Timor-Leste Health Program 2013–2021
CONCEPT NOTE

Contents[1]

[1] The table of contents is a slightly amended version of that suggested in the IET Facilitated Design Approach Guidelines.

Executive summary

Rationale for engagement in the country and in the health sector
Timor-Leste's Strategic Development Plan and the Program of the Fifth Constitutional Government provide a national policy environment with which Australia's aid policy—for development assistance overall and in health—is closely aligned. Australia also has a regional strategic interest as Timor-Leste is a near neighbour, there is a long history of cooperation and Australia has technical expertise and funds that can be of assistance. Although there has been a rapid growth in oil and gas revenues and the beginnings of large-scale infrastructure development, government institutions and the capacity to deliver effective services remain weak. Health status is low compared with international averages, and the health service is comprehensively constrained by low-performing systems. Under Ministry of Health (MoH) leadership, AusAID support can help to overcome these challenges faster than would otherwise be possible, thereby preventing much illness and death, especially for mothers and children. When people's health is improved, especially for women and children, there are well-documented spin-offs in areas such as educational attainment, livelihood security and economic productivity.

Rationale for the program focus
The program will focus on those aspects of the health system that are most likely to have an impact on the health of mothers and children. This will require a broad range of support including for leadership, many aspects of management, human resources, procurement and logistics. It will not include health outcomes related to, for example, communicable diseases (other than those that most affect children), non-communicable diseases, and injuries. Similarly, the program will not cover systems aspects that are not the main priorities for maternal and child health outcomes, such as hospital construction, salaries, and transfers of patients abroad for treatment.

Program description
The design is for an eight-year program with a major review point after four years. The scope is nationwide, covering a population of about 240 000 women of child-bearing age and 190 000 children under 5 (the population is on track to double by 2030). The program will support both demand-side and supply-side interventions—the former being about people's health-related behaviour and the ways they can influence change in the health services, and the latter about improvements in the efficiency and effectiveness of service delivery.[2]

The program goal is that mothers and children live longer and healthier lives, with the main indicators being the maternal mortality ratio and under-5 mortality rate. The end-of-program outcome is that households, especially the most vulnerable, increasingly practice behaviours that are conducive to better maternal and child health and nutrition, and use reproductive, maternal, newborn and child health services.

These are supported by a set of inter-related intermediate outcomes that deal with the competence of health providers; personal and community attitudes and behaviours; advocacy; data management; and a broad array of management skills, behaviour and systems.

[2] Enabling health-related actions by individuals or communities is often referred to as 'demand-side intervention', and strengthening the provision of services is often referred to as 'supply-side intervention'. While demand and supply are wider and more complex than this, the terms are occasionally used in this way in this Concept Note.

AusAID currently has a portfolio of seven projects in health in Timor-Leste. Most of these will end by 2015 and those that are most relevant to the content and approach of the new program will have their key elements merged into it. These cover areas such as maternal and child health, birth spacing, and health systems development. ATLASS-II, which supports skills development for secondary and specialist care, will continue alongside the new program.

Budget and preferred delivery mechanisms
The budget is estimated at up to AUD50 million for the first four years of the program, which represents about 14 per cent of the Country Program budget.

For the aid delivery mechanisms, current thinking is to use a mix of a managing contractor, a procurement and logistics contractor, and a small but increasing amount of sector budget support. We intend to consider the opportunity and benefit of linking or sub-contracting NGOs and others under a managing contractor. We will also consider limited ongoing support for World Bank and UN/WHO on technical analysis. Future support will be identified through regular planning processes and discussions with the Ministry of Health.

Governance arrangements
Subject to the joint design work with the MoH in early 2013, we anticipate a governance arrangement based on sector-wide approaches that have worked in countries at similar stages of development. The arrangement will conform with the intention of the Government of Timor-Leste (GoTL) to have 'one plan, one budget, and one monitoring and evaluation (M&E) framework' and will aim to work through the government's planning and management systems. This may lead to delays and make it harder to show attributable results, but is in keeping with Australia's commitment to the New Deal for engagement with fragile states.

Monitoring and evaluation
Program design will include the initial setting of indicators. The M&E framework will be finalised when design is complete, in agreement with the MoH and in keeping with GoTL's intention of having one M&E framework for the sector (and noting that that framework is some way in the future). Program M&E will also be consistent with AusAID's performance assessment framework (PAF),that will be managed at the level of the health delivery strategy and country program. The M&E process is likely to include annual plans with objectives and actions; joint annual reviews; course corrections based on review findings; and an independent review three years into the first four years. The mid-term review will consider the case for a second four-year period. The final annual review in the first stage will advise on moving ahead (or not), and trigger formal design and approval for the second stage.

Linkages to other programs
Several new AusAID programs aim to achieve outcomes that will impact on people's health. These include Governance for Development, BESIK-II, Seeds for Life, Roads for Development, Education and Training, and Eliminating Violence Against Women. Nutrition is being mainstreamed across AusAID's Timor-Leste programs. In-depth consultation has already begun in order to share lessons learned, to avoid duplication, and to find suitable ways to cooperate. This consultation and, where appropriate, joint working will continue during design and implementation.

Key risks and their management
The Risk and Value Assessment identified two high-risk areas: the operating environment and fraud. In the operating environment, limited government ownership

due to pressing day to day issues and focusing on external supported activities could delay or dilute outcomes. We will manage these risks through continuing to strengthen engagement with the MoH at all levels and by using a range of aid management approaches including contracts with implementers outside government (multilaterals, NGOs, procurement and logistics contractor and so on). We will mitigate the risk of fraud through a range of measures including a fiduciary risk assessment, requiring audit (preferably increasingly on performance rather than inputs), varying the type and intensity of oversight to reflect risk levels; providing technical assistance to support improvements in financial management; and scrutinising financial accounts in areas such as procurement and construction.

The assessment also identified a number of moderate risks, including continuing problems around gender and disability, and damage to Australia's reputation and its relations with GoTL. While the overall risk and value rating is 'low', risks will need careful monitoring. Overall, this is a very challenging operating environment that will require time and resources to sustain progress.

Design next steps

The design process will include joint planning with the MoH and engagement with development partners (DPs), civil society, and internal AusAID stakeholders. Using the facilitated design approach, we will have three design workshops between March and May 2013. We will use a similar approach to contestability as in the concept stage, using the management team and an independent reference group before submission for independent appraisal, peer review and FADG approval.

1. Rationale for engagement in the country and in the sector

1.1 Rationale for engagement in Timor-Leste

The policy environment

Timor-Leste's *Strategic Development Plan 2011–2030* sets out the country's development agenda. This key policy document acknowledges the rapid changes of the last decade and the significant progress still to be made. In particular, while oil and gas revenues are growing rapidly, social indicators are likely to improve more slowly because there is still a gap in the institutional capacity necessary for driving development.

The purpose of the Strategic Development Plan (SDP) is to support the transition of Timor-Leste 'from a low income to upper middle income country, with a healthy, well-educated and safe population by 2030'. The plan aims 'to develop core infrastructure, human resources and the strength of our society, and to encourage the growth of private sector jobs in strategic industry sectors'. It covers three areas: social capital (which includes health, education and social inclusion), infrastructure development and economic development, underpinned by an effective institutional framework and a clear macro-economic direction.

The country faces a wide range of serious development challenges. Those relating to health are covered in-depth in Section 1.2. Non-health-specific challenges include very high unemployment, especially among the young; few rural opportunities beyond subsistence agriculture; urban–rural inequality; increasing numbers of potentially disenfranchised, unemployed youth in towns; a rural road network that has declined since independence; and poor quality of education in schools.[3]

Many of the SDP's short- and medium-term targets are about creating the institutional framework for development across the sectors. A key element in the plan is 'the development of transparent, accountable and competent institutions across our civil service' such that they can implement the SPD and provide quality services. The need for institutional development is illustrated by the plan's emphasis on administrative and governance reform that encompasses improvements in performance management; human resources planning, development and training; leadership and management; appropriate use of statutory authorities; and public financial management; and the use of quality data for decision making.

The SDP sets out an ambitious approach to long-term development. A major focus is on the management and use of the Petroleum Development Fund to drive economic development. Alongside this is a challenging program of public sector reform and institutional capacity development, to drive improvements in service delivery. The plan recognises that, while much progress has been made since independence in 2002, the level of development of institutions and the capacity to run them is still relatively low, and that much progress is yet to be made. See Annex 1 for the challenges as described in the SDP Summary, 2010.[4]

The SDP also recognises the importance of Timor-Leste's multilateral and bilateral relationships, including in the provision of development assistance. In relation to

[3] AusAID's Timor-Leste Program Performance Report, 2012, contains a useful summary of these problems.

[4] The SDP Summary is the 2010 precursor to the full SDP, used for widespread public consultation. It contains a fuller description of challenges than does the SDP itself.

Australia, the SDP states that the relationship 'will remain strong and positive'. This is echoed in the *Timor-Leste – Australia Strategic Planning Agreement for Development, 2011*[5], which established the 'shared vision to work together in close cooperation to improve the lives of all citizens of Timor-Leste and in so doing strengthen the bonds between our two peoples and our countries'. Importantly, the Agreement acknowledges the SDP as the overarching framework for AusAID projects and programs.

The Agreement confirms Australia's commitment to deliver a 'program of high-quality financial, technical and policy support to contribute to the implementations of the SDP'. The Agreement also confirms GoTL's commitment, inter alia, to 'pursue poverty reduction and improvements in health, education and other Millennium Development Goal outcomes'. The governments agreed to focus, among other priorities, on 'saving lives by increasing access to quality health services' in 2013.

A major part of the rationale for Australia's engagement in Timor-Leste, and reflected in the Agreement, is also set out in *An Effective Aid Program for Australia*[6], which makes clear that the Asia-Pacific region, including Timor-Leste as a near neighbour, will remain the primary focus of the aid program's efforts. The health policy priorities are described in *Saving Lives*[7]*.* In particular, Australia intends to focus on 'proven value-for-money interventions to reduce maternal and child deaths, particularly in high-burden countries such as Papua New Guinea and Timor-Leste, which have some of the highest rates of maternal deaths in the Asia-Pacific region after Afghanistan'.

In summary, the rationale for engagement in Timor-Leste is set out in the SDP and the Timor-Leste–Australia Strategic Planning Agreement. The policy framework in those documents is underpinned by an analysis of underlying development problems, the solutions to which are held back by low national capacity to deliver services. The SDP sets out an ambitious long-term framework for development. A large part of the case for continuing development assistance, including from Australia, is that it complements the government's big capital investments by investing in the development of services and human capacity.

The donor environment

The donor landscape continues to change, with the prospect of some partners, for instance USAID, reducing or removing their support. It is possible that others such as the Global Alliance for Vaccines and Immunisations (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) may increase their contributions.

The situation has evolved from donors providing more resources than government, soon after independence, to a scenario of the country having a sizable budget and donors being less predominant. For example, for a gross national income of USD$2,444 million in 2010, the OECD estimated net ODA at USD$292 million.[8] At 10.8 per cent, this was a much lower proportion than earlier in the decade, while still an important share. Donors still provide a significant part of spending on infrastructure, services and supplies—approximately USD$296 million[9] compared with USD$1.7 billion of government budget in 2012, that is, over 17 per cent.

[5] The Agreement is to be updated. If the new version contains any substantive changes relevant to the new health program, they will be picked up at the design stage.
[6] *An Effective Aid Program for Australia. Making a real difference – Delivering real results.* Updated June 2012.
[7] *Saving Lives: Improving the lives of the world's poor.* AusAID, November 2011.
[8] OECD Aid Statistics at a Glance: http://www.oecd.org/dac/aidstatistics/1901410.gif
[9] GoTL Aid Transparency Portal, accessed 7 December 2012.

However, the contribution of aid to the budget for goods and services is very significant. This is because over half the government budget is allocated to infrastructure and only about a third to recurrent spending, and most of the latter goes to salaries and wages. The country therefore uses aid for much of its service delivery, and Australian aid will provide a greater proportion of that budget as other donors reduce their inputs.

1.2 Rationale for engagement in health

In this section we show the close alignment between Timor-Leste's health goals and Australia's aid policy on health; and examine in detail the health challenges that the government and the people are facing.

Alignment of Australia's aid policy with national strategic priorities in health
Timor-Leste's Program of the Fifth Constitutional Government, 2012, and the Strategic Development Plan 2011–2030 on which the Program is based, include a focus on the needs of children, women and other vulnerable groups as one of the over-arching goals for health service delivery.[10]

The Ministry of Health aims to issue a new five-year plan in early 2013, which will be consistent with the SDP and government program. The health-related priorities in these documents can be categorised as health-outcome-related and systems-related. Priorities that focus directly on health problems include maternal and child health, vector-born diseases, nutrition, mental health, disability, and conditions related to aging. Priorities related to the development of essential systems and approaches for achieving health outcomes include primary health care, secondary and tertiary care, human resources, infrastructure, transport and communications, the private sector, and capacity development in general. Two features stand out: first, the government aims to develop a health service that covers the span of primary to tertiary care and a comprehensive range of health services. Second, there is a clear recognition that in order to achieve health outcomes, the systems must be in place and capable of delivering. For more detail on the SDP's actions, strategies and targets related to health, see Annex 2.

The Minister of Health has indicated that he wishes to have Australia's support for implementing the program, and that he wants to discuss the details early in 2013. The publication of the five-year plan and the finalisation of the MoH budget will provide a foundation for that discussion. See Sections 2 and 3 for Concept-stage thinking about how AusAID will respond to MoH priorities in the plan and budget.

There is much commonality between Timor-Leste's existing plans and Australian policy as set out in *Saving Lives.*[11] On the assumption that the government's main health strategies will not change significantly in the five-year plan, the health outcomes to which Australia will contribute are:

- reduced maternal deaths, through increased access to skilled birth attendants, emergency obstetric care and family planning
- reduced child deaths, through increased immunisation coverage, improved nutrition and prevention and treatment of common childhood illnesses

[10] Strategic Development Plan p 36
[11] Saving Lives: Improving the lives of the world's poor. AusAID, November 2011, p9

- reduced cases of and deaths from communicable and non-communicable diseases that affect the poor, through surveillance and prevention of priority diseases.

Australia will also contribute to achieving 'increased use and improved quality of affordable health services, underpinned by stronger country health systems, through increased funding and mobilising community demand.'

To achieve those outcomes, *Saving Lives* makes it clear that Australia recognises the importance of strengthening health systems in order to obtain health benefits:

> Australia's priority is to support partner countries to manage sustainable health systems that deliver equitable, affordable and quality health services and make best use of public and private providers. These services must be evidence-based and responsive to the needs of poor and vulnerable citizens.
>
> Australia will support partner countries to identify and respond to their own national health priorities, particularly those that affect poor people. To do this, Australia will promote leadership and accountability for health and support partner government investment in critical elements of their health system, including trained health workers, procurement and supply systems for medical supplies, information on national health issues, basic health infrastructure and service delivery.[12]

Health-related challenges faced by the people of Timor-Leste

Challenges facing Timor-Leste concern the health status and health-related behaviour of the people and the state of the health services. The draft Timor-Leste Health Delivery Strategy sets out the key points, which are summarised in the remainder of this section.

Health status is well below international comparison and apart from child survival, off track for MDG's

The 2010 Demographic and Health Survey for Timor-Leste (DHS) shows some improvements in important health indicators. It also shows that the indicators are still poor and, particularly for women and children, that they are among the worst in the region and, in some cases, in the world. Tables 1 and 2 show a selection.

Table 1: Selected maternal and child health indicators[13]

Indicator	Timor-Leste DHS 2003	Timor-Leste DHS 2009–10	Regional average (East Asia and Pacific)[a]	Developing countries average [a]
Neonatal mortality (per 1000 live births)	21	22	14	26
Infant mortality (per 1000 live births)	60	45	21	47
Under-five mortality (per 1000 live births)	83	64	26	66
Maternal mortality ratio (per 100 000 live births)	N/A	557	88	290

[12] *Saving Lives,* p. 4.
[13] Table 1 and 2 are from the Health Delivery Strategy.

Table 2: Anthropometric status in Timor-Leste and East Asia and Pacific region

Indicator	Timor-Leste Living Standards Survey, 2007	Timor-Leste DHS 2009–10	Regional average (East Asia & Pacific)[a]	Developing countries average [a]
Wasting (6–59 months)	25%	19%	N/A	12%
Stunting (6–59 months)	54%	58%	22%	34%
Underweight (6–59 months)	49%	45%	11%	22%
Short stature (women 15–49 years)	N/A	15%	N/A	N/A
Low BMI (women 15–49 yrs)	38%[b]	27%	N/A	N/A

Sources (Tables 1 and 2):
a. UNICEF. *The State of the World's Children,* 2011. Values should be considered indicative, since methods used to derive them are not strictly comparable to TLDHS.
b. Timor-Leste Demographic and Health Survey, 2003.

Maternal mortality, at 557/100 000 live births, is among the highest in the world and is more than five times higher than the regional average. Under-5 mortality, at 64/1000 live births, is more than double the regional average; of which neonatal mortality (in the first month after birth) accounts for 22/1000 live births. Under-5 mortality has improved significantly, and puts Timor-Leste on track to meet MDG 4, but neonatal mortality has changed little in the last decade. Nearly 90 per cent of under-five mortality is the result of diarrhoea, malaria, pneumonia, measles and neonatal causes—all of them preventable and most of them easily treated if the right care is available.

The problems are exacerbated by the poor nutritional status of many women and children, which is also preventable and in many cases treatable. About 15 per cent of Timor-Leste women of reproductive age are of short stature and at least 5 per cent are anaemic, both of which are nutrition-related and significant contributors to maternal mortality. Similarly, poor nutrition of children, reflected in Table 2 above, contributes very significantly to child illness and mortality.

Population growth
The population is growing by 2.1 per cent per annum. The United Nations (UN) predicts that the population will double by 2035[14], a rate of growth that will put growing pressure on the country's already limited resources. Birth and fertility rates that are among the highest in the world affect the pace at which the population is expanding(see Table 3).

Table 3: Population indicators and world ranking

Indicator	Timor-Leste	Ranking in world [c]
Crude birth rate [a]	39.4	177 of 196
Total fertility rate [b]	6.53	194 of 196

a. CBR=births per 1000 population b. TFR=average children per woman
c. Rank among the 196 countries with populations over 100 000.
Source: UN Population Division, estimates for 2005–2010

Not only do these rates contribute to poverty as a result of high dependency ratios, they also contribute to poor health in women and children. For example, there are fewer household resources such as cash (including for health care) and food to go

[14] UN Population Division estimate.

around; hygiene is harder to control in larger, poorer households; overcrowding increases the spread of disease; and, in a context of high unmet need for family planning, multiple births increase the risk of maternal ill-health and death.

Other health-related indicators are also below international standards
Despite impressive improvements in the decade since independence, there is a range of other commonly-used indicators against which Timor-Leste is below the regional average. These include levels of skilled care at birth, caesarean section, breastfeeding, coverage of immunisation and vitamin A supplementation, use of oral rehydration therapy for diarrhoea treatment, insecticide-treated mosquito nets, and swift use of antibiotics in the treatment of childhood pneumonia. In addition, standards of water, sanitation and hygiene behaviour are relatively low, which adds considerably to exposure to pathogens. Unmet demand for family planning is estimated at about one-third of all married women. Although this is high, there has been a significant and very encouraging rise in the contraceptive prevalence rate, from around 7 per cent in 2003 to 21 per cent in 2009–10 (DHS, 2010).

Constraints faced by the Ministry of Health
The Ministry of Health's institutional weaknesses, in part a consequence of the earlier political upheaval, prevent it from delivering a full set of basic health services across the country. Particular bottlenecks that have a direct impact on service delivery include too few midwives, nurses and doctors available and in post; lack of regular, formal supervision; stock-outs of commodities such as medicines, contraceptives, transport, fuel and other essential consumables; and lack of maintenance for health equipment and buildings.

Recent analysis of the human resources situation showed key constraints to be lack of basic information about the workforce combined with lack of both a workforce data system and the capacity to manage such a system; shortage and inequitable distribution of skilled health workers and health managers; and poor living and working conditions. Key elements that need addressing include human resource management systems, policy, finance, education, partnership, and leadership. Other parts of government need to be engaged, especially finance and education. The analysis suggested four areas for intervention: scaling up the workforce; changing the skills mix; improving retention; and improving workforce distribution around the country.[15]

Management skills that are below the standard needed to run the health service add to the MoH's challenges in the centre, districts and communities. Systems breakdowns arising from poor management often lead to the MoH at the centre and in districts working in 'emergency mode', undermining routine operations.

With regard to health financing, the government has increased funding for the sector, but the increase has not kept pace with the expansion in the total national budget due to the Petroleum Fund. For example, per capita expenditure on health rose from USD$23 in 1999 to USD$31 in 2010[16], and the 2012 budget was USD$40 per capita.

Timor-Leste also faces challenges around the way the budget is apportioned within the sector. In recent years, for example, spending has increased on salaries, infrastructure and sending patients abroad for treatment, while it has gone down on

[15] Buchan, J. & Weller, B., 2012. *Human Resources for Health in Timor-Leste*. Health Resource Facility, Canberra.
[16] Chakraborty, S. et. al., 2011. *Timor-Leste Health Financing Note, final version*. World Bank Human Development Sector Unit, East Asia and Pacific Region. World Bank, Washington DC.

essential supplies for health facilities. The availability of cash for health facilities has reduced. Increased centralisation of financial controls, for example for vehicle maintenance, has constrained service delivery.

About 36 per cent of the 2013 health budget is allocated for salaries and wages. Figures vary hugely among countries, but this is roughly the mid-point for percentages worldwide.[17] Issues around the proportion spent on remuneration are complex and may have more to do with the overall budget than whether it is too low or too high. Whether or not higher allocations for salary and other areas are justified, if they have been paid for by reducing other essential budget lines, the result will be a negative effect on service delivery. During the design stage we will investigate the drivers of any decision-making that undermines pro-poor spending on healthcare, including questions around salaries and wages.[18]

The Basic Package of Health Services that the MoH plans to deliver is similar to the approach used in other low- and middle-income countries. It is, however, ambitious and will be costly to implement. As part of our investigation of budget-allocation processes and drivers, we will also look into the degree to which the basic package is feasible, how much it will cost, and any GoTL plans for implementing or amending it.

Also linked in part to the health budget are matters such as lack of essential infrastructure, including housing. On infrastructure, lack of satisfactory housing for health workers is a serious disincentive for assignment to rural postings, especially for more skilled workers such as nurses, midwives and doctors. Low salaries (or simply the pursuit of increased income) are a powerful incentive for health workers, to refer patients to their own private services. This practice can undermine public service provision through the diversion of public resources (staff, drugs, equipment and facilities) to private provision; it also creates opportunities for low-quality care such as over-prescription of medicines, and undermines efforts to make treatment free at the point of delivery.

Examples of how the centralised funding and accountability systems constrain service delivery include reporting on inputs rather than performance; the mixing of finance for service delivery with finance for local administration; and unpredictability of funds available to local managers.[19] Strengthening the currently low level of financial management skills at local level would help to create an environment conducive to more delegation. Other areas in which there is potential for improvements include planning and budgeting based on better costings for service provision, and management account systems for monitoring expenditure. Planning for future service delivery also needs to account for changes in private sector provision.

Potential for people themselves to do more

On the demand side, many people, especially in rural areas, could take more action to improve their health status if they knew how to, if they had the resources, and if enabling factors, such as water and roads, were in place. Income poverty is a key constraint. Nevertheless, enabling people to change their health-seeking, dietary, child-feeding and hygiene-related behaviour and to demand better health services

[17] Vujicic, Marko, et. al., 2009. *Working in Health*. World Bank. Salary and wage bills vary between about 10 per cent and 80 per cent of total public health-sector health budgets.
[18] We will also examine in more detail in the design stage the complexities of the health budget, how it is allocated and the results it achieves.
[19] Kathy Whimp, *Draft Report of Preliminary Observations on Service Delivery Bottlenecks in East Timor*, April 2010 (marked for internal AusAID use only).

has much potential to improve health outcomes for all, especially women and children.

One key matter to be addressed in design and implementation is the non-progressive influence of citizens who promote traditional views of social norms and behaviour, and limit the access of women and children to health care. Examples include men, older people (including mothers-in-law), and traditional or religious leaders.

Joint demand and supply-side action is needed
Box 1 outlines the actions that, combined, can consolidate and accelerate the improvements already achieved. In summary, a combination of more effective delivery of essential health services and behaviour change among the population would have a major impact on priority health outcomes.

Box 1: Changes needed for better maternal and child health outcomes
The above analysis suggests that improving maternal and child health outcomes in Timor-Leste will require: (i) higher household incomes, stronger food security and better education of girls and women; (ii) greater use of safe water, improved sanitation, good hygiene, and optimal feeding of infants and young children; and (iii) increased use of reproductive, maternal, neonatal and child health (RMNCH) services. With regard to (i), multi-sectoral action is clearly needed. In relation to (ii), it will be crucial to help communities and households change behaviour and demand improved services. For (iii), while some of the interventions that are effective in preventing maternal and child deaths can be delivered 'vertically', decades of experience have shown that the gains achieved through such approaches are rarely sustained and therefore the national systems must be strengthened.

Source: Timor-Leste Health Delivery Strategy.

AusAID's place among the development partners
The rationale for a new, large-scale AusAID health program is partly determined by what other development partners are doing and planning.

Fifteen other development partners work in health. In 2010 they contributed about 40 per cent of all spending in the sector, with their funding spread across more than 100 projects. The larger and more influential development partners in health are:

- bilaterals: AusAID, the EC, USAID, Government of Cuba
- multilaterals: UNFPA, UNICEF, WFP, WHO, World Bank
- global health partnerships: Global Fund and GAVI.

Australia is the largest health funder, followed by Global Fund. Australia is also the main contributor to the World Bank-managed multi-donor trust fund. UNFPA, UNICEF and WFP have received funding from AusAID Timor-Leste but all of this support is coming to an end. USAID is expected to reduce its engagement in Timor-Leste, making Australia's position as primary bilateral even more prominent than it already is.

AusAID's contribution to health in 2008–2012 has been around AUD35.8 million, with two-thirds of that allocated to two projects. Current main projects are National Health Strategic Plan Support Project, via a World Bank-managed multi-donor trust fund, and support to the Royal Australasian College of Surgeons aimed at building skills in secondary and specialist care in hospitals, especially for women and children. The remaining third of AusAID health funds are allocated to four small projects implemented by international NGOs and UN organisations, in family planning, maternal, child and newborn care and nutrition. At AUD50 million over the first four

years of a possible eight-year program, the new program would represent about 14 per cent of AusAID's Country Program in 2013–2017.

The current portfolio of relatively disconnected projects does not have the strategic potential of a more coherent program planned and implemented jointly with government in cooperation with other development partners. It is also harder to deliver outcomes that continue after the end of donor inputs, which puts sustainability at risk.

Harmonisation among the main partners is led currently by AusAID and WHO, but is still embryonic. AusAID's emerging leadership on harmonisation and alignment in health, and its deepening strategic relationship with WHO and the World Bank (both of which tend to have strong legitimacy with national governments), reflect the growing importance that Australia is now giving to government partnership, policy dialogue, and sector or program approaches. WHO is enthusiastic about contributing to the design of the new program and to look at partnership options, and WHO's South East Asia Regional Office (SEARO) is putting together a team to work with AusAID.

In terms of the policy environment, this scope is in-keeping with Australia's aid-effectiveness objectives. It is consistent with the Paris and subsequent agreements, Australia's commitment to the New Deal for Engagement with Fragile States and support for the g7+ group.[20] It is also in line with GoTL's aim to increase partnership approaches rather than disparate projects.

Potential for AusAID cross-sectoral working
Australia is investing in other programs that will directly or indirectly contribute to health outcomes. New initiatives in water, sanitation and hygiene (BESIK-II), community development (NPSD), roads for development, governance for development, education and training, and prevention of violence against women[21]—all in various stages of design—are a foundation for collaboration in areas that intersect with health, both within AusAID and among AusAID's implementing partners across the sectors.[22] The addition of a large-scale program to improve health services is a natural step in building a strategic portfolio aimed at delivering health outcomes.

Health and development
Finally, an over-arching part of the rationale for investing in health is that a healthier population contributes more to economic development. In particular, there is much evidence globally that improved health for women and girls has a positive impact on family and community health. Better health leads to better education outcomes and vice versa. A healthier population is better able to maximise livelihood opportunities and this in turn supports long-term economic growth for the nation. There is, thus, a mutually supporting connection with the other interventions in AusAID's country program mentioned above, all of which aim to strengthen Timor-Leste's economy and to improve, equitably, the lot of its citizens.

In summary, in terms of the rationale for engaging in the sector, there is a clear strategic case for helping to strengthen Timor-Leste's health service in order to

[20] g7+ is currently chaired by Timor-Leste, so Australia's substantial support for the group helps cement a strong government-to-government relationship that should facilitate engagement around the new program.
[21] The approach to violence against women now includes children, for example through non-violent schools, in recognition of the scale of this problem.
[22] BESIK-II and roads for development are in the early stages of implementation; the rest are in design.

achieve health and other economic and social outcomes. Unacceptably high morbidity and mortality, especially for mothers and children, can be reduced through well-targeted investment in the health service. Australia is the biggest health donor and is growing—none of the like-minded development partners and NGOs working in health approach Australia's potential for influence and funding. The policy environment is conducive to a large-scale, sustainable aid investment in the sector. In this situation, Australia can make a fundamental difference to the lives and well-being of the people of Timor-Leste.

2. Rationale for the focus of the new program

On the basis of the government's strategic priorities and the analysis set out above, the program will focus mainly on health outcomes for mothers and children. Because these outcomes cannot be achieved without a better-performing health service, the program will support interventions to strengthen parts of the health system that are essential for making those gains. In order to achieve maternal and child health outcomes, systems improvements including the development of competent staff required in leadership and governance, management (including financial management), human resources, infrastructure (particularly at the primary care level), data management, procurement (including of drugs and other consumable supplies), and logistics including transport and communications. Box 2 illustrates WHO's authoritative view on the links between a strong health system, critical services, and maternal mortality.

Box 2: A strong health system is needed for gains in maternal health
The best measure of a health system's performance is its impact on health outcomes. International consensus is growing: without urgent improvements in the performance of health systems, the world will fail to meet the health-related goals. As just one example, the number of maternal deaths has stayed stubbornly high despite more than two decades of efforts. This number will not fall significantly until more women have access to skilled attendants at birth and to emergency obstetric care.

Source: Everybody's business: Strengthening health systems to improve health outcomes: WHO's framework for action. World Health Organization, 2007, page iii.

Critically, the program will also support community-oriented interventions to encourage changes in individuals' health-related behaviours and the attitudes and practices of communities that impact on health.[23] Gender and disability dimensions will cut across the program's work. The common element in all of these is capacity development for national institutions and individuals within or closely linked to the Ministry of Health, including in its relations with the for-profit and not-for-profit private sector. The program is likely to contribute to a greater or lesser extent to all of these areas, sharing the effort with GoTL and other development partners. In the design stage we will identify the top priorities for early intervention and those that can come later or will be covered by government or other development partners.

Progress in the short term is as important as the longer-term strengthening of the health system. To ensure that people have increased access to quality services in the short term and can accelerate changes in their health-related behaviour, we will

[23] Community norms in areas such as sexual health or hygiene behaviour at water points can constrain the ability of individuals to achieve change. They need changes in the attitudes and behaviour of society if benefits are to be realised.

focus from inception on critical areas such as human resources, management of supplies, transport, and promotion of individual behaviour change. Alongside working with government, we will also build our funding and strategic partnerships with national and international NGOs and other partners to scale up service delivery in the short term. Learning from BESIK, we will also work directly with district authorities and district-level civil society.

Areas that we will not support include those that are already well funded by GoTL or other development partners, and those that are less directly linked to outcomes for mothers and children. Systems-related areas include construction, equipping and staffing of hospitals; salaries and wages; and international transfers for treatment abroad. Health areas that will not be a focus include tertiary care; communicable diseases such as malaria, tuberculosis, HIV and dengue fever; neglected tropical diseases; non-communicable diseases; abortion; and injuries.[24] The program will also not cover areas that AusAID is already funding through other projects, though some of these will merge with the new program as they come to an end—see Section 3.

3. Program description

3.1 Introduction

In this section we describe the program scope and logic. The scope is based firmly in the rationale set out in Sections 1 and 2. The logic is set up in such a way as to maintain a clear line of sight from immediate outcomes, through the end-of-program outcomes to the program goal.

The major thread that runs through the program, from short to long term, is improved services for mothers and children. A crucial enabling factor for achieving those improvements will be policy and operational dialogue with government, especially the Ministry of Health, and with like-minded development partners, NGOs and other influential stakeholders. The AusAID health team's ability to understand and be able to operate effectively in the sector's political-economic environment will be vital in determining the success of the program. To that end the health team will work closely with the AusAID Timor-Leste governance team and will draw on the policy-enabling delivery strategy.

[24] While directly linked to the health of mothers and children, abortion is all but illegal in Timor-Leste. If Australia were to take a firm, principled line on abortion in the short term, it could undermine the program and, potentially, the rest of the aid program.

3.2 Program scope

This is an eight-year program with a review point at four years, when major changes in scope or approach can be considered. In this section we describe the program scope in terms of using government systems, priority population groups, and the need for behaviour change by service providers and institutions as well as individuals.

A focus on government systems and non-governmental providers nationwide
The scope of the program will be nationwide coverage with a focus on elements of the health system where bottlenecks constrain the ability of mothers and children to access preventive and curative services. It will aim for an increasing use of government systems for planning, monitoring, procurement and financial management. This scope includes increasing women and children's access to quality health services in the shorter term.[25] Rather than depending entirely on major changes in the way the MoH works at central level, the program will use lessons learned, for example, by the BESIK program in working with district authorities where improvements can be achieved more quickly. It will also build on the AusAID health team's existing relationships with NGOs and other implementing partners to expand the delivery of maternal and child health-focused services. This is likely to require significant boosting of the capacity of the NGO sector. In this way, the program will develop an approach that involves government and non-governmental bodies working in close strategic and operational partnerships. By the end of the program and beyond, a program of this scope should be able to contribute to major gains in maternal and child health through the combined actions of the health services, communities and individuals.

The approach requires solid, trust-based working relations with the Minister of Health, Vice Ministers, officials in the centre and districts, and with the non-governmental sector. These relationships need to be underpinned by a sense of mutual accountability. A solid relationship already exists at the centre, based on dialogue around the existing portfolio, and the consolidation and deepening of this will be rightly seen as a successful outcome. The real long-term gains will come, however, from helping the MoH to achieve sustainable change in the way it operates at the centre, in districts and in health facilities. As a combined approach that involves working also with individuals and communities, helping them to demand more of the health services and to change their own health-related behaviour, a program of this scope will lead to greater use of health services, strengthened capacity of the service to meet need, and to bigger improvements in health. There are significant risks associated with a reliance on institutional change in the government sector (see Section 9). Working in parallel with partners outside government will help to alleviate those risks and deliver shorter-term outcomes.

Improvements in health financing, a crucial element in government systems, will be included in the scope of the program after NHSSP-SP ends in June 2015. In our dialogue with the MoH and Ministry of Finance (including via the AusAID Governance for Development program), we will look not only into financial management systems and capacity but also into the potentially more difficult areas of health finance policy and the allocation of resources across the MoH budget.

[25] The main outcomes in which AusAID is interested are for mothers and children. However, improvements in the health system's ability to delivery services will have beneficial impacts across the population.

Priority target populations

The population of Timor-Leste contains approximately 240 000 women of child-bearing age (15–49 years) and 190 000 children under five. These populations are due roughly to double by 2035 (UN Population Division estimates for 2010). Broadly, these are the priority target groups for the new program. The detail is, however, more complex. Headlines from the review of inequality data carried out for this concept note include the following:

- income poverty is concentrated in rural areas
- key health and nutrition indicators such as infant mortality, under-five mortality, stunting and wasting are worse in lower-income groups
- factors positively linked to health indicators, such as maternal education, safe birth attendance, post-natal care, and infant and young child feeding practices, are better in the higher income groups
- however, important childhood illnesses such as diarrhoea, fever and acute respiratory infections are associated more with higher income groups, better educated mothers and urban areas.[26]

About 70 per cent of Timor-Leste's population lives in rural areas. It is clear from the preliminary review of inequality data, therefore, that if the program is to have equitable outcomes the bulk of its beneficiaries will be women and children in rural areas.

Changing the behaviour of service providers as well as users

The scope of the program will encompass both the provider (the supply side) and users (the demand side) of health services. In addition to increasing the use of services it will also deal with personal behaviours that affect health outcomes.

On the supply side, the program will support changes in the way that people work in health institutions in the public sector, for-profit and not-for-profit private providers[27], and in the formal and informal sectors. The desired changes will target the institutional weaknesses described in Section 1. On the demand side, the program will help reduce barriers to accessing health services and will help people to reduce the ways they are exposed to health risks.

Other AusAID-funded programs will impact on health-related behaviours and exposure to health risks (see Section 8). The scope of the new health program will be such that it avoids duplication while creating opportunities for cooperation.

Cost effectiveness and value for money

In the design stage we will carry out sufficient economic analysis to demonstrate cost effectiveness and value for money. Interventions anticipated in the program—antenatal and post-natal care, safe delivery, rapid response to neonatal ill-health, family planning, childhood disease prevention and so on—are among the most cost-effective ways of achieving health outcomes for mothers and children. As such they should provide value for money for Australia's investment.

The design process will not examine cost-effectiveness and value for money related to choices among sectors as that is a matter for decision at the level of country

[26] We will be carrying out a more in-depth inequalities analysis during the design stage, including into the apparent anomaly around childhood illness.

[27] The degree to which the private sector will feature in the program will depend on investigations to be carried out during design and on dialogue with the MoH. Options range from policy dialogue with the MoH with regard to its stewardship role, to collaboration with the medical association on private care or contracting of social marketing providers.

program and sector delivery strategy. We will, however, consider matters such as choices among providers and the potential for outcomes to continue beyond the period of program funding. It is clear, for example, that the approach set out below, by enabling GoTL to provide quality services in the long term, will sustain benefits beyond the end of AusAID funding. It will therefore provide greater economic returns than support for interventions that do not help GoTL to resolve systemic problems in the health sector. We also aim to demonstrate that the wider health and non-health benefits mentioned in Section 1.2 will add to a greater return on investment.

3.3 Program logic

The goal and outcomes set out below are captured in diagram form at Annex 3, which usefully shows linkages and feedback loops. Box 3 lists the outcomes for ease of reference but does not show the cross-linkages. The precise language and definition of outcomes and the overall structure will be refined in the design stage.

Box 3: Draft program outcomes

Program goal
Mothers and children live longer and healthier lives.

End of program outcome
Households, especially the most vulnerable, increasingly practice behaviours that are conducive to better maternal and child health and nutrition and use reproductive, maternal, newborn and child health services.

Intermediate outcomes

1. Service delivery. MoH ensures equitable availability of integrated high-quality reproductive, maternal, neonatal and child health (RMNCH) services for all mothers and children.
2. Medicines and supplies. MoH managers ensure high-quality essential health infrastructure, supplies, equipment and transport are available as needed for RMNCH services and used properly.
3. Health workforce. MoH managers ensure sufficient skilled health workers are available, equitably deployed, follow standard treatment guidelines for RMNCH services, and report accurately.
4. Health financing. MoH secures adequate funds for the health sector and ensures they are utilised efficiently, responsively and accountably for maternal and child health.
5. Health information. Citizens and MoH access high-quality information and use it for advocacy, planning and monitoring and evaluation (M&E) of RMNCH continuum of care.
6. Leadership and governance. GoTL and civil society lead and jointly govern efforts to improve maternal and child health.
7. Community mobilisation. Communities determine their maternal and child health priorities and take action to achieve them.

Program goal[28]

The program goal is that **mothers and children live longer and healthier lives**, with the main indicators being the maternal mortality ratio and under-five mortality rate.[29] While changes in these indicators should begin to demonstrate impact during the program, there should be a long-term improvement well beyond its eight-year life.

The SDP contains indicators for process rather than health outcomes. For example, by 2015, 70 per cent of pregnant women will receive antenatal care at least four times, and 65 per cent will have an assisted delivery. By 2020 the SDP focus is more on Health Posts and Community Health Centres being in place and staffed, and less on the number or quality of services. During our joint design process with the MoH we will make sure that health outcomes and indicators used for the program are consistent with government plans.

End-of-program outcome, 2022

The end of program outcome (EOPO) is that **households, especially the most vulnerable, increasingly practice behaviours that are conducive to better maternal and child health and nutrition and use reproductive, maternal, newborn and child health services**.

The EOPO contributes directly to the program goal because individuals avoid ill-health by taking preventive action independently of the health service, for example hand-washing with soap, covering stored water, safe disposal of children's faeces, breast-feeding, better infant and young-child feeding, or use of modern family planning methods. The two parts of the outcome also mutually reinforce each other: behaviours conducive to better health help to empower people to use services (for example, through knowing what they need and what is provided) and to influence the availability and quality of care, while their use of services should also help keep them informed about ways they can help themselves.

The EOPO also contributes to the goal because the use of services will enable the prevention, early detection and treatment of ill-health, will inform people of the action they can take at home or in the community, and will give them access to modern family planning methods.

Further specification during the design stage will include defining the targets for coverage for essential services, and which services will have most impact on health outcomes for mothers and children.[30]

Intermediate outcomes

1. **Service delivery:** MoH ensures equitable availability of integrated high-quality RMNCH services for all mothers and children.

In the short term, this will entail support through NGOs to deliver primary maternal and child health services at public sector health posts and SISCa (mobile clinics). At

[28] Terminology varies in AusAID documents. In the concept note we use the following ranking: goals, end-of-program outcomes, intermediate outcomes, and immediate outcomes.
[29] Indicators will be defined for nutrition.
[30] These and similar specifications for other outcomes will appear in the design document. Some may also be defined in the indicators that will be finalised at a later stage. We have not included access to services at this level as it fits the logic chain better as an intermediate outcome (because increased access is one of the factors that enable people to use services).

a later stage, it may also involve technical assistance (TA) to update standard treatment guidelines and overhaul the current SISCa approach.

2. **Medicines and supplies**: MoH managers ensure high-quality essential health infrastructure, supplies, equipment and transport are available as needed for reproductive, maternal, neonatal and child health (RMNCH) services, and used properly.

The most urgent interventions will be TA for reform of SAMES, GoTL's drug procurement body, possibly coupled with procurement on behalf of GoTL as an interim measure. Reform of transport management is equally urgent, and we may also use our procurement agent to supply and manage vehicles on an interim basis. Another early investment will be TA and funding for blood bank services (probably contracted from the Red Cross by MoH). Later we will provide support to renovate, build and equip health posts and, possibly, accommodation for primary health care staff in rural areas.

3. **Health workforce**: MoH managers ensure sufficient skilled health workers are available, equitably deployed, following standard treatment guidelines for RMNCH services, and reporting accurately.

AusAID is already supporting TA for a MoH health workforce database, the development of a comprehensive human resources development plan and specialist training for doctors. As an urgent measure to increase the numbers of midwives, we will help the MoH explore the possibility of recruiting from Indonesia or sending Timorese there for midwifery training. At the same time we will work with education sector colleagues, Ministry of Education and the MoH to strengthen the quality and capacity of pre-service training for midwifery and nursing in the national university (UNTL). In the medium term, we will provide TA and funds as needed to bolster the capacity and quality of the National Institute of Health for in-service training, and work with MoH and DPs to devise integrated in-service training for midwives and nurses. At the same time we will provide TA to explore options for development of the community health workers (the PSF); at a later stage we may fund training to upgrade this cadre.

4. **Health financing**: MoH secures adequate funds for the health sector and ensures they are utilised efficiently, responsively and accountably for maternal and child health.

AusAID is already supporting training in public financial management (PFM) to MoH and Districts Health Offices, and additional funds will be provided to districts for delivery of basic services. An early priority is TA for costing the first five-year plan and annual plan for the health sector and developing a medium-term expenditure framework (MTEF); these will enable MoH to justify the funding it seeks from MoF and DPs. We will consider direct financing to facilities as a short-term intervention, in cooperation with district health authorities.

5. **Health information**: Citizens and MoH access high-quality information and use it for advocacy, planning and M&E of RMNCH continuum of care.

The first priority is to encourage and support MoH to streamline the health management information system (HMIS) and persuade other DPs to accept and use a simplified HMIS. Once there is agreement on a new HMIS, we can provide TA to re-design data-entry forms and software and promote the use of information for planning and M&E. In 2014 we will contribute funds for a new national Demographic

and Health Survey. We will work with MoH and other stakeholders to commission other studies as and when they become necessary.

6. **Leadership and governance**: GoTL and civil society lead and jointly govern efforts to improve maternal and child health.

Assisting MoH to update the national reproductive health policy and to develop a new comprehensive child health policy will be an early priority. When lessons from initial experiences with health councils become available we will provide funds for expansion of approaches that succeed in involving the most vulnerable (including women) in joint governance. As opportunities arise, we will fund civil society organisations that demonstrate the potential for leadership on key issues, especially women's reproductive health.

7. **Community mobilisation**: Communities determine their maternal and child health priorities and take action to achieve them.

In the medium term, we will work with MoH and NGOs to pilot-test initiatives for community mobilisation in support of behaviour change, based on international experience. Later, as we learn what works in Timor-Leste, and as increased capacity to support such activities becomes available, we will gradually expand and continuously monitor this intervention.

3.4 Phasing the existing portfolio into the new program

In accordance with the policy decision to move towards program approaches, we have prepared a plan for phasing the current portfolio of health projects into the new program. The plan will affect different projects at different times, and it does not include all of them. The projects relating to mother and child health will be consolidated as set out briefly below.

(i) *The National Health Sector Strategic Plan Support Project* (NHSSP-SP) contains health-systems-strengthening components relevant to the new program focusing on public financial management. A selection of these will therefore be taken over when the NHSSP-SP comes to an end in 2015. (This project is also a vehicle for activities that can respond to the Minister's requests for health-systems problem-solving in the short term, and thus may be useful in building the MoH's confidence in, and engagement with, preparations for the new program.)

(ii) Projects with NGOs, Marie Stopes International and Health Alliance International (MSI and HAI), provide capacity building and some service provision in a range of maternal and child health, reproductive health and family planning, and demand and supply side activities: vital elements of the health system that the new program will support. When these projects come to an end in December 2014 it is likely that at least some of the work will continue under the new program. We will put transitional arrangements in place to make sure there is no gap in activity.

(iii) AusAID and USAID funded HADIAK, a project that aims to build MoH capacity in community health services, including in maternal and child health and birth spacing. The project finishes at the end of 2014. Parts are likely to continue into the new program, with the process to be defined in part through

the findings of an end-of-project evaluation. (Continuation of HADIAK may also be an opportunity for USAID to continue as a health-sector funder).

(iv) The ATLASS-II project supports skills development for secondary and specialist health care and runs into 2020. It will not become part of the new program although it has a complementary focus on maternal and child health.[31]

In summary, the picture by the end of the first four years of the new program is that all the existing projects other than ATLASS-II will have come to an end or will have been merged in one way or another into the new program.

4. Principles for engagement

The process of developing this Concept Note has involved three main streams of engagement: with the Ministry of Health, development partners, and internally within AusAID. Consultation with the MoH has started but has been constrained by the 2012 elections and the subsequent processes of budgeting, planning and allocation of responsibilities in the Ministry (slower in the MoH than in other ministries). The Minister has indicated that he wishes to engage in more depth on the joint design in early 2013, when those processes should have been resolved and the new five-year health plan will be in place.

In recent months the exchanges between the Minister and AusAID have shown agreement on major systems-related problems, mostly related in one way or another to management, logistics, transport and human resources. AusAID is aiming to assist in relieving some of the system bottlenecks before the new program starts, through the NHSSP-SP and the logistics and procurement contractor. This supportive approach is helping to build the relationship by showing that AusAID is able to be flexible and to respond to the Minister's priority needs. It is paving the way for genuine joint planning for the new program.

Responding to the MoH's immediate problems has also created opportunities for engagement with the more influential development partners. In this context, these are WHO and the World Bank. Discussions have been ongoing around, for example, the setting up of a commission to oversee the reform of SAMES, the government's medical procurement body, and the best ways that development partners can work together to relieve the MoH's systems-related problems in the short term. Engagement with these two partners in particular is fruitful and constructive.

We are aware of the potential risk that responding to the Minister's immediate needs may dilute the focus on outcomes for mothers and children and could, at worst, result in a non-strategic 'shopping-list approach' to Australian support. Throughout design and implementation, our engagement with all levels of the MoH and with other partners will maintain that strategic focus while using flexibility and responsiveness to (a) help the Ministry and strategic partners to clear immediate bottlenecks that affect the achievement of outcomes and (b) continue to sustain a trust-based working relationship with key stakeholders.

[31] An AusAID country program decision. The project and new program will cooperate closely.

Engagement internal to AusAID around the development of the Concept Note (and the Investment Concept) has included (i) two concept workshops and associated meetings in Dili, (ii) meetings between the design team and all the main stakeholder groups in the Canberra office, (iii) short papers on disability and gender following visits by Canberra-based specialists, and use of early findings from analysis into health inequities and HR.

Those actions—with GoTL, partners, and internally—reflect the putting into practice of a set of engagement principles that create a framework for how we will operate (see also the Engagement Plan at Annex 4). In brief:

- We will consolidate AusAID investments, work in partnerships and support national systems while building respect and trust in our partnership with GoTL.
- We will seek to ensure a sustainable, locally-owned health system is developed but we acknowledge that this will take time. Mothers and children should not be left with poor health outcomes in the meantime, so we will therefore give priority to: (i) interventions in the **short term** to support changes in key behaviours and equitable delivery of evidence-based high-quality services for mothers and children at primary and secondary levels; and (ii) interventions to improve **longer-term** prospects for sustaining short-term gains. We will seek a **balance** between short-term and longer-term interventions.
- We will base our choices on a sound understanding of the political economy, not least to ensure that short-term actions do not impede long-term reforms.
- We will limit our focus to interventions that are aligned with national priorities and have reasonable prospects for sustainability.
- We will not fund interventions that GoTL is able to support and we will not duplicate support provided by other DPs (and we will influence those DPs we fund, to ensure harmonisation and alignment).
- We will strive to maximise the impact of all of the available funding for the health sector (and, in particular, Australia's investments through multilateral agencies and global health partnerships) on key outcomes for mothers and children, especially the most vulnerable.
- We will seek ways to maximise the contribution of other sectors to improving these outcomes.
- We will proactively pursue policy dialogue and engagement with partners to facilitate a delivery environment that is conducive to achieving program outcomes.

Cooperation across the AusAID Country Program

The newer AusAID programs in Timor-Leste will contribute to four of Australia's five strategic goals: saving lives, promoting opportunities for all, sustainable economic development, and effective governance. The programs' health-related outcomes make them relevant to this program. The AusAID teams working in different sectors are already in close discussion on approaches, overlaps in interests and networks, and the potential for joint working. This cooperation will continue through program design and implementation.

Cross-cutting issues

Discussions at concept stage have touched on several aspects of equity: poverty, maternal education, rural/urban location, gender and disability. The health inequalities analysis showed that the greatest differences in child mortality and access to reproductive, maternal, neonatal and child health services were more strongly related to wealth quintile and maternal education than to urban or rural residence. With about 70 per cent of the population living in rural areas, this is nevertheless where most of the disadvantaged reside.

The program's focus on maternal health outcomes reflects the reality that women in Timor-Leste continue to be disadvantaged in terms of accessing care at critical times of pre-pregnancy, pregnancy, birth and in the post-natal period. Issues are structural (essential services not available) and attitudinal (not enough prioritisation of women's healthcare needs).

Our continued gender analysis in the design stage will deepen our understanding of the factors at play. We assume, for example, that more will be learned about institutional attitudes and behaviours that disadvantage women, but we should also learn more about social or religious beliefs, attitudes and constraints. For example, women themselves may be unenthusiastic or inhibited about access to services such as reproductive healthcare. Women may also be affected by men's decisions about what they can do.

Disability is less studied in Timor-Leste, but will be considered further in the design stage. Persons whose access to health services, or whose ability to take action to promote their own health, is impaired through physical or mental disability will by definition receive less benefit from what is available.

The recent short papers on gender and disability mentioned above form the basis for more in-depth investigations of these topics during design.

The policy environment appears conducive to dialogue on these issues. The Program of the Fifth Constitutional Government, for example, contains well-articulated commitments to social inclusion. It refers to the Gender Integrated Approach, part of the effort to achieve fair representation of women and men in government agencies; and, in the health sector, the protocol for early detection of disability in children. AusAID has helped the Ministry of Social Solidarity to develop a disability policy, which can serve as an entry point for further work in relation to health services.

The Strategic Development Plan, among other references to equity, prioritises maternal health, aims to improve equity of access through the allocation and use of resources including finances and facilities; flags the importance of health research that will influence more equitable and efficient resource allocation; includes in its core values equal access to quality care according to need; and promotes gender equality in relation to environmental health. Specifically on gender, the SDP lists a strategy for mainstreaming gender issues in sector planning in line with the national gender policy. Overall, the SDP states that the operational goal of health service delivery is to provide 'quality health care for Timor-Leste which specifically addresses the health issues and problems of women, children and other vulnerable groups such as the elderly and the disabled, in a participatory way'.

While these plans, policy positions and structures are not necessarily reflected in actual behaviours at the time of writing, they do provide a clearly articulated agenda for policy dialogue in the context of the new health program.

5. Total budget and preferred aid delivery mechanisms

Budget (AUD in millions)

At an estimated up to AUD50 million over the first four years of a possible eight-year program, the planned spend on the new program represents about 31 per cent of the Country Program on health in Timor-Leste in 2013–2019.

Year	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Indicative Budget (million)	5	10	15	20	25	25	25	25

Aid delivery mechanisms

In this section we consider options for approaches to delivery, types of delivery partnership, and types of aid. The definition of these terms, as we use them here, is as follows:

- ***Approaches to delivery*** include program-based and sector-wide approaches.

- ***Types of delivery partnership*** are about the institutional channel through which the aid is delivered. They include funding via another international development agency; directly with GoTL; via NGOs; with other Australian government agencies; or through a managing contractor.

- The ***types of aid*** we are considering include budget support; pooled funding; via a project or facility; using experts and technical specialists; and scholarships.[32]

The approaches and types are not mutually exclusive. We are considering a suitable mix that takes into account GoTL's likely ability to absorb resources and put them to effective use, as well as AusAID's internal management capacity. The mix is likely to include:

- A managing contractor (with possible sub-contracts with NGOs).
- A procurement and logistics contractor.
- Small but increasing sector budget support.
- Some ongoing support for a World Bank and WHO focusing on analysis.

On ***delivery approaches***, we intend to use a program approach. Because this encompasses much of the sector, involves a close partnership with GoTL and will pursue joined-up working with other development partners, it is likely to approximate a sector-wide approach. We are likely also to include projects within the program until government systems and sector budget support become more feasible (see Section 9 for the risks associated with the fragility of government systems). In our funding of

[32] This classification is based on helpful verbal guidance from AEG and PEDP during the Canberra discussions mentioned in Section 4.

projects (implemented by partners such as UN organisations or NGOs), we will cooperate closely with government, in alignment with national priorities.

On ***types of delivery partnership***, our preferred choice is a mix of support directly to the MoH, support for NGOs (probably including faith-based organisations), development partners such as WHO and WHO, and a managing contractor. Again, we anticipate that direct support for the MoH will be phased and will depend on the strengthening of management and financial systems. The program itself will help the MoH to strengthen those systems. Before agreeing to fund the MoH directly, we will conduct the necessary assessment as per the Working in Partner Systems guidance from PEPD.

AusAID will need the services of a managing contractor to supplement its in-house capacity. We therefore anticipate using a managing contractor to handle a significant part of delivery through other partnerships, including sub-contracting and grant-management for NGOs and other partners.[33] The managing contractor may also handle direct support to government. We will be considering in more detail during the design stage the possible involvement of the managing contractor in the governance arrangements (see also Section 6).

In determining the types of delivery partnership, we will assess them against criteria including the function of each partner and their track record; their comparative advantage and value for money; efficiencies that may be gained from cooperation with development partners; administrative arrangements tailored to AusAID's and partners' resource constraints; monitoring arrangements for performance and risk (contextual, programmatic, institutional); and partners' ability to cooperate with each other as needed.[34]

We also plan to use a mix of ***types of aid***. We intend support provided directly to the government's health budget to increase so long as fiduciary risk can be sufficiently reduced and managed. In particular, issues around transparency, public financial management, and the effectiveness of some aspects of government systems at the centre and in districts need to be resolved. Targeted budget support may be one vehicle for helping to resolve problems in those areas. The new health program, other AusAID programs, other organisations' support, and the GoTL itself, all aim to strengthen government systems. We will engage in particular with the governance team and draw on the guidance in the policy-enabling delivery strategy. A progressive use of government systems over time will be designed into the program, with the start point and rate of increase subject to there being proven ability to deliver health services (we will be helping strengthen those systems, including by using them where we think this is the best way to effect change). In the interim, and probably continuing after budget support begins, we will use a mix of project funding (linked to NGOs or the UN) and technical assistance.

Factors affecting the choice of delivery approach, delivery partnership and type of aid include:

- capacity within AusAID
- the range of likely organisations with which and through which AusAID will decide to work
- the need to minimise the complexity that multiple channels would create

[33] The managing contractor may also handle sub-contracts to other firms, for example, if the program involves construction of health posts and community health centres.
[34] Criteria drawn largely from the Carana Model Delivery Strategy, p. 17. We will refine this framework during the design stage.

- transaction costs
- the speed with which GoTL strengthens its systems to a level at which sector budget support becomes feasible.

We will analyse these factors during program design and decide on the mix accordingly.

In our approach to program management, we will consider using a strategy that allows us to adjust the level of oversight and control depending on the quality and effectiveness of implementation carried out by partners. We may apply this to implementing partners such as the UN and NGOs as well as to government. Mediating the level of control in this way is preferable to a simple turning on and off the flow of funds in response to changes in partner performance.

In summary, the core of our vision is for a program approach, working directly with GoTL, using sector budget support supplemented by grants for selected development partners and NGOs and overseen by a managing contractor. Political and institutional realities require a more nuanced and broad-based approach that will be managed through gradual transitions over time and, we anticipate, move in the direction of that vision.

6. Governance arrangements

The program will be overseen through a joint GoTL–AusAID governance arrangement. The nature of this will depend partly on the final structure that GoTL agrees for the MoH, and will be a central part of the more comprehensive engagement and joint design process in early 2013. At present we are considering approaches that have been used in a sector wide approach or similar programs around the world, and these are explored below.

The governance of large and complex programs such as this, which depend heavily on the quality of working relations with government and other development partners, tends to evolve over time. This can start with relatively informal arrangements, especially when priorities and broad directions are being discussed and agreed, before moving to more formal agreements and structures.

If the present pattern of dialogue between AusAID, the MoH, WHO, the World Bank and the EC continues to develop as it has during the concept phase, it would be on a reasonable trajectory for eventual progress towards deeper policy discussion and a joint planning process. However, such trajectories are rarely smooth, and it is likely that the dialogue will shift between periods of high energy and dormancy. As part of keeping the process moving, it will be necessary to involve more development partners in the pre-program discussions, with the aim of promoting sector thinking and greater cooperation in support of the new five-year health plan.

As a part of broadening and deepening that dialogue, we will finalise options for governance and partnership arrangements that are in keeping with the MoH's pursuit of 'one plan, one budget, and one M&E framework'. Options for consideration in early 2013, based on the experience of sector wide approaches tailored to the Timor context and are not mutually exclusive, include:

- a Statement of Intent about working in partnership; this may include outline structures and ways of working (the Country Compacts used in the IHP+ may be useful models for such a statement)[35]
- a formal Program of Work for the program as a whole and including agreements on annual objectives and milestones
- a Memorandum of Understanding on joint management arrangements
- a Code of Practice covering the ways partners will work together, where not included in the MoU
- a Partners' Meeting, convened twice a year to plan and receive the reports of joint annual reviews and to agree any course corrections that are necessary.

The partners who are central to such arrangements are AusAID and GoTL in the form of the MoH. However, if genuinely collaborative working among partners becomes possible, other development partners may be able to join the arrangements.

If approaches such as the ones listed above do not emerge as possible during the design stage, then more 'project-like' governance is an option. While much less aligned with aid effectiveness principles, they would allow for a focused set of governance arrangements. A suitable option in this situation would be a Program Steering Committee chaired by the Minister, Vice Minister or a senior MoH official (possibly jointly chaired with AusAID). To ensure inclusivity, membership could include a representative each of District Health Management Teams and District Health Councils, as well as one or more bilateral agency, multilateral organisations and influential NGOs and faith-based organisations. AusAID's management contractor would also be a member.[36] A core group of the Steering Committee would also be considered, to focus on more strategic matters and including as a minimum the Minister or his representative and AusAID's Director of Health and Education.

7. Performance management: M&E

This section briefly considers our approach to M&E as it stands at the concept stage. An outline M&E framework will be developed as part of design, and then translated into a fully elaborated M&E plan at inception by the program's M&E specialist. The health team will assist by proposing sector-specific methods and indicators based on international practice in health programs. We will also ensure consistency between (a) program-specific indicators and the country PAF that will be developed in parallel with the new program's design[37], and (b) the program's M&E framework and the government's intention to move to a single M&E system for the sector.

Apart from the initial setting of indicators for each of the outputs and outcomes and their agreement with MoH, key steps and organisational arrangements for M&E are likely to include the following:

[35] The International Health Partnership Plus is a global health partnership that aims to promote the Paris Principles, in particular harmonisation, alignment and the use of country systems. With a secretariat hosted by WHO, IHP+ has an increasing number of donor and country partners and a growing track record in promoting aid effectiveness.

[36] There can, however, be sensitivities about contractors being part of governance arrangements because of potential conflicts of interest. In programs in other countries AusAID may be moving away from their involvement. We will look into this in more depth in the design stage.

[37] AusAID's PAF guidance is currently being finalised. We will ensure that the program conforms to the country program and sector delivery strategy PAFs. This may need to be an iterative process as the country PAF has to be produced by the end of 2013.

- Annual plans that contain clear objectives and actions and verifiable targets (quantitative and qualitative as appropriate), ideally developed jointly with MoH and consistent with overall sector development plans.

- Annual reviews of plan implementation, preferably implemented jointly with MoH. Ideally these should be joint annual reviews of development in the sector and include the participation of all partners that provide support, including bilaterals, multilaterals, major NGOs, and professional associations. The review would not be independent but may commission specialist reviewers, internal or external to AusAID or other partners, to guide the process.

- Course corrections or advice on the following year's plans on the basis of the review findings.

- A brief summary report of the annual review, tabled at the annual Australia/Timor-Leste bilateral meeting, with consideration of any major strategic findings.

- An independent mid-term review in the first half of year three (which may replace the joint annual review).

- The mid-term review would be the main basis for a decision on whether and how to progress towards a second stage of the program after the first four years. The following (and final) annual review would revisit any major concerns raised at mid-term, and would pave the way for a formal design and approval process for the second stage.

- The M&E framework and plan will track indicators through monitoring and explore key evaluation questions through special studies.

In addition to assessing performance against objectives and indicators, the annual and mid-term reviews would revisit and propose adjustments to the risk appraisal, taking account of any changed perceptions of probabilities and impacts and the emergence of any new risks.

The scope of M&E will include some complex areas like the monitoring of expenditure through sector budget support. The more complex, the more costly—we anticipate that the cost of M&E will be around 5–7 per cent of the total budget.

8. Linkages to other programs

In this section we refer first to other AusAID programs, and then to programs of other development partners.

The concept stage for the health program has already seen productive exchanges with the managers and advisers on other AusAID programs. In particular, the Governance for Development team has provided invaluable advice on the institutional and political environment across the new government, and in particular in the MoH. The BESIK team has advised on the situation with regards to the likely pace of developing sound partnerships, the importance of delivering results early, the need for good planning, use of government systems, and the centrality of understanding the political economy. The fact that the health and education teams

are headed by the same Director means that there is valuable learning from education as they are further ahead in the design process.

The relevance of Governance for Development, BESIK-II, Seeds of Life, Roads for Development, Education, and Violence Against Women programs to the outcomes envisaged for the health program has been described above, mainly in Section 3, and does not need repeating here. However, the focus in Section 3 was about common interests in health-related outcomes. Three additional points relate to policy dialogue:

- While each program will lead on policy dialogue in its specific context, program managers will need to maintain the quality of communication that is already established among the teams in order to share knowledge and to ensure cooperation on common policy issues or engagement with common stakeholders.

- Part of the policy engagement will take place beyond the scope of the individual programs and will be led under the auspices of the Country Program as a whole.

- We will frame policy dialogue around the program's outcomes. Health policy as expressed in GoTL documents is broadly in keeping with priorities generally accepted as appropriate for developing countries facing similar problems. Dialogue is therefore less likely to be about changes in policy than about identifying the priorities to pursue, the outcomes to be achieved, and mobilising the political and institutional muscle to achieve them. We will update the Engagement Plan periodically during implementation to reflect developments and lessons learned in this process.

An area that several programs have in common is capacity building for management. As much of management development is generic, there should be opportunities for cooperation among programs pursuing this outcome, and we will explore this during the design stage.

Looking beyond the Timor-Leste program, discussions are taking place about how best to stay aware of health-related work initiated in Canberra. To reduce the risk of MoH or NGO partners being more aware than the Dili team, and to avoid potentially embarrassing differences in policy or strategy between Dili and Canberra, the team will continue to build communications with the managers of Canberra-based initiatives such as the NGO cooperation program (ANCP), Government Partnerships for Development and Australia Awards.

With regard to programs funded by other development partners, we will assess the degree to which the achievement of AusAID-supported outcomes will depend in part on the success of partner programs. If this is significant, we will engage with them insofar as possible to monitor progress and to either leverage their success or mitigate the effect of their failure on the AusAID program.

9. Key risks and their management

This section summarises the risks analysed in the Investment Concept using the Risk and Value Assessment Tool. The full assessment is attached at Annex 5.

Two categories of risk warrant a rating of 'high' in that assessment. The first is the operating environment, whereby unless the program responds closely to government priorities and readiness to engage, it will risk possible lack of ownership and engagement; contractors and staff will need to be sensitive to the high level of demands already faced by MoH counterparts and ensure they do not add excessively to management transaction costs. The second is the risk of financial loss arising from fiduciary weaknesses in government.

High risks

Operating environment:

(a) The Minister and senior officials may not engage sufficiently with AusAID for the design to be genuinely owned by government. Australian aid will need to ensure it aligns closely behind MoH priorities and processes to ensure ownership, commitment and engagement, and to ensure Australian support is valued and brings about long-lasting systemic improvements.

Our approach to mitigation is based on the comprehensive engagement plan that we have developed and will periodically update, under-pinned by the stakeholder map that which we will also be developing further and in more depth. The plan contains actions for engaging the Minister and senior officials and for reacting flexibly and with clear objectives when opportunities for meetings (formal or informal) or email exchanges arise. We also engage indirectly, for example through our WHO and World Bank colleagues, with whom we have common interests on which they communicate with the Ministry (the meetings of the health development partners are also a useful forum for planning joint engagement with the Ministry). We will continue to develop our understanding of the political economy, keep informed of developments in the MoH, and maintain high levels of communication with our contacts in the MoH and influential organisations.

(b) The MoH may take longer than anticipated to resolve key bottlenecks such as human resources[38], financial management or medical procurement and logistics. Delays in institutional change would have a knock-on effect, diluting or delaying intermediate outcomes.

Mitigation: we will continue to assess MoH bottlenecks that limit the delivery of maternal and child health services, and will design and adapt our approach to capacity development accordingly, bearing in mind also that bottlenecks may be caused as much by political economy as by shortage of capacity. Collaboration with Governance for Development will be important.

Fraud/fiduciary:

(c) There is the potential for lack of transparency or loss arising from sector budget support. In addition, government systems such as maintenance of buildings, equipment and vehicles, procurement, and financial management—the strengthening of which are likely components of the program—are prone to fraud. Inputs such as funds for construction, training, travel and so on can be misappropriated.

[38] The departure of Cuban health workers will have an impact on service delivery in locations where they are not rapidly replaced by staff with similar competencies.

Our mitigation includes not providing budget support until a rigorous analysis has been completed and systems deemed sufficiently secure; tight management controls on inputs; and scrutiny of program-related financial accounts.

Moderate risks

Other risks, for all of which the Risk and Value Assessment was 'moderate', include:

- the potential for the church or religious organisations to undermine progress on reproductive health including family planning
- lower than expected impact as a result of factors such as under-performing health staff and limited behaviour change by individuals and communities
- potential for harm arising from contact with children
- potential for natural disasters to undermine health status or delay implementation
- insufficient consideration of matters related to gender and disability, leading to inequity in service provision
- an undermining of AusAID's reputation by, for example, lower than anticipated results or government malfeasance
- damage to Australia's relations with GoTL as a result of misunderstandings or disagreements over program strategy
- unpredictability due to the new approach that the program is taking, compared with the current project portfolio.

Our current assessment is that mitigation of these risks such that they do not create significant threats to the program is manageable. As mentioned above, we will revisit our assessment on all risks during the design stage, and we will continue to scan for risks that are not yet listed.

Based on the Risk and Value Assessment, our concept-stage conclusion is that the overall risk rating is low.

10. Design next steps

The next steps, including ongoing analytical work, the design principles and processes, and the quality assurance processes, are set out in full in Section F of the Investment Concept.

Annex 1: Summary of development challenges facing Timor-Leste

The summary of development challenges in the Strategic Development Plan succinctly reinforces the case for external assistance in moving the country forward. The extract below includes high-level objectives as well as a description of some of the underlying development constraints.

Urban-rural and regional imbalances are inevitable in a fast-changing and hydrocarbon-rich economy. The SDP needs to adopt strategies to promote development in both rural and urban areas to prevent regional and social imbalances from reaching destabilising levels.

Shortage of skilled human resources in the key sectors of education, health, agriculture, industry, and services will have to be overcome to achieve economic success. Therefore, the SDP puts education and training at the very core of the strategy.

Fragile institutions of the state will have to be strengthened so that the government can provide key services and act as a strong partner to the private sector. One of the core goals of the SDP is to build implementation capacity**.** E-governance can play an important ancillary role, by connecting the citizenry with the government through online tools.

Post-conflict mentality is a collective reality that cannot be ignored when a nation has endured the severity of losses, faced the realities of past injusti**c**es, and experienced generations of conflict. This painful legacy is not often included when considering strategic planning. The SDP must mobilise the collective will and consciousness of the population, including the hopes built up during decades of struggle, to fulfil the goals of independence and self-determination within the context of the Timorese experience.

There is abundant economic opportunity for Timor-Leste. The following goals are achievable by 2030, and many may be achieved by 2020:

- Every child has access to free, compulsory and mandatory education through Grade 12.
- All Timorese are literate.
- All citizens have access to primary health care.
- No child perishes because of inadequate water supply, malnutrition, or lack of health care.
- Every citizen has the opportunity to acquire new skills based on 21st-century technologies, such as wireless broadband, high-yield agriculture, and cutting-edge healthcare delivery.
- Extreme poverty is eradicated through universal access to public services, ample job opportunities, and economic development in all regions.

The Strategic Development Plan offers a Vision to 2030, a Framework of Action to 2020, and a Public Investment Plan to 2015. The aim of the SDP is to combine an inspirational outlook with a specific timetable, and a set of key performance indicators and objectives that can be benchmarked for progress.

The Strategic Development Plan is developed with a long-term economic vision for Timor-Leste: by 2030, Timor-Leste will have joined the ranks of upper-middle-income countries, having ended extreme poverty, eliminated the economic gap with the

emerging economies of ASEAN, and fostered a democratic and environmentally sustainable society.

The next decade (2011–2020) will focus on creating the basic conditions for development in all areas: infrastructure, education and training, health, agricultural productivity and food self-sufficiency, sustainable urbanisation, and development of key industrial and service sectors.

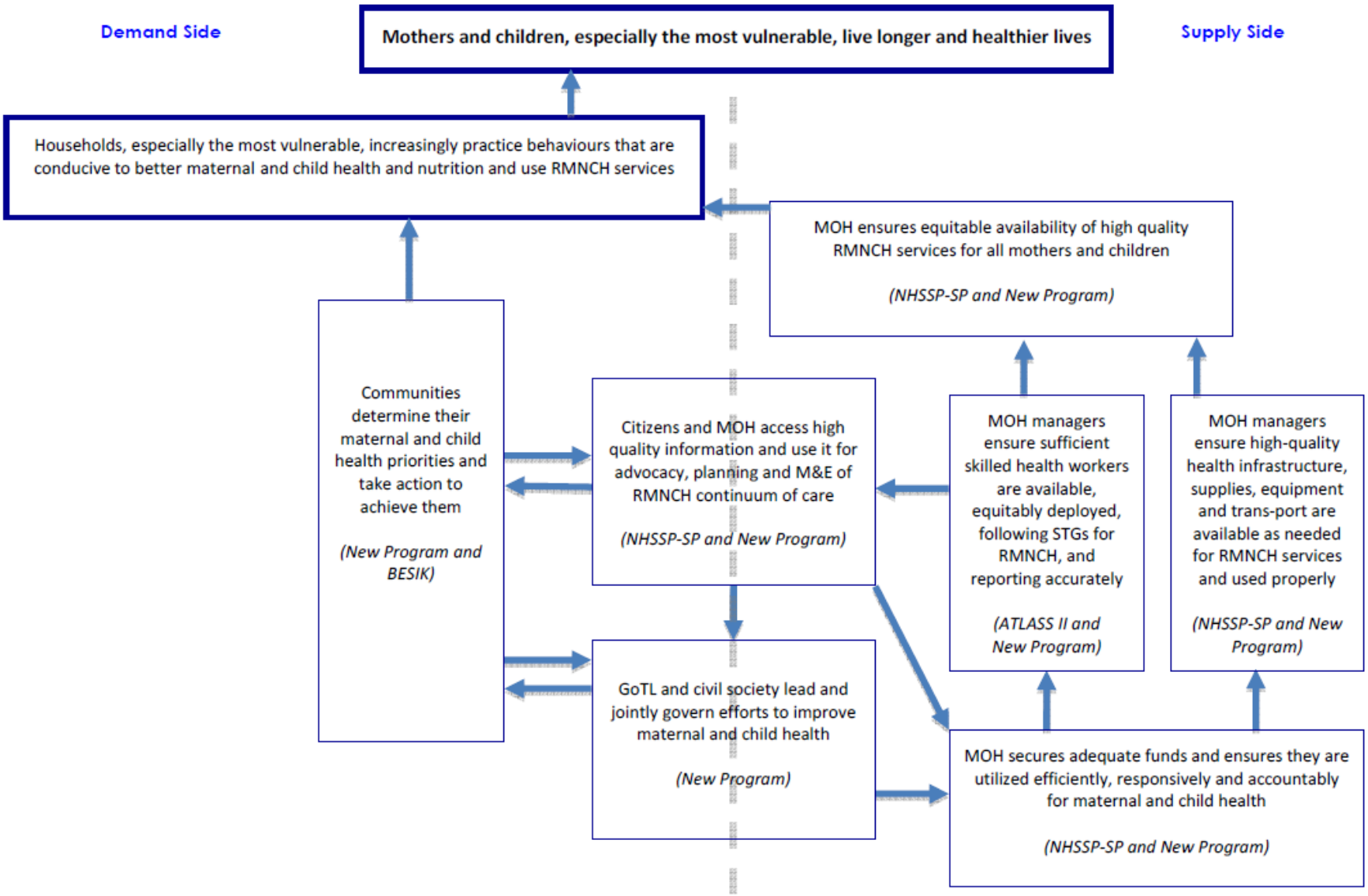
Human capital investment includes six pillars: health, nutrition, primary and secondary education, vocational training, higher education, and research and development. Timor-Leste will build a publicly-financed primary health system, accessible to all. This system will require around four per cent of (rising) GNP in public outlays the two decades ahead, meaning expenditures of around $100 per person per year in 2010, and rising to at least $350 per person per year by 2030. Timor-Leste will intensify nutritional programs, especially for young children, in the coming years to break the cycle of poverty and under-nutrition that robs children of their physical and cognitive potential during an entire lifetime.

Annex 2: Strategic Development Plan 2011–2030: Summary of actions, strategies and targets in the health sector

Source NDS p. 221

	2015 (Short Term)	2016 – 2020 (Medium Term)	2021 – 2030 (Long Term)
HEALTH By 2030, Timor-Leste will have a healthier population as a result of comprehensive, high quality health services accessible to all Timorese people. In turn, this will have reduced poverty, raised income levels and improved national productivity.	Sucos with a population between 1,500 and 2,000 located in very remote areas will be serviced by Health Posts delivering a comprehensive package of services The delivery of health services by private providers and the not-for-profit sector will be fully regulated and be in compliance with the public health care system 70% of pregnant women will receive antenatal care at least four times and 65% of women will have an assisted delivery 90% of children will be immunized against polio, measles, tuberculosis, diphtheria and hepatitis B There will be increased awareness of HIV/AIDS, tuberculosis, malaria, and other vector-borne diseases 80% of malaria outbreaks will be controlled 90% of Ministry of Health buildings will have access to electricity, water and basic sanitation	All Health Posts will be staffed by at least one doctor, two nurses and two midwives There will be a Health Post for every 1,000 to 5,000 people Sub-district health centres will provide care for 5,000 to 15,000 people and manage approximately four Health Posts Villages more than one hour walking distance from a Health Post will have a local village midwife or community health worker who has been trained by the Ministry of Health Cardiac, renal and palliative health care services will be available at the National Hospital Cardiac, renal and palliative health care services will be available at the National Hospital 54 district health centres will be located in districts that do not have hospitals Focus will shift from primary care to the delivery of specialist health care	There will be a district hospital in all 13 districts There will be a specialist hospital in Dili 100% of health facilities will be fully equipped and staffed for management of chronic diseases 100% of health services health will be delivered from infrastructure that is functional, safe, environmentally friendly and sustainable There will be comprehensive high quality health services accessible to all Timorese people

Annex 3: Timor-Leste Health Program: Program logic at concept stage



Annex 4: Health Design Engagement Plan—Timor-Leste

Contents

1. Introduction

AusAID's Timor-Leste Health Team is designing a new program that will contribute to better health for mothers and children. The program, due to begin in 2013–2014, will be aligned to the GoTL's health plans and priorities. Basic government documents include the *Strategic Development Plan 2011–2030, National Health Sector Strategic Plan* and the MoH's forthcoming *Five-Year Plan*. Together, these documents commit GoTL to strengthening health care and improving, in particular, health outcomes for women and children. The new *Strategic Partnership Agreement* between Australia and Timor-Leste underlines our shared commitment to this goal. The new program is also entirely in keeping with the analysis and objectives of the *Health Delivery Strategy.*

AusAID's main partner for the new program will be the Government of Timor-Leste (GoTL), with whom a strong, trust-based working relationship will be essential. The plan also covers other external stakeholders such as WHO, the World Bank, other development partners, and civil society, as well as AusAID teams working on programs that have common interests or overlapping areas of work.

AusAID already enjoys a great deal of engagement with the GoTL on health. Most of this is with the Ministry of Health and deals with the portfolio of ongoing projects. Engagement around the new program has also started. We expect engagement to fluctuate as a result of the Ministry's other preoccupations. The plan needs clear objectives and a timetable, but also needs to be opportunistic, raising matters or responding to the MoH when the chance arises. For this reason, the engagement plan is in two parts:

- This short document, setting out objectives, principles and approaches, which will need only occasional updating.
- A set of annexes covering more immediate objectives, stakeholder analysis and speaking points , which the Dili health team will update frequently enough to reflect the changing situation on the ground.

Key features of our approach to the new program will shape our engagement with stakeholders:

- The new program will be the largest element in an increasingly integrated health portfolio. We are ending the plethora of small and disparate AusAID-funded projects in the sector.

- It will support delivery of quality basic services in the short term as well as longer-term health system strengthening. The systems approach is a pre-requisite for achieving the overarching aim of improving the health status and quality of lives of women and children.
- In keeping with the Paris principles on aid effectiveness, we intend the program to align behind government strategies and plans, harmonise with other donors and agencies, and make greater use of GoTL systems where possible. Those systems are likely to include planning, budgeting, and M&E and reporting processes. Budget support may be possible in the medium to longer term.
- The program will be designed and implemented through greater engagement between AusAID and the GoTL. We aim for joint design and implementation.

2. Objectives of the Engagement Plan

The strategic outcome of this plan is for ***AusAID, the Government of Timor-Leste (especially the Ministry of Health) and other key organisations in the health sector to build and maintain a productive, effective working relationship***.

To achieve that working relationship, we will develop and maintain:

- a clear and continually updated understanding of the institutions and senior figures in the sector and the dynamics that drive them
- a strong technical understanding of health needs and key programs
- knowledge of aid effectiveness principles and of international experience in applying them
- working knowledge of GoTL processes
- up-to-date overview of other key health partners and their programs (bilateral donors, multilateral agencies, NGOs, faith-based organisations and others)
- effective engagement in policy and operational dialogue, which is 'on message', with GoTL.[39]

3. Principles for keeping a rapidly evolving plan on track

Relations are evolving as the new government reorganises the MoH and as AusAID explains its intentions for a new partnership approach. The details of engagement will also evolve rapidly to reflect emerging information, new opportunities for dialogue, and new relationships.

To help keep us focused on creating and strengthening new relationships, we will apply a set of principles as we move forward:

- *Partnership.* To base the relationship on a shared understanding of the needs of the health sector and of the contribution of GoTL, AusAID and other development partners to its development.
- *Opportunism.* To seize opportunities in meetings with Ministry officials and development partners, initially to explain AusAID's intention of moving from a portfolio of disparate projects to a more strategic and partnership-based approach, and later to continue developing and maintaining that approach.

[39] Commissioning Minute, 26 March 2012.

- *Advocacy for harmonisation and alignment.* To advocate with other development partners (bilaterals, multilaterals, NGOs, FBOs) our intention of pursuing a more harmonised and aligned approach to development in Timor-Leste, and to take steps to put that into practice.
- *Prioritisation.* To consult with MoH and development partners on the design of the new health program, to make sure the process is transparently based on bringing together the country's priority needs and AusAID's preferred focus within those needs.
- *Australian leadership.* To strengthen our leadership role in promoting among all partners a priority-focused, evidence-based approach.
- *Internal coordination.* To coordinate across sectors in which AusAID is working.

4. Engagement with GoTL and other external and internal stakeholders in the concept and design stages

Issues of engagement to date

In September and October 2012, health team members were able to introduce the topic of the new program into discussions on other matters and in email exchanges with the Minister of Health. Progress was initially slower than the health team would have liked, mainly because of factors outside AusAID's control. However, the email exchanges accelerated in October, culminating in a fruitful meeting with the Minister.

Observations from this early stage of engagement include the following:

- Access to the new Minister has been patchy and will remain unpredictable. It has, however, been positive. He has laid out his immediate priorities, and helping him to achieve them (through NHSSP-SP) will cement the relationship. He wishes to discuss the new program after he has sorted out the MoH restructuring and the budget.
- Building a relationship with new appointees at DG and director level has also not been as fast or intensive as desired. Lack of delegation from the Minister and uncertainly about who will be in what posts constrains officials' ability to have in-depth and frank discussions.
- Because Ministers and officials have their hands full with other priorities, AusAID's expectations have to reflect the reality that relationship building may take longer than desired, and should set timetables accordingly.

Engagement priorities in the short term

In the period before we can discuss the new program with the Minister, we will:

- Work with him and his staff to provide the support needed, via NHSSP-SP, to help meet his immediate needs (all of which are relevant to the new program as they are stepping stones to a better-functioning MoH). This work will create valuable opportunities for policy dialogue around sector issues related to the new program.
- Collaborate with other key stakeholders such as WHO and the World Bank to provide that short-term support and to promote sector-wide working. This will also create opportunities for policy dialogue and will strengthen our strategic relationships with these organisations. Such relationships are essential for the new program (and for the Delivery Strategy as a whole).

- Maintain our engagement with officials in relation to the existing AusAID portfolio. We will adjust our engagement depending on who is appointed to which post in the restructured MoH, consolidating or building anew, depending on who is in which Directorate or department. We will explore informally with these officials our ideas for the new program when it seems judicious to do so.
- Manage expectations to avoid GoTL treating the new program as a 'shopping list'. We have developed and will continually update a set of speaking points and a two-page description of our initial ideas, which help define the boundaries to the program approach.
- Continue to develop our links with a range of organisations such as health-related national and international NGOs and FBOs, professional associations (especially nurses, midwives and doctors), and private-for-profit providers. Knowledge gained from these links will help in program design by clarifying the institutional environment in which the new program will operate. We may also develop partnerships with some of the organisations, for example selected NGOs and FBOs, for program implementation.
- Begin to prepare existing projects in the health portfolio for eventual transition (or not) into the new health program.
- Build on existing strong communications within AusAID Dili. BESIK-II, Governance for Development, and Education will all contribute to health outcomes in the shorter or longer terms. We will continue to work with colleagues to share knowledge about stakeholders and to cooperate on activities and interventions that will contribute to each program's outcomes. Illustrations include institutional strengthening in the MoH (a GfD interest), behaviour change related to water, sanitation and hygiene (BESIK) and long-term health outcomes related to girls' education.
- Strengthen our communications with other AusAID sources of funds for health activities in Timor-Leste. Being informed about ANCP, PSLP, ECTAS and ALAF will enable us to discuss Australian health-related aid knowledgably with MoH and other stakeholders. It may also give us some leverage with the way those funds are spent or to encourage the programs and their recipients to respect the principles of harmonisation and alignment.
- Continue to develop the stakeholder map begun in the second concept workshop and use the analysis for tuning the engagement plan. We will also use the map to inform the political economy analysis in the design stage.

For engagement with the MoH, we will create entry points to Ministers and officials. Entry points may be, for example, meetings on other subjects (or on other projects within our portfolio) at which we can raise the design of the new program. Social events that stakeholders attend can also be actively exploited for informal dialogue. We will sometimes be able to plan such opportunities in advance, but many will be opportunistic.

5. Beyond the design stage

It is important to distinguish between engagement with stakeholders *about* the program and engagement *within* the program. In the design stage, AusAID will seek policy dialogue with MoH ministers and officials and with other development partners in order to make sure the design is appropriate, that it responds to GoTL priority needs, and that it gains their support and cooperation. In the implementation stage, engagement will encompass a much wider agenda, for example the following:

- continuing policy dialogue at central level with MoH and development partners

- ways of understanding and responding to the needs of district and community-level stakeholders such as health officials and staff
- ways of supporting health service users to be effective advocates, so that they can influence the availability and quality of care at community and facility level.

It is important to recognise that AusAID's direct engagement will be more likely at the central level. At district and community level, engagement will be less direct, for example though contracted NGOs or through the MoH's internal systems and processes.

6. Methods of engagement during implementation

Mechanisms that AusAID will use in the implementation stage will depend on the stakeholders and the purpose of the engagement. Mechanisms may be formal meetings with a particular focus on the program; activities that are part of program implementation; or less formal and, perhaps most often, ad hoc opportunities for raising matters of concern. A preliminary and non-exhaustive list of examples includes:

- A program steering committee, government led, to oversee implementation; a valuable forum for policy and strategy engagement.
- Program activities such as technical support for district officials or health workers, at which broader issues about health service performance can be explored.
- Implementation meetings with officials around complex issues such as procurement and human resources.
- Opportunities created or seized for ad hoc, high-level raising of policy and strategy matters (for example, side discussions at government-to-government talks).
- Other ad hoc opportunities seized for operational matters, for example, raising program matters in meetings called mainly on other agendas.
- Joint Annual Reviews that include this program, other development-partner programs, and the government's own services.
- Discussions with AusAID-supported advisers, in this program and in others such as BESIK, GfD and Education.

7. Annexes to the Engagement Plan

The 'living document' part of this plan is to be found in the annexes. The main text will be updated periodically, for instance around the time of the design workshops, contracting, and review points during implementation. The annexes, however, will be updated much more frequently. Triggers for updating will include information obtained during meetings or communications with the MoH, development partners or NGOs, or through the many networks in which the health team are members. Decisions will be made at the weekly health team meetings as to whether enough new knowledge has been gained to make it worthwhile to update the engagement actions or speaking points, or to revise key reference documents such as the stakeholder map or MoH organogram.

The annexes are:

A: MoH organogram and list of directorates and departments
B: Table of objectives and talking points for key individuals and organisations
C: Generic talking points

Annex 5: Timor-Leste Health Program: Investment Concept Risk and Value Assessment

(Annex A of Investment Concept)

	Likelihood	Consequence	Rating
1. **Operating environment**: What impact might the operational or physical environment (political instability, security, poor governance, lack of essential Infrastructure etc.) have on achieving the intended objectives/results?	Possible	Major	High
a) Risk of low national ownership: Minister and senior officials may not engage sufficiently with AusAID for the design to be considered genuinely joint. Australian aid will need to ensure it aligns closely behind MoH priorities and processes to ensure ownership, commitment and engagement, and to ensure Australian support is valued and brings about long-lasting systemic improvements. Mitigation: AusAID's engagement plan, based on in-depth stakeholder mapping, contains actions for dialogue with the Minister, officials and influential partners such as WHO, the World Bank and major NGOs. AusAID will continue to develop its understanding of the political economy, keep informed of developments, update the plan regularly, maintain high level of policy and operational dialogue with stakeholders, and put in the effort to make the GoTL—AusAID relationship work. Appointment of a Health Specialist to the AusAID team, with expertise in policy dialogue, will supplement existing influencing and partnership skills. b) It is possible that the MoH will take longer than anticipated to resolve key bottlenecks. An example of problems already shown to be challenging is drug procurement and logistics—stock-outs of medicines are commonplace. The current re-organisation of SAMES may or may not resolve this issue. If reforms proceed more slowly than anticipated the impact on EOPOs will in turn be slower. Mitigation: in the design stage AusAID will continue to assess MoH bottlenecks that are on the critical path for maternal and child health (such as SAMES), and will tune our approach to capacity development accordingly. Although it will take time, greater involvement of citizens in governance should increase pressure on MOH to make its systems work better. The design will allow for shifts in types of aid to help address bottlenecks or leverage emerging opportunities. We will work locally with district authorities and NGOs, similarly to BESIK, to help deliver short-term results. Collaboration with GfD. c) Church attitudes to sexual and reproductive health may constrain improvements and uptake of some priority services including family planning. Mitigation: policy dialogue with MoH, development partners and NGOs; engagement with progressive church-related organisations; diplomatic handling of sensitive issues.			
2. **Results**: What is the risk that this investment will fail to achieve intended results or have negative unintended consequences? Would the failure to achieve the results in the proposed timeframe, or at all, affect the targeted beneficiaries directly? What level of impact would this have on beneficiaries?	Unlikely	Major	Moderate
There is a possibility that changes in health-related behaviour and use of services will be lower than anticipated. Potential contributing factors include, for example, under-performance by the health workforce and the associated supply-side systems in delivering high-quality care in poor communities, and people in those communities not changing their own health-related behaviour or demanding and using health services as much as is planned. Mitigation includes paying close attention to possible weaknesses in the program logic during design and implementation, in particular to political economy aspects that may disrupt achievement of immediate and intermediate outcomes; close partnership working with MoH; and partnerships with NGOs that are effective and have the potential for scaling up in service delivery, health behaviour change and community mobilisation. We will consider flexible delivery approaches so that we can adjust resources or types of support in response to constraints or opportunities.			
3. **Safeguards** Do any of the activities involved in this investment have the potential to cause harm relative to safeguard issues (child protection, displacement and resettlement, environment and disability)? If so, what level of impact would this have?	Unlikely	Moderate	Moderate
Contact and working with children under 18 years will be a routine part of health service delivery (affects GoTL and NGO staff, not AusAID). At present there appears to be no potential for people to be physically, economically, or occupationally displaced, but insufficient program attention to vulnerability, for example disability or gender, could fail to reduce inequalities. Climate change could affect health status, for example through the impact of extreme weather			

events or increase in disease vectors, thereby reducing the program's impact. Mitigation: significant climate change mitigation is beyond the scope of this program, though there may be opportunities, in collaboration with other programs, to strengthen community resilience to climate-change-related impacts such as food insecurity; the response to natural disasters will be decided case by case; on child protection, we will apply AusAID's child protection policy; we will carry out further investigation of gender and disability during design and look for opportunities for people with disabilities to participate in design and implementation in keeping with GoTL and AusAID policy.			
4. **Fraud/Fiduciary**: Is there a risk of fraud or that funds will either not be used for the intended purpose or will not be properly managed by a recipient individual, organisation or institution? If so, what level of impact might this fraud or loss/misuse of funds have both on our reputation and in terms of achieving objectives?	Possible	Major	High
Lack of transparency and potential for financial loss associated with sector budget support. We will be unable to track, in detail, the use of AusAID funds provided as sector budget support, so identifying some fraud would be harder. Government systems, the strengthening of which are likely to be in the program (maintenance of buildings, equipment and vehicles, possibly drug logistics, financial management) are prone to fraud. Inputs such as funds for construction, training, travel and so on can be misappropriated. Mitigation: AusAID will carry out a fiduciary risk assessment for the MoH; will require audit (preferably increasingly on performance rather than inputs); will vary type and intensity of oversight to reflect risk levels; will provide TA to work with the MoH on its financial management systems; will scrutinise program-related financial accounts; and will use AusAID's new procurement facility until GoTL financial management is shown to be robust enough for use of AusAID funds. Using the systems while helping to strengthen them, with careful and ongoing risk management, is a strategy for partnering with GoTL.			
5. **Reputation**: Could any aspect of the implementation of this investment potentially cause damage to the reputation of AusAID or the Australian Government? If so, what level of impact might this have?	Possible	Minor	Moderate
Failure to achieve objectives could undermine Australia's reputation and relations with GoTL, development partners and other Australian stakeholders. Any evidence of fraud would be damaging. Mitigation: high discipline in program monitoring with corrective action when needed; financial risk mitigation as above. The design will ensure that the program has the flexibility to respond quickly and appropriately to a deterioration in the implementation environment or alternatively to capitalise on improvements in the implementation environment in order to lock in progress.			
6. **Partner relations**: Could any aspect of this investment, such as failure to achieve objectives, potentially damage Australia's relationship with key partners? If so, what level of impact might this have?	Unlikely	Major	Moderate
At present, partner relations with key organisations (MoH, WHO, World Bank) are exceptionally good. Ongoing implementation of the engagement plan and its regular updating should protect and enhance those relationships. It has proven more challenging to have any influence with GAVI and the Global Fund, which, as in many other countries, have been less concerned with harmonisation of donor efforts. Multiple national and international NGOs in health also create a challenge in terms of a coordinated approach. The existence of both Canberra-based and Dili-based channels for supporting health-related work have the potential to undermine consistency in Australia's health delivery strategy, risking at best a lack of information about initiatives and at worst contradictions in the strategy. On the government side, relationships with Ministers and senior officials have generally been constructive but can be fragile, easily damaged through misunderstandings, misinterpretations (possibly related to political economy factors) or disagreements over program strategy, content or performance. Open clashes on policy need to be avoided on, for example, family planning. Mitigation: continued close attention to fostering good relations with MoH and major development partners through implementing the engagement plan and keeping it updated; use the plan to maintain strong policy dialogue and to stay sensitive to political-economy factors; ongoing policy dialogue in partnership with WHO, World Bank and other key stakeholders; increased engagement with GAVI, Global Fund and NGOs (including through AusAID departments responsible for relations with international organisations); diplomatic approaches to problem solving around program design, implementation and review.			
7. **Other**: Are there any other factors specific to this investment that would present a risk (e.g. this is a new area of activity or is an innovative approach)? If yes, please describe and rate the risk.	Possible	Minor	Moderate
The program is a new approach for AusAID in Timor-Leste, so contains a degree of unpredictability that could lead to unforeseen consequences. Possible pressure for low-strategic-worth spending as other donors reduce funding or leave Timor-Leste. Mitigation: the design will incorporate lessons from AusAID and other agencies; rigorous contestation			

during design; strong partnership-working with remaining development partners to maintain strategic integrity.	
Overall Risk Rating:	LOW
1. Is the total investment value above $100 million?	No

		Value Rating	LOW
Overall categorisation:	**Risk**	**Value**	
	LOW	LOW	