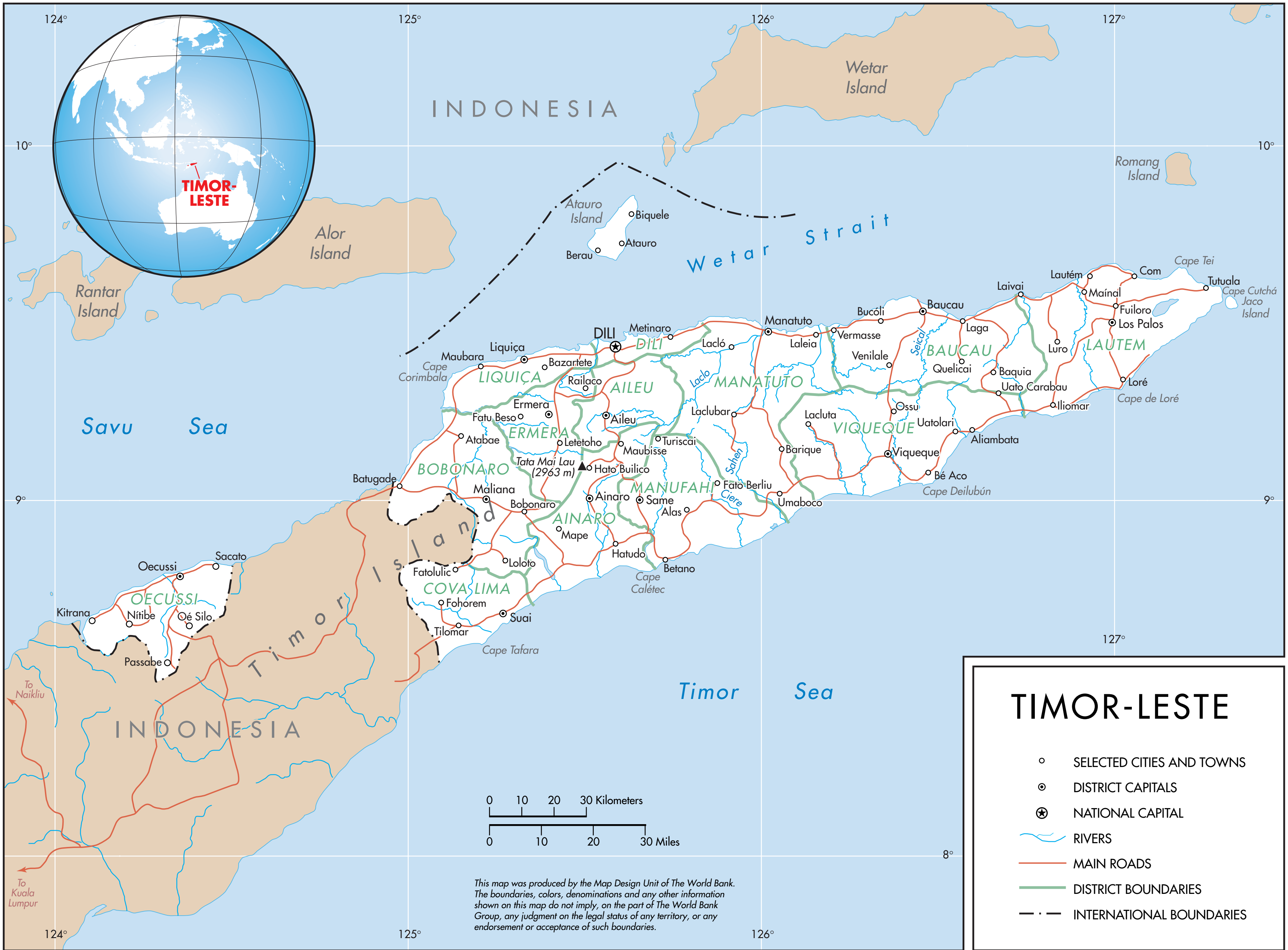
Annex 8. Comments of Cofinanciers and Other Partners/Stakeholders

The following is a summary of comments received from MOH during the ICR mission. Several of these are consistent with findings of the ICR team:

- HSRDP II components and sub-components were a natural progression of issues addressed under HSRDP I, but a 27-month implementation period was too short, especially considering the reconstruction of 4 hospitals.
- World Bank procurement requirements and timeliness of replies sometimes caused delays in procurement processes.
- High turnover of technical assistance hindered timely implementation of some activities, including procurement and information systems.
- The whole rehabilitation process has been carried out in the context of rationalization.
- Development of policies and strategies created an environment within the Ministry where MOH was keen to reflect on them avoiding ad-hoc decisions.
- The length of Aide Memoires and complexity of issues addressed has not resulted in staff being able to benefit fully from findings and recommendations.

Annex 9. List of Supporting Documents

- Project Appraisal Document
- Trust Fund for Timor-Leste Grant Agreement – TF-29888
- EC Grant Agreement – TF-51363
- Amendments to Grant Agreements
- Aide Memoires
- Implementation Supervision Reports (ISRs)
- Progress Reports
- ICR for HSRDP I
- "Rehabilitating the health system after conflict in Timor-Leste: a shift from NGO to government leadership" – article published by Oxford University Press in 2006
- Interim Evaluation of the Trust Fund for Timor-Leste (TFET) – 2004
- Mid-Term Evaluation of the EC Grant – TF-51363
- "Health sector Resilience and Performance in Times of Instability," School of Public health and community Medicine (Australia) and Menzies School of Health Research (financed by AusAID)
- Timor-Leste Demographic and Health Survey (DHS), 2003.
- "Timor-Leste Standards of Living Survey (TLSLS)," 2001 and 2007, Timor-Leste Directorate of National Statistics (DNE), World Bank, UNICEF.
- UNICEF, "Timor-Leste Multicluster Indicator Survey" (MICS), 2002.
- Consultants reports following field visits



TIMOR-LESTE
SELECTED CITIES AND TOWNS
DISTRICT CAPITALS
NATIONAL CAPITAL
RIVERS
MAIN ROADS
DISTRICT BOUNDARIES
INTERNATIONAL BOUNDARIES
INDONESIA
Wetar Island
Alor Island
Rantar Island
Romang Island
Atauro Island
Wetar Strait
Savu Sea
Timor Sea
Timor Island
TIMOR-LESTE
DILI
LIQUIÇA
AILEU
MANATUTO
BAUCAU
LAUTEM
ERMERA
BOBONARO
MANUFAHI
AINARO
VIQUEQUE
COVA LIMA
OECUSSI
Tata Mai Lau (2963 m)
Cape Corimbala
Cape Tei
Cape Cutchá
Jaco Island
Cape de Loré
Cape Deilubún
Cape Calétec
Cape Tafara
To Naikliu
To Kuala Lumpur
0 10 20 30 Kilometers
0 10 20 30 Miles
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