Timor - Leste

National Health System Profile

1. TRENDS IN POLICY DEVELOPMENT

In fact if the factors that influence the health status of a given population is studied, it is seen that healthcare contributes in a small measure to the overall health status. Education, income, housing, food, water and sanitation are among the most important determinants of health. The Ministry of Health of Timor-Leste is aware of these determinants of the health status and has assumed from its inception a vision that implies a broad definition of health - **"Healthy Timor-Leste people in a healthy Timor-Leste."**

With this vision statement, the Ministry of Health envisages a community enjoying a level of health that will allow them to develop to their full potential in a healthy environment. The fact that the vision implies a healthy Timor-Leste means that sectors other than health should contribute to reach the peak that this vision foresees (i.e., a multi-sectoral approach to health).

The vision also reflects the aim to reduce poverty to an extent where the level of production and income allows its entire people to enjoy a healthy life and to have the minimum means to cover their basic needs. Only a healthy community can achieve the goal of poverty alleviation.

As stated in the Democratic Republic of Timor-Leste's Constitution, the right to proper health and medical care is the fundamental right of every individual and the state is obliged to protect and promote it. The overall system of health administration is universal and free of cost. Its effectiveness to provide proper health and medicare to the citizens is dependent upon the capacity of the state to deliver. However, the management of the system is decentralized and participatory in nature.

Mission

Consistent with the vision statement, the mission of the Ministry of Health is to strive to ensure the availability, accessibility, and affordability of health services to all the people of Timor-Leste; to regulate the health sector; and to promote community and stakeholders' participation (including those from other sectors).

Goals

From these three components of the mission (ensuring availability, regulating, and promoting participation) the Ministry of Health also expects to contribute to the overall goal of improving the health status of its population. Further, the Ministry of Health aims to provide quality healthcare to the people by establishing and developing a cost-effective and need based health system which will specially and address the health issues and problems of women, children, and other vulnerable groups, particularly the poor, and the approach is based entirely on people's participation.

Health priorities are among the most crucial factors in the Development Plan. Development strategies have been devised to emphasize the importance of providing adequate access to primary healthcare, focusing on the prevention aspects, and the question of clinical support in underserved areas. It had proposed to develop a system of primary healthcare – 'easily accessible to both the individuals, the families and the community and at a cost that the community and country can afford.' While women's right to health would be ensured, special emphasis was placed on reproductive health and on the prevention of health hazards.

The National Development Plan has set the following targets:

Infant mortality rate currently estimated 88 per 1000 live births, to decline significantly within five years;
Health sector policies will receive priority to ensure the basic level of health of the workforce; and
The share of health would rise significantly from 7.6 percent of the total budget in fiscal year 2002 to 13.7 percent in fiscal year 2007.

http://www.minsau.gov.tl/

2. TRENDS IN SOCIO-ECONOMIC DEVELOPMENT

2.1 Economic trends

Measured by both income and human development indicators, Timor-Leste is one of the world's least developed countries. Incomes are low, with per capita GDP estimated at only US$ 478. Timor-Leste has made considerable progress in rebuilding its economy over the past three years. Real GDP is estimated to have grown by 15 percent in 2000 and 18 percent in 2001. However, the positive signs of recovery suffered a setback as the late arrival of the rains in 2002 and 2003 impacted adversely on agricultural production which reflects the decline in GDP by about 5 percent in 2002-03 (Timor-Leste Millennium Development Goals-Final Draft, 2003).

Human development indicators placed Timor-Leste among the 10 poorest countries on the earth. According to Human Development Report 2004, the national Human Development Index (HDI) was estimated at 0.426, however, it has improved from on HDI value of 0.395 in 1999.

In Timor-Leste, around 41 percent of the population is living below the poverty line (Health Profile 2002, Ministry). Around 20 percent of the population lives below the poverty line i.e., US $ 1 per day. The vast majority, 85 percent of poor people live in rural areas (Timor-Leste Millennium Development Goals-Final Draft, 2003 and Health Profile 2002).

- http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20535285~menuPK:232599~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html (World Bank)
- http://hdr.undp.org/hdr2006/statistics/flash/statistics_trends.cfm (HDI)
- http://www.unescap.org/pdd/publications/index_survey.asp (UNESCAP)

2.2 Demographic trends

The total population of Timor-Leste in 2004 was 1,015,187 and the population growth rate was around 3.2 percent in 2006. Total fertility rate is 6.7 in 2006.

In 2006, the life expectancy at birth was 59.5 years. Females have outnumbered males as female life expectancy was 60.5 years whereas male life expectancy was 58.6 years during same period (Timor Leste 2006 Health Statistics Report).

IMR in 2006 was 88 per 1,000 live births. The most common causes of infant mortality are infectious disease, low utilization of skilled assistance for antenatal and poor reproductive health (Timor Leste 2006 Health Statistics Report).

The urban population in Timor-Letse constituted 15 percent of the total population in 2002 and the remaining 85 percent comprised rural population in the same period (Democratic Republic of Timor-Leste Health Profile, August 2002).

- http://www.who.int/whr/en/ (WHR)

2.3 Social trends

The adult literacy rate was 58.6 in 2002 (Democratic Republic of Timor-Leste Health Profile, August 2002).

The increase in Gross Enrolment Ratio (GNR) in Primary education has been negligible. It increased from 142 in 2000-01 to 143 percent in 2001-02 for both the sexes. But in the case of secondary education, there was a nominal increase from 31 percent in 2000-01 to 35 percent in 2001-02 (UNESCO reports).

- http://www.uis.unesco.org/profiles/EN/EDU/countryProfile_en.aspx?code=6260 (UNESCO)
- http://iresearch.worldbank.org/PovcalNet/jsp/index.jsp (WB)

2.4 Food supply and nutritional status

Ten percent of the total population of the infants weighed less than 2,500 grams during 2003 (according to the UNICEF's, *The State of the World Children, 2005*).

Forty-six percent of children below 5 years of age were underweight and 49 percent in 2002-2003. (11 questions of 11 SEAR countries).

- http://www.searo.who.int/EN/Section13/Section38.htm (Nutrition) http://www.who.int/nutrition/en/

3. HEALTH AND ENVIRONMENT

3.1 Water supply and sanitation

In 2001, 56 percent of the total population (72 percent urban and 51 percent rural population) had access to an improved water source (Timor-Leste Millennium Development Goal, August 2003).

In Timor-Leste, around 33 percent of the population had access to adequate sanitation facilities in 2002 with 65 percent urban population and 30 percent rural population (according to UNICEF's, *The State of the World Children, 2005*).

- http://www.searo.who.int/EN/Section23/Section1000.htm (water and sanitation) http://www.who.int/water_sanitation_health/en/
- http://www.searo.who.int/EN/Section314_4295.htm (Water)

4. HEALTH RESOURCES

4.1 Human resources for health

The Ministry of Health is currently providing medical services to all the 13 districts throughout Timor-Leste with the active assistance of a team of international medical officers and specialists. In order to maintain the high standards of medical services and to ensure the provision of adequate ongoing health services to the people, the ministry has estimated that it will require approximately 25 district medical officers and 27 medical specialists for health services (Democratic Republic of Timor-Leste Health Profile, August 2002).

In 2002, 47 Physicians (12 national and 35 international), 624 nurses and 226 midwives provided healthcare services to the people (Democratic Republic of Timor-Leste Health Profile, August 2002).

- http://www3.who.int/whosis/core/core_select_process.cfm?country=tls&indicators=healthpersonnel&intYear_select=all&language=en (Human Resources)

4.2 Financial resources for health – present and projected financial resources for the health system, healthcare finance and expenditure

The total expenditure on health in 2001-2002 was US $ 6 million from a total budget of US$ 64 million, making health the second largest area of expenditure after education. In 2002-2003, the health expenditure planned was to the tune of US $ 7 million under the Consolidated Fund for Timor-Leste. The allocation was mainly to support the delivery system of ongoing services, improve their range and quality, develop and implement the support system, policy and management system.

WHO, UNICEF, UNFPA, and other UN agencies contributed more than US$ 8 million for the health sector under the Consolidated Fund for Timor-Leste (Democratic Republic of Timor-Leste Health Profile, August 2002).

Total expenditure on health as percent of GDP has increased from 7.7 percent in 1998 to 9.7 percent in 2002. Private expenditure on health has also increased from 32.1 percent of total expenditure in 1998 to 36.1 percent in 2002. On the other hand, public expenditure on health has decreased from 67.9 percent of the total health expenditure to 63.9 percent of total health expenditure during the same period.

Timor-Leste has given specific attention to the health services, the public expenditure as percent of the government spending on health, has also increased from 6.7 percent in 1998 to 9.0 percent in 2002. Moreover, the per capita health expenditure has also increased from US$ 40 in 1998 to US$ 47 in 2002 (as per WHO, *the World Health Report, 2005*).

http://www.who.int/countries/tls/en/

4.3 Physical infrastructure for health

In Timor-Leste, currently one referral hospital is functioning in Baucau district with 114 beds. Four more such hospitals with a provision of 24 beds in each are being set up in four districts - Cavalima, Bobonaro, Oecusse, and Ainaro (Maubisse). Apart from the inpatient medical services offered, surgical operations under general anaesthesia are also planned to be performed. The following four levels of Community Centres are available in every district:

Level 1: In order to provide basic health services a network of level 1 health posts and mobile clinics have been deployed. These centres are 4-8 kms from the houses of the patients'. The services provided include: curative consultation, antenatal and postnatal care, immunization, growth monitoring, and health promotional activities.
Level 2: In every sub–district there is a community health centre providing promotive, preventive, and curative services. Theses include out-patient consultations supported by a simple laboratory.
Level 3: At this level, apart from the facilities that are provided at the lower levels, basic emergency obstetric care like-manual removal of placenta, forceps or vacuum-assisted delivery or treatment of other obstetric complications are provided. These facilities are located in districts bordering Dili, Aielu, and Liquica.
Level 4: This facility is available in five districts of Timor-Leste. Facilities include an in-patient department with 10 to 20 beds where medical cases can be diagnosed, treated, and referred to higher levels if needed. Complete laboratory services and other diagnostic facilities are available. Minor surgical procedures like stitching, drainage of abscesses, or any other surgical procedures not requiring general anaesthesia, are available (Democratic Republic of Timor-Leste Health Profile, August 2002).
http://www.minsau.gov.tl/

4.4 International partnership for health

Timor-Leste has concluded partnership with WHO, UNICEF, UNFPA, RACS, and CordAID and fifteen international non-governmental organizations (INGOs) for coordination of activities in the health sector.

5. DEVELOPMENT OF THE HEALTH SYSTEM

5.1 Health policies and strategies

In Timor-Leste, the Ministry of Health came into being in September 2001 with following objectives:

Reduce levels of maternal and infant mortality

Reduce the incidence of illness and death due to preventable communicable and non-communicable diseases, including HIV/AIDS
Improve the nutritional status of mothers and children
Improve reproductive health in Timor-Leste
Ensure that all people have access to health services
Ensure the delivery of a minimum healthcare package at all levels of services
Collaborate with all stakeholders in the health sector to achieve national goals for health
Ensure that sufficient and adequate training for health professionals is undertaken to meet national requirements
Regulate the employment of all health professionals to ensure minimum standards of professional practice
Increase woman's access, both to health information and to quality health services
Increase the availability of mental and dental heath services. (Democratic Republic of Timor-Leste Health Profile, August 2002).

Millennium Development Goals (MDGs)

- http://www.who.int/topics/health_policy/en/ (health Policy)

The progress made towards achievement of health related MDGs is given at Annex-5.

5.2 Inter-sectoral cooperation

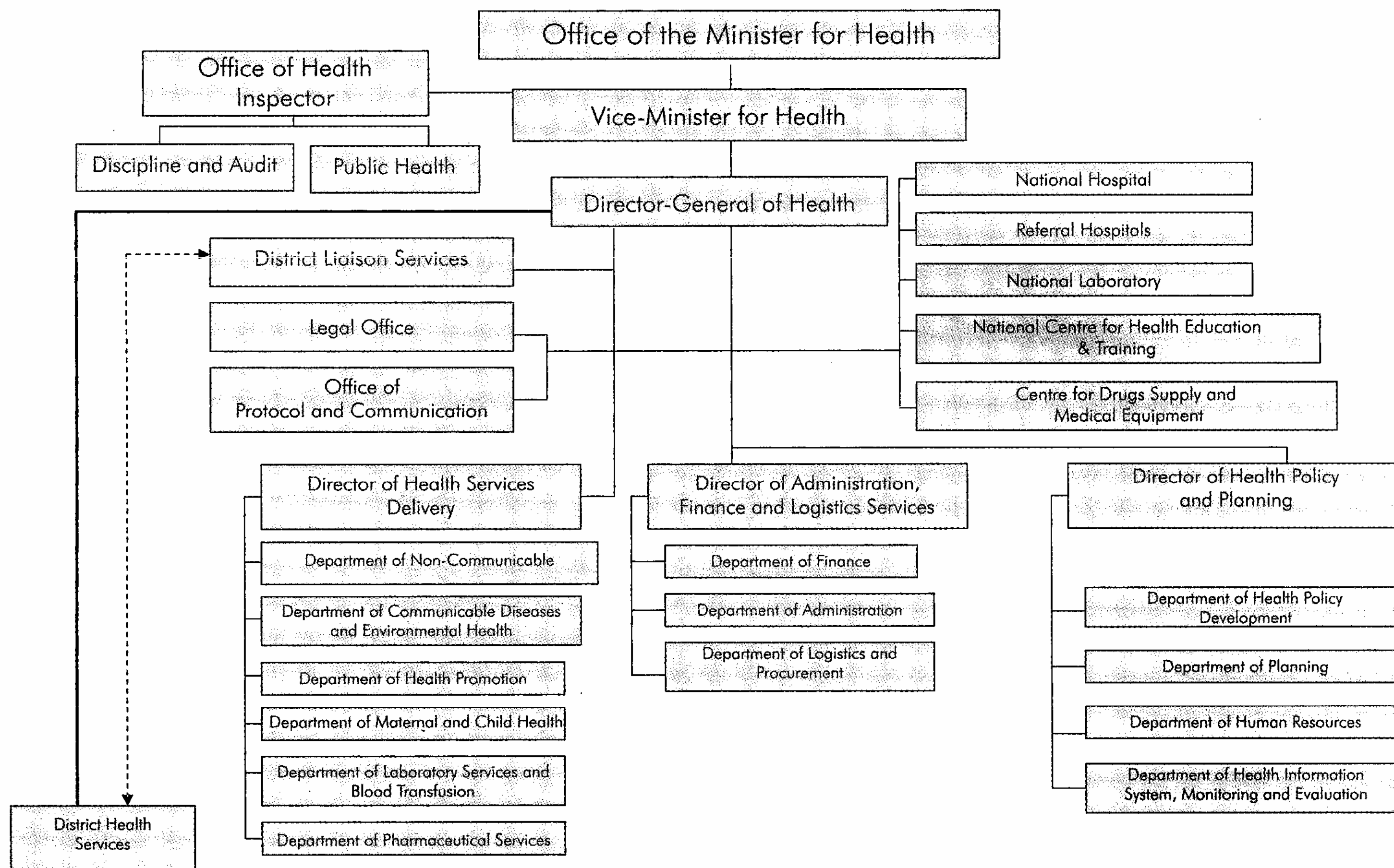
Organization of the health system

Initially, the WHO together with the UNICEF acted as 'Temporary Ministry of Health' during September 1999-January 2000 in Timor-Leste. The International Committee of Red Cross (ICRC) and fifteen INGOs together with military medical teams from the International Force for Timor-Leste (INTERFET) provided curative services to the general population. During that interim period, the WHO coordinated the important role played by NGOs in providing health care services to the people.

An Interim Health authority was formed in February 2000 followed by the creation of the Division of Health Services in July 2000. The Ministry of Health came into being in September 2001. (as per Democratic Republic of Timor-Leste Health Profile, August 2002).

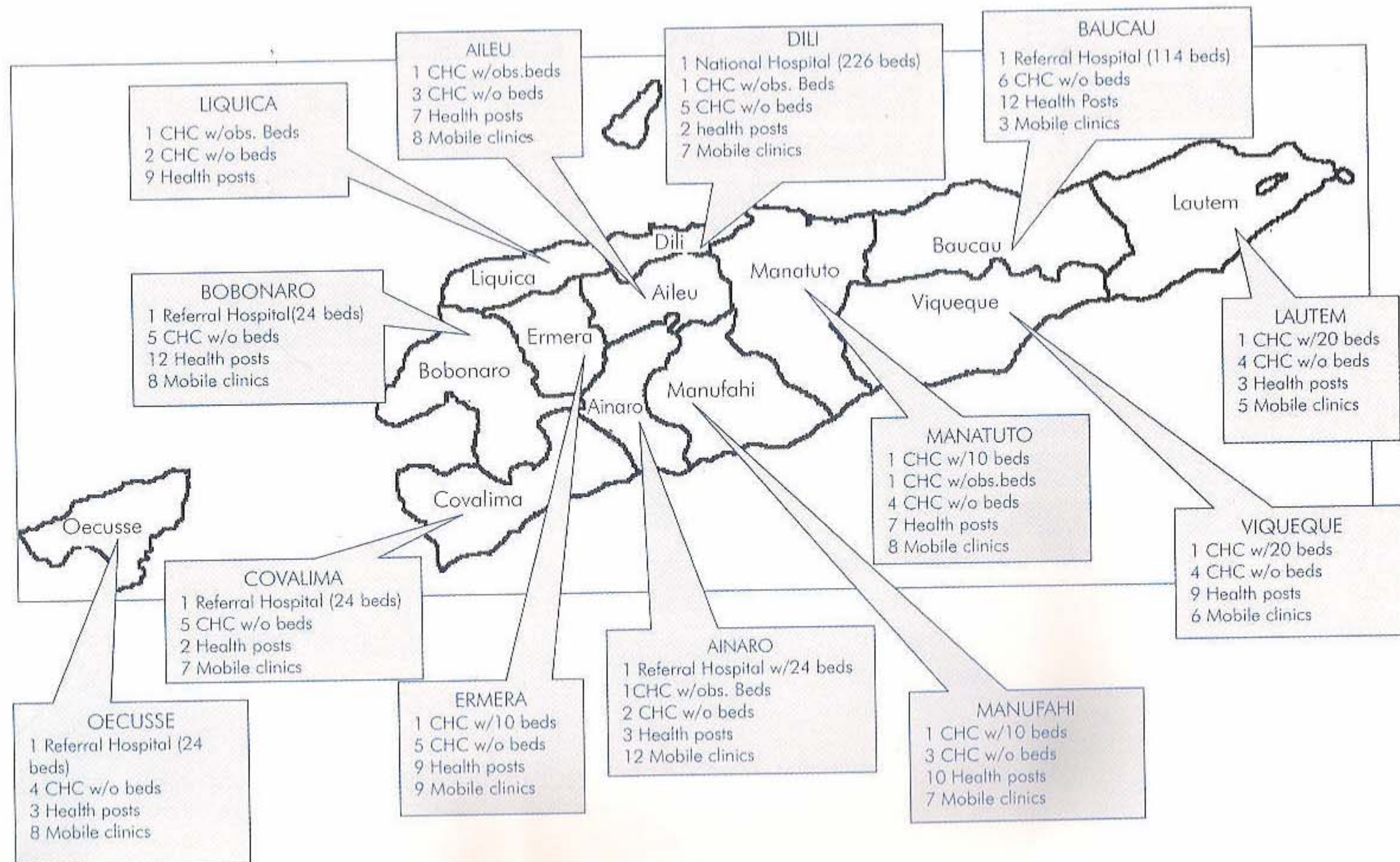
Annex 1

ORGANISATIONAL CHART OF MINISTRY OF HEALTH



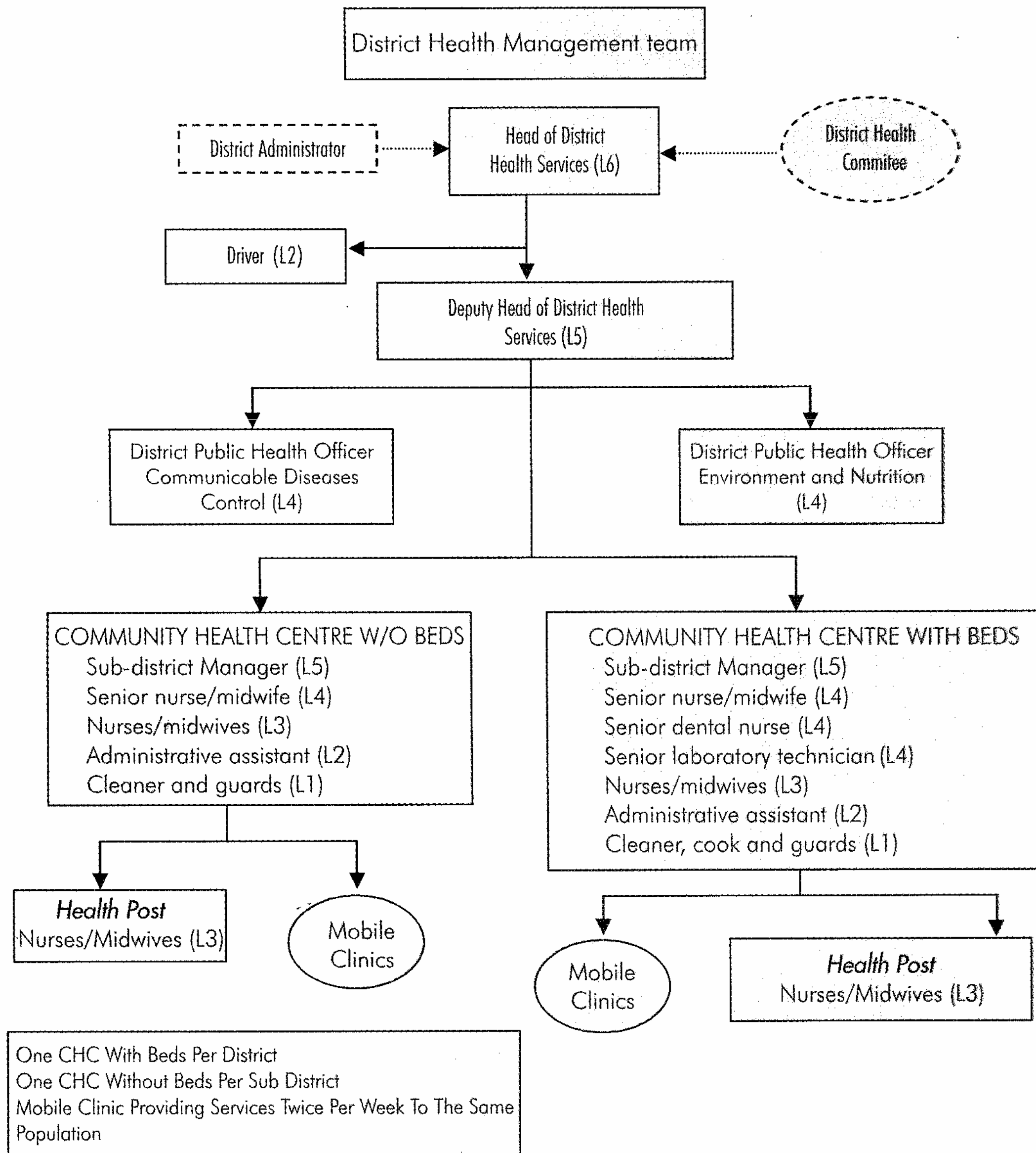
Annex 2

DISTRIBUTION OF HEALTH FACILITIES IN TIMOR-LESTE



Annex 3

ORGANISATIONAL CHART FOR DISTRICT HEALTH SERVICES



- http://www.searo.who.int/EN/Section1243/Section1255.htm (health System)

6. HEALTH SERVICES

6.1 Maternal and child health/family planning/adolescent health

Timor Leste 2006 Health Statistics Report indicated that skilled health personnel attend only 27.2 % of the total child births. A national family planning policy and programme is just beginning to get underway. The contraceptive prevalence rate is very low, which is less than 10%.

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- http://www.searo.who.int/EN/Section13/Section1245.htm (Adolescent Health)
- http://www.searo.who.int/EN/Section13/Section37.htm (Child Health) http://www.who.int/child-adolescent-health/OVERVIEW/AHD/adh_over.htm
- http://www.searo.who.int/EN/Section13/Section390.htm (Gender, Women and Health) http://www.who.int/fch/en/ (maternal Health)
- http://www.searo.who.int/EN/Section13/Section36.asp (Reproductive Health) http://www.who.int/reproductive-health/index.htm
- http://www.searo.who.int/EN/Section13/Section36/Section129/Section396.htm (making Preg. safer) http://www.who.int/making_pregnancy_safer/en/

6.2 Immunization

In Timor-Leste, routine childhood immunization was recommended in early March 2000. To prevent an expected outbreak of measles, more than 45,000 children were immunized during a special campaign. National Immunization Days (NIDs) for Polio eradication in the entire territory were observed in November and December 2000 with a total coverage of over 84 percent.

At the same time, the EPI coverage was noted to be low. At least 50 percent of the children of 5 years or younger have not received basic immunization. Study indicates that vaccination for population of 5 years old or more during 2001 was as follows:

- BCG coverage: 73.6 %
- Polio 3 coverage: 62 %
- DPT 3 coverage: 63.2 %
- Measles coverage: 60.5 %

(Timor Leste 2006 Health Statistics Report)

The next NIDs were supposed to be held in September and October 2002, in which approximately 130,500 children were expected to be vaccinated in each of these two rounds (as per Democratic Timor-Leste Health Profile, August 2002).

One of the main constraints faced by the country in terms of the efforts to expand immunization is the poor level of knowledge on health matters in the general population. Another related problem is limited capacity of laboratories. The Central Laboratory of Dili does not cover all the branches of medicine and has been conducting a limited range of tests. There is a basic network of health laboratories at district and periphery levels with only malaria and tuberculosis microscopy carried out in most districts (as per WHO, Biennial Report, January 2000-December 2001).

- http://www.searo.who.int/EN/Section1226.asp (Immunization)

- http://www.who.int/immunization_monitoring/routine/immunization_coverage/en/index4.html (HQ)

6.3 Prevention and control of locally endemic diseases

In Timor-Leste, HIV/AIDS has become the most devastating disease. Sexually transmitted infections (STI) are common in sexually active age groups. Around 35 STI cases per week were reported mostly in Dili and Baucau districts. Indeed the danger may be even greater in Timor-Leste, since the risk of HIV/AIDS is particularly high in countries that have been affected by conflicts, population displacement, and widespread destruction. Other factors which contribute to epidemic development include low level of HIV/AIDS/STI awareness and poverty (as per National Development Plan, May 2002).

Tuberculosis (TB) is a major public health problem in Timor-Leste with an estimated 8,000 active TB cases nationally, which is over 2.5 percent of the total population (as per Timor-Leste Health Policy Framework, June 2002).

Timor-Leste is endemic for leprosy. The results from a recent survey conducted by the International Leprosy Mission in Oecussi district demonstrated an astonishingly high prevalence i.e., around 115 cases per 10,000 amongst those examined, which is a very high prevalence rate of leprosy as compared to any other country or territory. Currently, there is no leprosy control programme in the country (as per Timor-Leste Health Policy Framework, June 2002).

Malaria is highly endemic in all districts of Timor-Leste, with the highest morbidity and mortality rates reported in children. Due to the breakdown of surveillance, vector control activities, and treatment facilities, malaria had shown a three-fold increase in Timor-Leste following the crisis in 1999. Four epidemiological types of malaria have been identified, which include forest malaria, rice field malaria, coastal malaria, and swamp malaria. The peak transmission periods are July/ August and December/January. (as per Timor-Leste Health Policy Framework, June 2002)

Timor-Leste is also highly endemic for lymphatic filariasis. There are three existing species: *Brugia timori*, *Brugia malayi* and *Wuchereia bancrofti* and patients with clinical manifestation of chronic lymphatic obstruction have been well documented (as per Timor-Leste Health Policy Framework, June 2002).

- http://www.searo.who.int/EN/Section10.htm (CDS) http://www.who.int/infectious-disease-news/
- http://www.searo.who.int/EN/Section10/Section18.htm (HIV)
- http://www.searo.who.int/EN/Section10/Section21.htm (Malaria)
- http://www.searo.who.int/EN/Section10/Section2097.htm (TB) http://www.who.int/tb/en/
- http://www.searo.who.int/EN/Section10/Section20.htm (Leprosy)
- http://www.searo.who.int/EN/Section10/Section2096.htm (LF)

7. TRENDS IN HEALTH STATUS

1. http://www.who.int/healthinfo/bod/en/index.html (Burden of Disease)

7.1 Life expectancy

In Timor-Leste, life expectancy at birth during 2006 was 59.5 years with 58.6 years for male and 60.5 years for female (Timor Leste 2006 Health Statistics Report)

- http://www.who.int/healthinfo/bod/en/index.html (Life Expectancy)
- http://www3.who.int/whosis/hale/hale.cfm?path=whosis,burden_statistics,hale&language=english

7.2 Mortality

Infant Mortality Rate

The infant mortality rate (IMR) was 88 per 1,000 live births in 2006. The most common causes of infant mortality are: infectious disease, low utilization of skilled assistance for antenatal and poor reproductive health (Timor Leste 2006 Health Statistics Report).

Under-5 mortality

Under Five Mortality Rate (U5MR) was reported as 130 per 1,000 live births during 2004 in Timor-Leste.

Maternal Mortality ratio

The maternal mortality rate (MMR) has been estimated to be as high as 660 per 100,000 live births considered to be one of the greatest problems in the country. Poor reproductive health is a major cause of maternal mortality with an increasing incidence of teenage pregnancies. (Timor Leste 2006 Health Statistics Report)
http://www.who.int/whosis/mort/profiles/mort_searo_tls_timorleste.pdf

8. OUTLOOK FOR THE FUTURE

8.1 Future vision

The Ministry of Health in Timor-Leste is aiming to ensure provision of health services to all its people, regulate the health sector, and promote the participation of stakeholders from health and other sectors. The Ministry of Health is committed to use the available resources in the most cost-effective way.

8.2 Proposed strategies

As stated in the National Development Plan, Timor-Leste has one of the lowest literacy rates in the world. Health priorities are among the most crucial in the Development Plan. Development strategies have been devised to emphasize the importance of providing adequate access to primary health care and focus on prevention and clinical support in underserved areas. It is proposed to develop a system of primary health care, easily accessible to individuals and families in the community through household participation, and at a cost that the community and country can afford to maintain at each stage of its development. Women's rights to health would be ensured, which is particularly focused on improving the reproductive health and on prevention of health hazards.

Specific high burden diseases like malaria, tuberculosis, diarrhoeal disease, respiratory infections, leprosy or mental health, and reproductive health, including high maternal mortality, will need special attention. Diseases with a high risk such as HIV/AIDS also have a high priority in the agenda of the Ministry of Health.

8.3 Basic Health Indicators including the U.N. Millennium Development Goals

- http://www.undg.org/documents/5382-Timor-Leste_MDG_Report_2004_-_Timor-Leste_MDG_Report.pdf (MDGs)

See Annex -4

Timor-Leste

Annex-4

Country reported Data for Basic Health Indicators including health related MDG Indicators

Indicator	Latest available data	Year	Source	Remarks
POPULATION AND VITAL STATISTICS				
Total population (in thousands)	1,015	2004	9	
Population density (persons per sq km)[a]	69	2004	1	
Sex ratio (males per 100 females)	97	2004	9	
Population under 15 years (%)	45	2004	9	
Population 60 years and above (%)	5	2004	9	
Crude birth rate (per 1000 population)	42.3	2006	8	
Crude death rate (per 1000 population)	10.6	2006	8	
Natural (population) growth rate (%)	3.18	2006	8	
Total fertility rate (per woman)	6.7	2006	8	
Urban population (%)	15	2002	1	
SOCIOECONOMIC SITUATION				
Gross national product per capita (US$)	478	2002	1	
Adult literacy rate (%)	58.6[b]	2002	3	
Prevalence of low birth weight (weight <2500 grams at birth) (%)	10	1998-2003[c]	4	
Prevalence of underweight (weight-for-age) in children <5 years of age (%)[d]	45	2002	1	

HEALTH SYSTEM				
INPUTS				
Facilities				
Indicator	Latest available data	Year	Source	Remarks
Number of health centres	4	2002	1	

[a] Computed value based on reported land surface area of 14, 610 sq. km.
[b] Data are from national sources
[c] data refer to the most recent years available during the period specified
[d] Study based on four districts.

Human resources				
Physicians per 10,000 population	2.5	2005	9	
Nurses per 10,000 population: Professional nurses	7	2002	1	Computed value
Budgetary resources				
Total Expenditure on Health (THE) as % of Gross Domestic Product (GDP)	9.6	2003	10	
Public Expenditure on Health (PHE) as % of Total Expenditure on Health (THE)	76	2003	10	
Private Expenditure on Health (PvtHE) as % of Total Expenditure on Health (THE)	24	2003	10	
Indicator	Latest available data	Year	Source	Remarks
FUNCTIONS				
Pregnant women attended by trained personnel during pregnancy (%)	36.1	2006	8	
Deliveries attended by trained personnel (%)	27.2	2006	8	
Contraceptive Prevalence (%)	9.7	2006	9	
Coverage of diphtheria, tetanus, and whooping cough among children <1 year (%)	63.2	2006	8	
Coverage of poliomyelitis among children < 1 year (%)	62	2006	8	
Coverage of measles among children < 1 year (%)	60.5	2006	8	
Coverage of tuberculosis among children < 1 year (%)	73.6	2006	8	
Women that have been immunized with tetanus toxoid (TT) during pregnancy (%)	52.5	2006	8	
Environment				
Population with safe drinking water available in the home or with reasonable access (%)	56	2001	5	
Population with adequate excreta (sanitation) disposal facilities available (%)	19	2001	5	

OUTCOMES				
Life expectancy at birth (years):	59.5	2006	8	
Indicator	**Latest availabl e data**	**Year**	**Source**	**Remarks**
Infant mortality rate (per 1000 live births)	88	2006	8	
Under-five mortality rate (per 1000 live births)	130	2004	8	
Maternal mortality ratio (per 100,000 live births)	660	2000	8	
Out-of-Pocket Spending on Health (OOPS) as % of Private Expenditure on Health (PvtHE)	26	2003	10	
GENDER EQUITY				
Life expectancy at birth ratio (females as a % of males)	104	2003	11	computed
Seats held in parliament (% of women)	26.1	2004	3	
Female share in employment (non-agricultural sector) %	35	2001	5	
Primary school enrolment ratio (females as a % of males)	91	2001	5	

Indicator	Latest available data	Year	Source	Remarks
MDG HEALTH RELATED INDICATORS				
G1.T2.I4 - Prevalence of underweight children (under-five years of age)	45	2001	5	
G1.T2.I5 - Proportion (%) of population below minimum level of dietary energy consumption	N.A.			
G4.T5.I13 - Under-five mortality rate (probability of dying between birth and age 5)	130	2004	8	
G4.T5.I14 - Infant mortality rate	88	2006	8	
G4.T5.I15 - Proportion (%) of 1 year-old children immunized for measles	60.5	2006	8	
G5.T6.I16 - Maternal mortality ratio	660	2000	8	
G5.T6.I17 - Proportion (%) of births attended by skilled health personnel	27.2	2006	8	
G6.T7.I18 - HIV prevalence among young people	10-350		8	
G6.T7.I19 - Condom use in high risk population	N.A.			
G6.T7.I20 - Ratio OF children orphaned / non-orphaned in schools	N.A.			
G6.T8.I21a - Malaria death rate per 100,000 in children (0-4 years of age)	N.A.			
G6.T8.I21b-Malaria death rate per 100,000 (all ages)	N.A.			
G6.T8.I21c - Malaria prevalence rate per 100,000	9	2001	5	
G6.T8.I22a - Proportion (%) of population under age 5 in malaria risk areas using insecticide-treated bed nets	N.A.			
G6.T8.I22b - Proportion (%) of population under age 5 with fever being treated with anti-malarial drugs	N.A.			
G6.T8.I23a - Tuberculosis death rate per 100,000	N.A.			

Indicator	Latest available data	Year	Source	Remarks
G6.T8.I23b - Tuberculosis prevalence rate per 100,000	N.A.			
G6.T8.I24a - Proportion (%) of Smear-Positive Pulmonary Tuberculosis cases detected and put under directly observed treatment short course (DOTS)	N.A.			
G6.T8.I24b - Proportion (%) of Smear-Positive Pulmonary Tuberculosis cases detected and cured under directly observed treatment short course (DOTS)	80	2001	5	
G7.T9.I29 - Proportion (%) of population using biomass fuels)	N.A.			
G7.T10.I30a - Proportion (%) of population with sustainable access to an improved water source, rural	51	2001	5	
G7.T10.I30b - Proportion (%) of population with sustainable access to an improved water source, urban	72	2001	5	
G7.T11.I31 - Proportion (%) of urban population with access to improved sanitation	44	2001	5	
G8.T17.I46 - Proportion (%) of population with access to affordable essential drugs on a sustainable basis				

Sources:

1. Timor-Leste Ministry of Health, *Health Profile*, Dili, 26 August 2002
2. The World Health Organization, *The World Health Report 2005*
3. UNDP, *The Human Development Report 2004*
4. UNICEF, *The State of the World Children, 2005*
5. Timor-Leste, Millennium Development Goals Report (Final Draft), August 2003
6. The World Health Organisation, CORE Indicators 2005
7. Census Timor-Leste 2004, http://dne.mopf.gov.tp
8. Timor Lest 2006 Health Statistics Report
9. 11 questions of 11 SEAR countries 2007. WHO- Regional Office for South-East Asia, India
10. World Health Report 2006. WHO, Geneva
11. Human Development Report 2006, UNDP

Millennium Development Goals (MDGs)

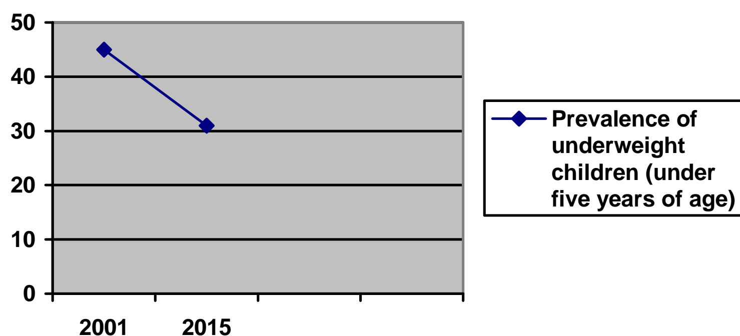
Timor-Leste had organized a two-day workshop on the Millennium Development Goals in March 2003 with the objective to raise awareness and increase understanding of the MDGs and help to take stock of the present situation. The government of Timor-Leste had prepared a National MDG report as follow-up action of the workshop covering all eight goals of MDG. At this juncture, the progress made towards achievement of health related MDGs, is given here:

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Target : 2	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	
Indicators	2001	2015 MDG Target
Prevalence of Underweight children (under 5 years) (%)	45	31

Status and Trends

Results from the Household Survey show that about four-in-five households indicated that they do not have enough food for at least two months in a year (December-January) and two-in-three do not have enough food for at least four months (November-February) indicating significant seasonal food insecurity. Domestic production of rice and maize was adequate to feed only about 79% of the people. The country depends on imports including food aid for the rest of the population. About 45% of the children below 5 were underweight, which is an indicator of hunger. Improving food security is an immediate priority of the government.



Challenges and Constraints

Subjective assessments of food adequacy suggest that food insecurity is widespread. Close to eight in every ten persons experience inadequate food provision at some point during the year. Food security is closely related to not having enough rice and maize. Food availability is based on the harvest cycle at the national and regional levels. Food shortages are the highest during the months from

November to February, at the end of the rice harvest, and before the maize harvest. This needs policy and programme responses to deal with group-specific and seasonal vulnerability.

Enabling National Strategies and Policies

The government strategy is to increase food production to enhance self-reliance in the medium-term. Substantial investments are allocated for rehabilitation and construction of small and medium size irrigation schemes to support increased production. Also, efforts are under way to establish and expand agricultural research and extension services.

Role of Development Partners

The international community has provided substantial food aid in the last quarter of 1999 and 2000 as part of the relief measures. Subsequently, food aid has been declining. There is need to augment the domestic supplies with imports and food aid. Also, support to increased production of food, particularly rice and maize, in the short and medium terms is critical for enhancing food security. Improvements in marketing infrastructure and processing are essential to bring domestic production to the market at competitive prices. Creation of jobs and sustainable livelihoods are important for the purchase of food available, by those that either do not produce food or produce inadequate amounts. Continued support from development partners in these areas is necessary.

Development Prospects for 2015

Timor-Leste has adequate land, water and other resources, and appropriate agro-climatic conditions to produce adequate food to meet the requirements of the growing population at competitive prices. The major constraints so far have been, the lack of adequate infrastructure including marketing and support services. The agricultural sector strategy aims to achieve food security and improve self-sufficiency, diversify agricultural production, improve export earnings, increase rural incomes, and create additional jobs in rural areas. However, it remains constrained by a lack of enabling policies, incomplete information on existing resources, inadequate quality control, and lack of or limited financial services including credit in the rural areas. The Ministry of Agriculture, Fisheries, and Forestry plans to develop strategies and programs/projects to address these issues. The overall prospects are good for the country to achieve self-reliance in food and ensure food security for its population.

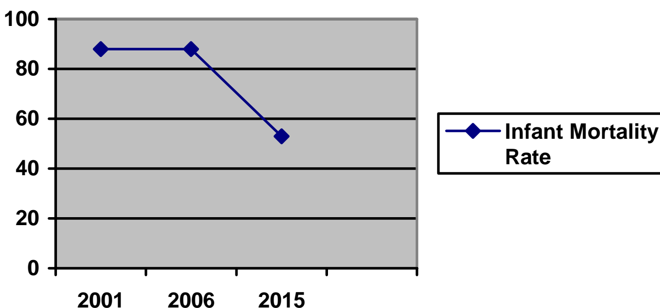
GOAL 4: REDUCE CHILD MORTALITY

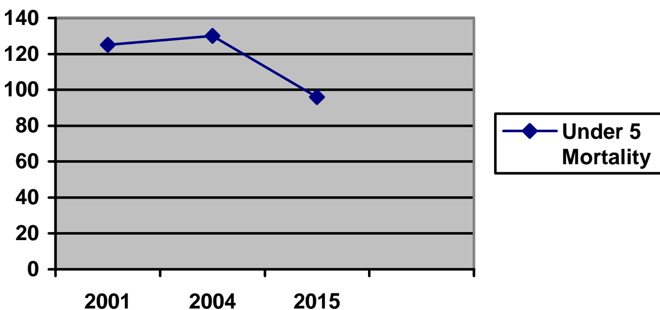
Target : 5 Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate		
Indicators	**2001**	**2015 MDG Target**
Under-five mortality rate	125	96
Infant mortality rate	88	53
Proportion of 1 year old children immunized against measles (%)	47	100

Status and Trends

The 2002 Multiple Indicator Cluster Survey (MICS) conducted in August 2002 showed an infant mortality rate (IMR) of 88 per 1,000 live births and an under-five mortality rate of 125 per 1,000 live births. There are significant regional differences in these rates. The under-five mortality rate in the highland areas of the country was 153 per 1,000 live births, while that in the two major urban areas of Dili and Baucau was 72 per 1,000 live births, or less than half of that in the highland areas. The Ministry of Health data for 2002 show that 56% of the children were covered by DPT-3 immunizations and 47% received measles vaccinations. There is some concern about the reliability of the data as the base fertility rate used may be too low.

The current status and MDG target for 2015 for IMR and under 5 mortality are shown in the following graph:





Challenges and Constraints

Malnutrition remains a serious problem throughout the country with 43% of the children in the under-five years of age found to be moderately malnourished and 13% severely malnourished. Only about half of all households have access to safe drinking water, varying from a maximum of 85% in the two major urban centres to 24% in some areas in the east of the country. Information from the Ministry of Health indicates that vaccination activities at the local health facilities are undertaken only on a weekly or monthly basis. It is desirable to provide these services routinely for children who visit the facility. The service delivery capacity of the Ministry of Health is limited by factors such as: human resources and technical skills constraints, availability of adequate basic equipment, and drugs in health facilities. Alongside the Government, private practitioners, churches, and other non-governmental organisations also provide health services.

Role of Development Partners

The Ministry of Health is supported by a number of donors including TFET, Australia, Japan, Portugal, USAID, UNFPA, UNICEF, WHO and ECHO (an NGO), to implement the various programs. They cover, among others, Integrated Management of Childhood Illness (IMCI), including training of health staff in the development of community IMCI initiatives, and training on the management of moderate and severe malnutrition.

Enabling National Strategies and Policies

The Ministry of health has drafted a National Policy on Immunization, which is being finalized. It aims to improve health promotion and education regarding the benefits of immunization among the people, and improve immunization coverage in all districts. A national policy on community nutrition has been discussed with the stakeholders and is being drafted. The relevant national targets include: health promotion and education of pregnant women and family members; promotion of exclusive breastfeeding of infants for the first six months, and introduction of safe and nutritionally adequate complementary foods thereafter, with breastfeeding continued up to the second birthday or beyond; improving the nutritional status of pregnant women; improving ante-natal, delivery, and newborn care by training medical staff and establishing adequate facilities and promote appropriate family planning methods.

The aim is also to develop a national child health policy, train health providers in IMCI and implement them in all districts, introduce and implement integrated child development programme, develop and implement community nutrition activities, and strengthen routine growth monitoring of children up to the age of 5 years.

Development Prospects for 2015

Given the short time span available to Timor-Leste, the tentative national targets are to reduce infant mortality by 20% by 2005, 30% by 2010 and 40% from the baseline by 2015. In the case of immunizations the national goal is to achieve 80% coverage by 2005 and achieve and maintain 90% coverage by 2015. The national targets for achieving the MDG target of reducing childhood mortality should be realizable if the collaborative efforts are continued and reinforced for effective immunization against the childhood diseases, wider implementation of community-based health and nutrition activities, and effective implementation of IMCI as a whole.

GOAL 5: IMPROVE MATERNAL HEALTH

Target : 6 Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio		
Indicators	**2001**	**MDG Target 2015**
Maternal mortality ratio per	420-800	252

100,000 live births		
Proportion of births attended by skilled health personnel	24%-38%	60%

Status and Trends

The WHO has estimated the maternal mortality ratio to be as high as 800 per 100,000 live births. Other estimates, as in UNDP's *Human Development Report*, based on the Indonesian data, show a lower figure of 420 per 100,000 live births. The maternal mortality ratio is notoriously difficult to calculate, especially in a small country like Timor-Leste, where even a small variation in the number of deaths reported can skew the figures significantly. The Demographic and Health Survey (2003) has included questions on the observed number of maternal deaths during the past 12 months, which may provide indicative figures for the country as a whole. A nationwide monitoring of maternal mortality on a continuing basis is needed. The MICS survey indicated that skilled health personnel attend only 24% of births, whereas the Ministry of Health service data for 2002 show that about 35% of the expected number of deliveries during the year were attended by skilled personnel.

Challenges and Constraints

The provision of outreach health services to the dispersed members of the population has been a major challenge. It is made worse by the further dispersal of the population in rural areas as the people return to their ancestral lands. It is difficult to attract midwives to work in remote locations, with little or no communication facilities. Also, the country is dependent on expatriate obstetricians/gynaecologists to provide emergency obstetric care, which may not be sustainable. It will be several years before there is an adequate availability of Timorese specialists in these areas. Shortages of basic drugs and adequate equipment are common in health facilities to handle the antenatal, delivery, and postnatal complications. A national family planning policy and programme is just beginning to get underway. The contraceptive prevalence rate is very low. Less than 7% of women aged 15-49, married or in union, are using modern contraceptive methods.

Enabling National Strategies and Policies

The National Development Plan (NDP) objectives in the health sector include: (i) reduce levels of maternal and infant mortality, (ii) improve the nutritional status of mothers and children, (iii) improve reproductive health in Timor-Leste, and (iv) increase women's access both to health information and quality health services. The country is developing a National Safe Motherhood Strategy that includes health promotion. The Ministry of Health is trying its best to provide emergency obstetric care by deploying midwives in peripheral health facilities and is working with other partners to increase the proportion of births attended by trained personnel, through various training courses and other interventions. The Ministry is beginning to implement a national family planning programme. Work is being carried out to improve health facilities at all levels throughout the country.

Role of Development Partners

The UNICEF, WHO, and UNFPA agreed on a joint action programme on reproductive health in 2000. The three agencies have cooperated in providing delivery training to midwives including safe motherhood approach, clean and safe delivery, and management of Sexually Transmitted Infections (STIs). The UNFPA has provided funding for obstetricians/gynaecologists through the UNV programme in order to make emergency obstetrical care available at the main hospitals. The WHO is helping the Ministry of Health to formulate a national reproductive health strategy, which will include a family planning component.

Development Prospects for 2015

Given the short time period available to Timor-Leste, the tentative goal is to reduce maternal mortality by 15% by the year 2005, 40% by 2010 and by more than 50% from the baseline by 2015. The national goal is to increase the proportion of births attended by skilled health personnel by 20% by 2005, 40% by 2010 and 50% from the baseline by 2015.

The prospects for achieving the goals for 2015 are bright in the sense that the ongoing provision of emergency obstetric care in peripheral health facilities will make a major dent in the soaring number of maternal deaths. However, such emergency care has to be put on a more sustainable basis. Efforts to increase the percentage of births attended by trained professionals are being made by the Ministry of Health and development partners. Although, it requires some time to institutionalize, the national goals in this regard are however achievable. A major increase in the contraceptive prevalence rate will require long-term efforts.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Target 7: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS		
Indicators	2001	2015
HIV prevalence among 15-24 year old pregnant women	Data not available	
Contraceptive prevalence rate	<7%	
Number of children orphaned by HIV/AIDS		

Status and Trends

The prevalence of HIV is likely to be between 0.01% and 0.35% of the population, while condom use is less than 0.1%.

Challenges and Constraints

The awareness on HIV/AIDS remains low. According to Multiple Indicator Cluster Survey (MICS) (2002), only 16% of respondents (women aged 15-49) had ever heard of HIV/AIDS.

Enabling National Strategies and Policies

The NDP objectives in the health sector include: reduction in the incidence of illness and death due to preventable communicable and non-communicable diseases, including HIV/AIDS. The strategies in this area include: (i) health promotion and education of population on HIV prevention, (ii) provision of safe blood and blood products, and (iii) training of medical personnel on syndromic management of sexually transmitted infections (STIs).

Role of Development Partners

WHO has developed and conducted training on the syndromic approach for management of sexually transmitted infections for health workers in the Ministry of Health and non-government health providers, particularly Café Timor. The WHO has also assisted the Ministry of Health in development of work plans to implement the National HIV/AIDS strategy developed by the health ministry. Family Health International is a major partner in the implementation of these activities.

Development Prospects for 2015

The national goal is to curtail HIV/AIDS prevalence rate and reduce it. This can be realized if further research on possible entry points is carried out and specific interventions are directed to target populations.

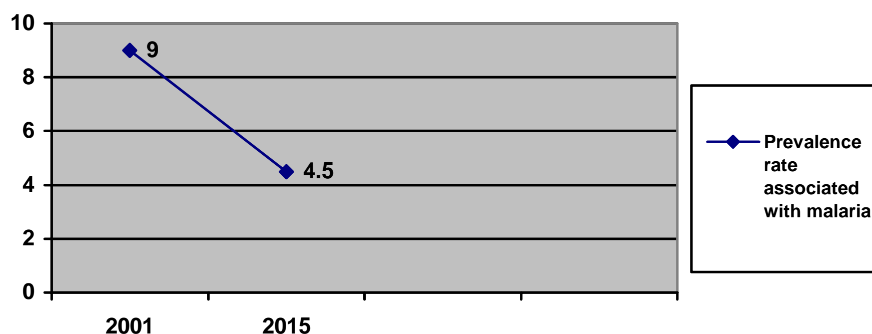
Target 8: Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases

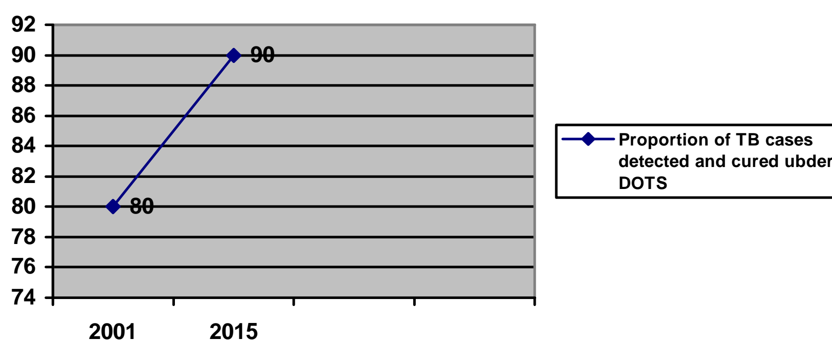
Indicators	2001	2015
Prevalence and death rates associated with malaria : Prevalence	9%	4.5%
Proportion of population in malaria risk areas using effective malaria prevention and treatment measures	20%	60%
Prevalence and death rates associated with tuberculosis	-	-
Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)	80%	90%

Status and Trends

There are approximately 70,000 cases of malaria in a year and 200 deaths, and 8,000 active cases of tuberculosis. Approximately 20% of the population is taking effective malaria prevention and treatment measures and 80% of detected cases of tuberculosis are cured under DOTS.

The current status and MDG target for 2015 for prevalence of malaria and Proportion of TB cases detected and cured under DOTS, are shown in the graph here under:





Challenges and Constraints

The achievement of the MDGs in the area of communicable diseases will require further strengthening of the public health system, which is in the early stages of development. In recent months, the Ministry of Health has produced several policy documents, including a definition of the Basic Package of Services, which should allow for more effective interventions. The lack of human resources in the public health system and their limited technical capacity is a major constraint. The interventions in all areas of public health need to focus on upgrading human resources. Health promotion activities are limited at present and will play a crucial role in achieving the communicable diseases' targets.

Enabling National Strategies and Policies

The Ministry of Health developed a National Health Promotion strategy with the assistance of WHO and involvement of other partners and stakeholders, through a series of workshops at the sub-district, district, and national levels. The strategy outlines the ways to implement health promotion not only for communicable diseases but also for other health issues in general.

Role of Development Partners

The WHO together with some International Non-Governmental Organisations (INGOs) such as: Christian Children's Fund, Health Net International, and World Vision as well as local NGOs, assisted in the development of a proposal for combating Malaria, for funding by the Global Fund. The technical proposal was approved in May 2003 and preparations and assessments are being conducted

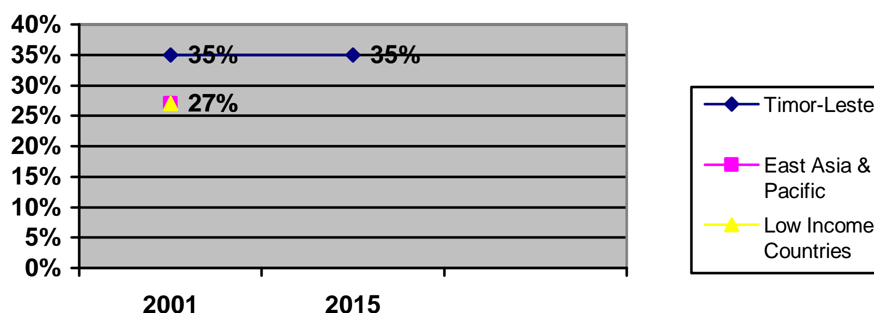
by the Global Fund to facilitate the signing of the grant. The WHO also supported the development of another proposal on TB, for submission to the Global Fund. The WHO has provided technical assistance on the control of communicable diseases and in early 2000, developed a system for a nationwide weekly *epidemiological bulletin*. It has conducted several investigations on outbreaks and prevalence of various communicable diseases. It cooperated with NGOs in a national Roll Back Malaria Programme in 2000-2001, which included the distribution of insecticide-treated mosquito nets. A National Tuberculosis Programme is being implemented by Caritas (an NGO).

Development Prospects for 2015

The national goals are: to reduce morbidity and mortality of malaria by 50% by 2015; to have 60% of the population take effective malaria prevention and treatment measures; to reduce the mortality of tuberculosis cases by 90%, and to have 90% of the detected cases of TB treated under DOTS. The tuberculosis programme has been quite successful in implementing the DOTS treatment, and its continuation should mean that the targets set for the year 2015 would be reached. Malaria prevention and control is dependent upon energetic environmental actions and effective mosquito bed-net promotion and distribution (as per Timor-Leste Millennium Development Goals Report - Final Draft, August 2003).

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources			
Indicators	Timor-Leste		Global Target
	2001	2015*	
Proportion of land area covered by forest	35%	35%	
Land area protected to maintain biological diversity			
GDP per unit of energy use (as proxy for energy efficiency)			
Carbon dioxide emissions (per capita) plus two figures of global atmospheric pollution: ozone depletion and the accumulation of global warming gases			



The benchmark is preliminary and the target is pro-rata and indicative. It will be revised based on an in depth analysis during FY2003-04.

Status and Trends

Timor-Leste is blessed with a benign environment and a varied topography with rich resources on both the land and the sea. There are many microclimates that have varied flora and fauna and are suitable for growing a wide range of tropical and subtropical crops, herbs, and trees. More than a third of the land is covered with forests.

Yet, the forest cover is being rapidly depleted. It was estimated to be 51% in 1972, which declined to 35% by 1999. About 16% of the surface area was covered by dense forest and the remaining 19% by sparse forest. The demand for fuel wood is about 1.6 million cubic meters per annum i.e., equivalent to about 595,000 ha of forest and it is growing. Also, conversion of forest land into agriculture land is newly emerging problem. Data on other dimensions/indicators are not available. It is necessary to compile information on the key environmental indicators covering both land and marine resources to promote sustainable development.

Challenges and Constraints

Conversion of forest and other marginal lands to agriculture and deforestation to meet the growing fuel wood demand are some of the major challenges facing the country. Similarly, the challenges in the marine environment comprise: the delineation of marine boundaries between Timor-Leste, Australia and Indonesia; stocktaking of marine resources; and sustainable management of these resources including protection of vital ecosystems.

Other challenges in the environment sector include: policy formulation, putting in place environmental impact assessment requirements and enforcing these and the overall sustainable management of natural resources. Also, subscribing to the global conventions and agreements on environment and biodiversity is necessary.

Enabling National Strategies and Policies

The problem of growing fuel wood demand for the use of households and small industries is to be addressed through substitution of fossil fuels especially in urban areas. Other aspects would be addressed through setting aside protected areas and national parks, preserving and managing marine ecosystems, conserving and managing biodiversity, managing watersheds, and promoting sustainable development.

In the field of marine environment -- compilation of information (database) on the resource bases, strengthening capacities and putting in place affordable mechanisms to monitor exploitation and use of resources by the Timorese and foreigners, and policies to protect, regulate and promote sustainable use of resources are contemplated. The Government also plans to formulate a National Environmental Action Plan covering the management of both the land-based and marine

resources. It will introduce and implement environmental guidelines, require environmental impact assessment for major projects, and prepare environmental legislation.

Role of Development Partners

Donor involvement in the sector has been limited except with Norway through UNDP/UNOPS, and UNESCAP having implemented some activities. The UNDP has formulated a substantial program to assist the government -- in developing environmental governance capacity, sustainable management of natural resources and biodiversity, rural energy development, and efficient utilisation of household fuels. Further, the water resources and energy aspects are being examined under two sector studies supported by the Asian Development Bank (ADB) and Norway. Australia and many other private companies have been involved in the exploitation of offshore oil and gas resources. Also, Australia is expected to assist the Government in fisheries and marine resources management.

Development Prospects for 2015

There is much to be done in terms of reforestation, the declaration and management of protected areas, and watershed protection. Reforestation is both long-term and expensive with domestic funding unlikely to be able to make a significant contribution to needed efforts. Soil erosion is a significant problem, especially on hill slopes.

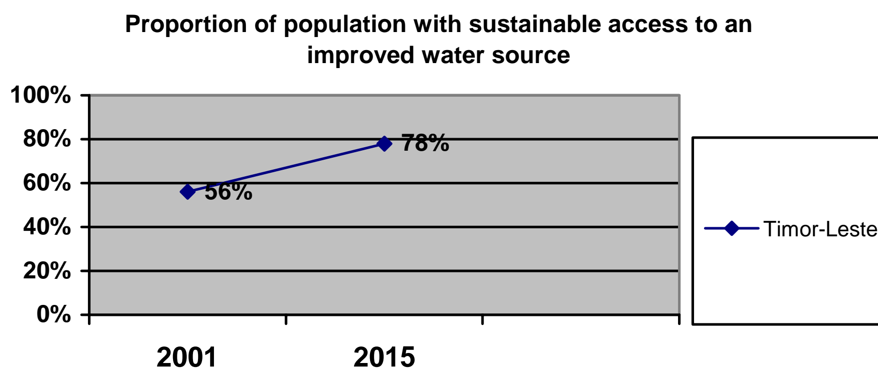
A beginning is to be made soon-- to survey and take stock of the marine resources, classify protected areas and species, determine allowable levels of exploitation of resources in unprotected areas-- within the framework of a national marine and fisheries management policy and strategy.

A study on the energy sector covering various alternative energy sources is under way. With technical assistance from development partners, the government intends to address these issues in the medium-term. The overall prospects seem good for the country to protect, utilise and sustain natural resources.

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water				
Indicators	Timor-Leste			Global Target
	2001	2015*	2020	
Proportion of population with sustainable access to an improved water source Total	56%	78%	85%	Halve proportion with access from 1990 level
Urban	72%	86%	100%	
Rural	51%	75%	80%	

*The benchmarks (baseline data) are preliminary and the targets are pro-rata and indicative. They will be revised based on an in-depth analysis during FY 2003-04.



Status and Trends

Data from the 2002 MICS survey show that the overall access to safe water in Timor-Leste is estimated at 56%, with 72% in urban areas and 51% in the rural areas. Access to piped water remains low with only about 13% of families having house connections and 16% served by community taps.

Morbidity and mortality related to water borne, hygiene, and sanitation related diseases in Timor-Leste are estimated to be very high. The 2001 draft report of the Vector Borne Disease Control Working Group of the Ministry of Health reported combined mortality data for watery diarrhoea, dysentery, and lower respiratory infections as 30% of the total. Rural communities rely mostly on springs and dug-wells for their water needs. In some peri-urban areas, shallow wells equipped with hand pumps are used. Rainwater harvesting is being considered as a viable alternative for isolated communities.

Challenges and Constraints

During the final years under the Indonesian system, fewer than half the Timorese population had access to clean water. The post-referendum violence and destruction in 1999, left most of the existing water facilities throughout the country badly damaged, if not destroyed.

As with most sectors, the Water and Sanitation Sector is facing shortages of human resources in the areas of resource management, sanitation engineering, quality control, plumbing technicians, cost estimation, and public information specialists. A majority of the current staff do not have sufficient skills in modern management of water and sanitation systems.

There is a pressing need for customer service centres, a warehouse, technical workshop areas, drilling and well equipment, heavy equipment, waste tanks, and procurement of sanitation material and supplies, including vehicles for waste collection and recycling. There is no capital budget for these activities and a limited fund is set aside for maintenance.

Moreover, most of the interventions have been concentrated in urban areas, with very little is trickling down to rural areas. Dispersal of the population among sparsely populated communities, especially in rural hill areas, makes it expensive to establish sustainable water supply systems and operate and maintain them.

A majority of the population has had little experience with modern water and sanitation practices and do not understand the hazards of unsafe water and sanitation practices. Addressing the health problems related to hygiene and sanitation and promotion of healthy living conditions will require a pervasive change in human behaviour. This will be an enormous challenge for the government and social leaders.

Enabling National Strategies and Policies

The primary objectives for the Water and Sanitation sub-sector in the National Development Plan include the following:

- Provide adequate, safe, and sustainable water supplies for the communities of Dili and major urban centres in districts, with the aim of full cost recovery from users of the water supply;
- Facilitate adequate, safe, and sustainable water supply and sanitation for village and rural communities through community-managed water and sanitation facilities;
- Facilitate at the national level, the safe disposal of sewage and wastewater in urban areas;
- Facilitate at the national level, the collection and safe disposal of nuisance surface waters from major urban areas;
- Facilitate at the national level, the collection and safe disposal of solid and hazardous wastes from major urban areas;
- Ensure the appropriate management of water resources for the purposes of water supply and sanitation in cooperation with other relevant ministries; and
- Inform the public of safe water and sanitation practices that systematically improve the environment and enhance human health and welfare.

Considerable efforts have gone into rehabilitating the existing water systems mainly in district towns in the last three years, whereas very little has gone to the rural areas. Notwithstanding, safe water supply even in urban areas is low in comparison with the ASEAN countries.

Integrated processes need to be established for long-term operational planning and development of water and sanitation resources. This may involve: the establishment of a suitable mechanism that can plan and implement programs for district and rural public works, specifically those for safe water; options for disposing of non-solid waste; and collection and recycling of solid waste, coordination of priorities of health authorities; and supporting programs of agricultural and community development.

Every effort will be made to ensure that adequately trained and skilled personnel will be maintained for addressing water and sanitation services programs with existing transitional donor support programs. Besides, water and sanitation will require support for inter-sectoral rural and district staff training and development and more extensive technical expertise. The technical options to resolve the identified needs will be based on simple technologies, which can be carried out by the communities themselves on a cost-sharing basis.

Public awareness will be raised by Health and Sanitation Promotion at community level through schools and other community based institutions and will include demonstration on construction/rehabilitation of simple water and sanitation facilities.

Role of Development Partners

Many development partners including the ADB (under TFET), bilateral donors, and INGOs have been involved in supporting the government and communities in rehabilitation, improvement, and construction of water supply schemes over the past three years. Further, continued assistance is necessary to extend the coverage of safe water supply.

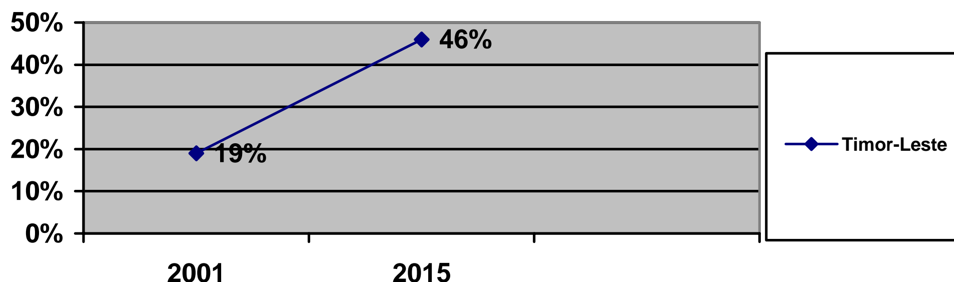
Development Prospects for 2015

Rural communities continue to rely mostly on dug-wells and springs for their water needs. Also, collection of rainwater is a viable option. Water and sanitation conditions in many primary schools are poor. A third of the primary schools require significant improvement in water and latrine facilities.

GOAL 7: Ensure Environmental Sustainability

Target 11: By 2020, achieve a significant improvement in the lives of at least 100 Million slum dwellers				
Indicators	Timor-Leste			Global Target
	2001	2015*	2020	
Proportion of population with sustainable access to improved sanitation: Total Urban Rural	19% 44% 10%	46% 63% 41%	85% 100% 80%	
Proportion of people with access to secure tenure				

*The benchmarks (baseline data) are preliminary and the targets are pro-rata and indicative. They will be revised based on an in-depth analysis during FY 2003-04.



Status and Trends

The characteristics of access to sanitation are largely similar to those on access to safe water, as illustrated above. Data from the MICS survey show the overall latrine coverage at 19%, with 44% in urban areas and 10% in rural areas.

Water and sanitation conditions in schools were poor even during the Indonesian rule. The 1999 violence and destruction left school buildings and their existing latrines and water facilities heavily damaged. With the support of the UNICEF and six INGOs, as a part of the ECHO supported project,

water and sanitation facilities in a majority of primary schools have been improved. However, about a third of the primary schools still require significant improvements in latrine and water facilities.

Challenges and Constraints

As with water, a majority of the Timorese population did not have access to latrines, and most of the existing sanitation facilities were destroyed or badly damaged during the post-referendum violence.

Enabling National Strategies and Policies

NDP vision and goals for 2020

The NDP aims to promote an orderly development of cities and towns that are pleasant (e.g., with parks and playgrounds), not crowded, affordable, and friendly environment. Community plans will be prepared through participatory rural appraisal processes with full participation of the beneficiary populations as a part of community hygiene and sanitation promotion.

Development Prospects for 2015

NDP targets are higher than the MDG targets and therefore meeting NDP targets would ensure meeting the MDG targets for Water and Sanitation. In the case of housing and urban development, the government is in the early stages of formulating polices on housing and urban development.