The First and Second Health Sector Rehabilitation and Development Projects in Timor-Leste

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1. Introduction

When troops from the International Force for East Timor (INTERFET) arrived in Timor-Leste (or, more precisely, East Timor since that was the official name of the territory at the time)\(^1\) in 1999 to restore peace and security and facilitate the establishment of a transitional UN administration, the health situation in the territory was precarious. Although the Indonesian government had funded the development of a health system during its occupation of the territory between 1975 and 1999, this system did not perform well. When the Indonesians left East Timor, the territory’s health indicators were amongst the poorest within the archipelago. The violent withdrawal of the Indonesian military from East Timor in 1999 resulted in the destruction of most of the country’s health infrastructure and supplies and the departure of most of the country’s senior health managers and doctors (Hill 2001: 1140; World Bank 2002: 56-57; Joint Assessment Mission 1999: 1; Morris 2001). When the Joint Assessment Mission, a team of specialists representing bilateral donor countries, the Asian Development Bank (ADB), the World Bank, and UN agencies, visited East Timor shortly after the 1999 violence, they concluded that the territory faced a serious risk of communicable disease outbreaks and, as a result, a considerable increase in ‘excess mortality’ (Joint Assessment Mission 1999: 1).

To address these problems, donors and the Interim Health Authority (IHA), the initial name given to the UN transitional administration authority that was responsible for health matters, agreed that two health projects should be included among the range of aid projects funded by the Trust Fund for East Timor (TFET), a multi-donor fund established to mobilise resources for reconstruction and development activities in health, education, agriculture, transport, power, and other key sectors. The first of these, the Health Sector Rehabilitation and Development Project (HSRDP I), began in mid-2000 while the second, the Second Health Sector Rehabilitation and Development Project (HSRDP II) began in mid-2001. The second was supported by a separate grant from the European Union. Both were administered by the World Bank (Tulloch et al 2003: 2; World Bank 2000a; 2001a).

The purpose of this paper is twofold: first, to assess the extent to which the HSRDPs have contributed to positive development results in the areas identified in the methodological framework for Phase 2: that is, governance, delivery of basic services to the poor, negative spill-over effects from violent conflict and disease, and economic growth and poverty reduction; and second, to explain why, in so far as it has contributed to positive results in these areas, it has done so. In relation to the first purpose, the paper suggests that the HSRDPs contributed to improved basic service delivery to the poor, reduced

\(^1\) Because Timor-Leste has only been officially known as ‘Timor-Leste’ since independence in May 2002, I only use this name to refer to the territory since that time. I use ‘East Timor’ to refer to the territory under the UN administration and the Indonesian government because that is what they called it—the UN referred to it using the English ‘East Timor’ while the Indonesians called it ‘Timor Timur’ which literally translates as ‘East Timor’. I use ‘East Timorese’ to refer to the people of Timor Leste, both before and after independence.
negative spill-over effects from disease, and poverty reduction through the restoration of basic health services and the reestablishment of a functioning health system more generally; and to improved governance through the development of a policy and institutional framework for the health sector. In relation to the second purpose, the paper suggests that the positive contribution of this program has reflected a variety of factors related to the design and implementation of the program as well as contextual political economy factors.

In presenting this argument, the paper begins by discussing the development of East Timor’s health sector prior to the introduction of the HSRDPs (Section 2) and providing an outline of the HSRDPs (Section 3). It then provides an assessment of the projects’ contribution to the development of the territory’s health sector, focusing in particular on the areas identified in the methodological framework (Section 4). In Section 5, the paper examines the factors that have enabled the HSRDPs to make a positive contribution in this respect, in so far as this is the case. The final section presents the conclusions to the paper, focusing on the question of the extent to which the HSRDPs might be replicable in other contexts.

2. The Development of the Health Sector Prior to the Introduction of the HSRDPs

East Timor’s health situation was poor prior to the end of the Indonesian occupation in 1999. The Indonesians constructed an extensive system of government hospitals, clinics and health posts manned by about 160 doctors and 2000 nurses and midwives (World Bank 2002: 56). The focal point of this system was the Community Health Centre (puskesmas). Located in all subdistricts, these Centres provided a variety of primary health services and coordinated ‘outreach’ care activities by health sub-centres, mobile clinics, and village midwives. These services and activities included national programs in maternal and child health, family planning activities, and anti-malaria and anti-tuberculosis campaigns. At the tertiary level, care was provided through eight small district hospitals, a central referral hospital in the capital, Dili, and the Central Health Laboratory. Overseeing the system was the provincial health department, although most key policy and programmatic decisions were taken in Jakarta (Joint Assessment Mission 1999: 1; Kelly 2001: 873).

Although this system provided a mechanism for the delivery of health services, it did not perform well. As the World Bank (2000a: 5) has noted, it suffered from a number of serious problems: it was chronically underfunded; public subsidies were not allocated in a pro-poor way, despite the fact that one of the stated objectives of the system was to deliver health services to the poor; it provided, in many cases, poor quality health services; it was unresponsive to the needs and demands of beneficiaries; its quality assurance systems and regulatory framework were inadequate; and it did not produce adequate information for planning and evaluation purposes. Perhaps its most serious problem, however, was that it was underutilised: the number of outpatient visits per capita per year was just over one and the number of outpatient visits per staff member per day employed in the health system was less than five, both low by international standards.
This suggests that the East Timorese either lacked confidence in the health system or faced serious barriers to accessing health services. Some have argued that the fact that the vast majority of doctors and senior health officials in the territory were non-Timorese engendered a lack of trust in the health system among the East Timorese.

The dysfunctional nature of the health system in East Timor during this time was reflected in basic health indicators for the territory. Life expectancy, at 55-58 years, was low, and infant mortality, at 85 per 1000 births, and under-five mortality, at 124 per 1000 births, were high compared to Indonesian averages (Joint Assessment Mission 1999: 1). Less than a quarter of all births were attended by a doctor or mid-wife, contributing to high maternal mortality rates. Outbreaks of preventable and communicable/vector-borne diseases were not uncommon, in part because World Health Organisation (WHO) immunisation targets were not achieved. Malaria and tuberculosis were particularly problematic, with the former accounting for 65 percent of all new outpatient visits to government health facilities in 1998 for school age children and 50 percent for the working age population and the latter accounting for 25 percent of new outpatient visits for the working age population and 46 percent for people over the age of 45 (World Bank 2002: 57).

What little the Indonesians achieved vis-à-vis health care in East Timor was destroyed during the massive violence that occurred during September 1999. As Kelly (2001: 873) has observed:

‘…….health care was deliberately disrupted and facilities specifically targeted: a third were severely or completely destroyed, and less than 9 % escaped damage. An assessment by the joint working group on health services in January, 2000, found that two-thirds still had no mains electricity, almost half had no mains water, and 67% lacked vital equipment. In the eastern Lautem district, all ten health posts were destroyed, Los Palos hospital was looted and damaged, and two nurses and one pharmacist were killed. I found one particularly petty reminder of the militia’s vindictiveness in the radiology room: an X-ray machine left for the rats to chew any available flex, because the exposure button was deliberately cut off and destroyed. A replacement button is unlikely to be found.’

The violence also resulted in the complete loss of all medical equipment and consumable items such as medicines and the departure of many skilled health workers and administrators. As one sign of the latter, of the 160 doctors in the territory under the Indonesians, only 30 remained after the Indonesian withdrawal in 1999 (Joint Assessment Mission 1999: 1). Some indication of the effect of this destruction on the delivery of basic health services and the health status of the population in territory is given in Figure One.

The immediate aftermath of the Indonesian withdrawal, numerous international NGOs poured into the territory to deliver emergency health services, including the International Committee of the Red Cross, Medecins Sans Frontieres, World Vision, and OIKOS. The
Catholic Church and religious charities continued to run clinics and small hospitals as they had previously, also assisting with the humanitarian effort. Between them, these organisations established 71 health facilities at the sub-district level or higher by February 2000, compared to 96 before the violence. They were relatively inactive, however, below the sub-district level and services consequently remained scarce at this level. In order to ensure that as many districts as possible received at least some health services, the NGOs each concentrated their efforts within particular areas (World Bank 2000a: 5).

At the same time, rapid progress was made in terms of establishing an authority to run the health system. Initially, the Joint Health Working Group (JHWG), a body that brought together representatives from UN agencies concerned with health, representatives from the NGO community, and Timorese health professionals in the East Timorese Health Professionals Working Group (ETHPWG), played the key role in this respect (Tulloch et al 2003: 11). For the most part, the JHWG focused on issues related to humanitarian relief, in particular, identifying ‘the most pressing needs in healthcare service provision, the measures that would rapidly address them, and the minimum short-term requirements for the fulfillment of these needs’ (La’o Hamutuk 2000). But it also began preparations for the establishment of a local bureaucratic authority to oversee development of the territory’s health system, agreeing at a workshop in February 2000 to a minimum set of standards for establishing such an authority (La’o Hamutuk 2000). This led to the establishment the same month on the Interim Health Authority (IHA) as part of the UNTAET structure. Headed by Jim Tulloch from the UN and Dr. Sergio Lobo, East Timor’s only qualified surgeon and a member of the ETHPWG, the IHA consisted of 16 senior East Timorese health professionals at the central level, another 13 at the district level, as well as six UNTAET health staff who were in East Timor at that time (Tulloch et al 2003: 8).

3. An Overview of the HSRDP

It was in this context that the first joint donor health mission was held in March-April 2000 to plan the rehabilitation and development of the health sector. Led jointly by the World Bank and the IHA and consisting of representatives from Australia, Portugal and the European Commission, it concluded that a sector wide approach was the most effective way to deliver aid to the health sector. According to the World Bank (2001a: 39), this approach ‘was designed to work at two inter-related levels: (a) to permit the definition of needs across the board—service delivery, rehabilitation of the health infrastructure, health systems and health policy development; and (b) to coordinate donor financing of the sector….’ The joint donor mission also concluded that the best option for East Timor was to focus on constructing a health system that met the needs of the East Timorese people rather than rebuilding the previous health system, the weaknesses of which it recognised. On this basis, it prepared a framework for action that led, after a few weeks of negotiation, to the introduction of HSRDP I (Tulloch et al 2003; 9; World Bank 2001a: 7).
The basic purpose of HSRDP I was to ‘address immediate basic health needs’, without constraining future health policy choices, while simultaneously developing ‘appropriate health policies and systems’ (World Bank 2000a: Annex 1). To this end, it consisted of two main components: (i) the restoration of access to basic services and (ii) the development of a policy and institutional framework for the health system. The first of these components was essentially short-term in focus and consisted of several sub-components: a) the implementation of a transitional strategy for service provision centred on accelerated delivery of selected high priority programs (e.g. immunization, tuberculosis, nutrition, and health promotion) as part of a broader program of delivering a basic packages of services to the greatest number people; b) the development of a pharmaceutical logistics system to assure the timely availability of drugs and medical supplies; c) the reconstruction, rehabilitation and re-equipping of a number of health facilities; d) the rebuilding of an administrative infrastructure at the central and district levels; e) the strengthening of capacity within the health system through training for the delivery of basic services, management, and administration; and f) the introduction of a small grants scheme and the establishment of district and sub-district health boards to support community and stakeholder participation. The second component had a more medium to long-term focus and involved defining and developing an initial set of health policies and regulations appropriate to the country; designing and planning the organizational structure and supporting systems that would characterise the health system; developing a human resources strategy for the health system; and supporting technical assistance, study tours and the preparation of policy papers on specific health issues such as health sector financing and private practice (World Bank 2000a: Annex 2; 2000b: 4). The first component assumed the highest priority under the project reflecting the magnitude of the short-term crisis facing the country’s health sector. Out of a total project budget of US$12.7 million, $10 million was allocated to funding the first component, while only $1.8 million was allocated to funding the second component. The remaining $0.9 was to be spent on establishing and running a Program Management Unit (PMU).

A key feature of HSRDP I was continued reliance on international NGOs to provide basic health services. While the government, in the form of UNTAET, had the resources to fund these services, it was recognised that it did not have the capacity to provide these services itself and that inviting the NGOs to stay was therefore the only strategy ‘that held out the possibility of restoring access to basic health services’ (World Bank 2001a: 40). At the same time, the European Commission’s Humanitarian Office (ECHO), which had been the principal financier of the NGOs since September 1999, agreed to provide additional funding to the NGOs to help the country make the transition from the emergency to the rehabilitation phase of health care. The result was an arrangement whereby the NGOs continued to act as the principal service providers in the health sector but submitted to overall coordination by the government and conditions outlined in a Memorandum of Understanding between them and the government (World Bank 2000a: 7; Tulloch et al 2003: 12). Although some NGOs were initially reluctant to submit to this arrangement, NGOs and the government reportedly established a good working relationship, facilitating their ability to provide necessary health services (Tulloch et al 2003: 26).
In mid-2001, donors and the Division of Health Services (the successor to the IHA) agreed that a second health sector rehabilitation and development project should be funded to continue and extend the work done under HSRDP I. HSRDP I had focused on the establishment of community health centres and mobile clinics to provide basic health services and rebuild public health programs in areas such as immunisations and health promotions. HSRDP II, by contrast, was intended to achieve greater utilisation of health services and greater quality of care by giving greater attention to hospital care, certain elements of the basic package of health services delivered through the first project, and capacity building in areas such as human resources, management, service provision, community mobilisation, and communications (World Bank 2001a: 7). In general terms, it gave greater attention than the first project to medium to long-term issues related to the health sector, particularly to the development of a policy and institutional framework for the sector.

The declared purpose of HSRDP II was to ‘rehabilitate and develop a cost-effective and financially sustainable health system in East Timor to be responsive to the immediate basic health needs of the population and, within a well-integrated and sustainable policy framework, to prepare the health system to meet future needs’ (World Bank 2001a: 35). It consisted of three components. The first of these focused on supporting on-going service delivery in the health sector and included the provision of technical assistance to district health management teams to help them in the development and implementation of district health plans, and the provision of pharmaceuticals to health facilities. The second component focused on improving the range and quality of health services, and developing and implementing supporting systems. It centred on activities aimed at strengthening referral systems and ‘rationalising’ the hospital system, rehabilitating the central laboratory, creating a functioning Autonomous Medical Supply entity, and improving the standardisation and quality of a basic package of health services. The third component focused on developing and implementing health sector policy and management systems. Activities under this component included conducting a Demographic and Health Survey to provide policy-relevant information and providing technical assistance to assist the government in formulating and implementing policy and in developing a human resource management strategy and strengthening systems management (World Bank 2001a: Annex 2; 2001b: 3-4). In financial terms, the second component was budgeted to consume the bulk of the resources—out of a total project budget of US$21.4 million, it accounted for $14.8 million, reflecting in large part the high cost of rehabilitating and re-equipping the hospitals as well as the cost of purshasing drugs to be stocked at the Autonomous Medical Supply entity. Of the remaining budget, the first component was allocated $3.5 million and the third component $2.7 million (World Bank 2001a: 44).

In contrast to HSRDP I, HSRDP II envisaged a shift in service provision from NGOs to the government. This was due in part to growing concern on the part of donors and the government about the relatively high cost of using NGOs as service providers and in part to the emergence of pressure for Timorese managers to assume greater control over the health system as the capacity of the IHA and its successors increased over time. In the
place of NGOs, new district health management teams (DHMTs) would assume responsibility for the delivery of services at the local level. To replace the Western doctors that NGOs had employed, donors and the government planned to recruit doctors from other developing countries and encourage expatriate East Timorese doctors to return home (World Bank 2001a: 8).

A final point that needs to be mentioned is that the two projects established a set of key performance indicators that acted both as a means of assessing the performance of the two projects and the country’s health sector overall. These indicators were specified in the Project Appraisal Document for HSRDP II and included indicators from both HSRDP I and HSRDP II. They focused mainly on outcomes vis-à-vis rehabilitation of the health system, the delivery of key health services, and the production of key policies. They are detailed in Table One.

INSERT TABLE ONE HERE

**4. Development Results**

Perhaps the most dramatic product of the HSRDPs has been the re-establishment of a functioning health service. Under HSRDP I, dozens of community health centres or health posts were either constructed or rehabilitated and six hospitals were rebuilt. By mid-2004, Timor-Leste was estimated to have six functioning hospitals, including a National Referral Hospital in Dili, 65 community health centres, and over 170 health posts. At the same time, health workers were hired, drugs were purchased, and services were delivered (World Bank 2004: 87-90). From a state of utter devastation in late 1999, by mid-2004 an estimated 87 percent of the population had a health facility within 2-hours walking distance from home and these facilities were within 2 hours driving time of a hospital in 10 out of 12 districts. Partly for this reason, the delivery of health services improved significantly between 1999 and 2004, as evidenced by data collected in relation to the above key performance indicators. By June 2004, an estimated 42 percent of births were being attended by a skilled health worker, an estimated 70 percent of children under 1 year old had been immunised for DPT3 and measles, and utilisation of health facilities had increased from approximately 0.5 visits per year to over 2 visits per year per capita (Program Management Unit 2004). These figures overstate the effect of the projects in so far as they are based on population figures that are probably an underestimate of the actual population size. These figures were due to be recalculated to reflect recent census results while I was in the field but this had not happened by the time that I left Timor-Leste. Nevertheless, it is clear that the projects have contributed significantly to the re-establishment of a functioning health service and in this way also contributed to positive development results areas identified in the methodological framework: improved basic service delivery to the poor, reduced negative spill-over effects from disease, and poverty reduction.

In addition to these achievements, the HSRDPs also contributed to improved governance within the territory. Initially, their main contribution in this respect was getting the
international NGOs to work in conjunction with the IHA to prepare district health plans. Involvement of the NGOs ‘allowed for the simultaneous preparation of district health plans for each of the 12 districts outside Dili, a task beyond the capacity of the IHA alone’ (Tulloch et al 2003: 10). The purpose of these plans was not to set in place an overall strategy for health system development, so much as to generate valuable data and innovative local ideas and provide a mechanism for coordinating health sector activity at the local level (Kelly 2001: 874). At subsequent stages, the focus of activity in the governance area shifted to the production of a national level Health Policy Framework and a set of key health laws and regulations. The Health Policy Framework, which was approved by the Council of Ministers (i.e. cabinet) in 2003, sought to provide a ‘comprehensive vision of the strategic policy direction of the Ministry of Health’ (Ministry of Health 2002: 14). It identified a variety of objectives for the Ministry of Health to pursue, including: ‘building on the achievements made to date in restoring public health and curative services; recognising the importance of the [Ministry of Health’s] stewardship role; delivering a basic package of affordable, effective interventions through a system of district health services that are able to respond to local needs; ensuring that basic services are provided to the poor, who remain primarily in rural areas; cooperating proactively with the private sector and non-governmental organisations……and exploring the development of contracting-out options for some ancillary and basic services, such as health promotion, which may be better managed by other providers’ (World Bank 2004: 85). The set of key health laws and regulations produced through the projects included the Organic Law of the Ministry of Health, the Basic Law for Health, and the Law creating the Autonomous System for Drugs and Health Equipment.

The creation of the Autonomous Medical Stores (SAMES) in May 2004 to manage the procurement and distribution of pharmaceuticals has, or at least, very likely will improve the quality of governance in relation to financial management in the health sector. Prior to the establishment of SAMES, individual health facilities were not charged for the drugs that they used, giving them little incentive to contain drug-related costs. With SAMES’s establishment charges for drug use are now posted against individual medical facilities while health facility managers have simultaneously been required to incorporate drug costs into their respective budgets. To the extent that SAMES performs it functions effectively, it should therefore work to reduce the incentive to overuse drugs, something that reportedly occurs regularly because of health workers’ current tendency to prescribe a range of drugs to treat a single condition, many of which are unnecessary (World Bank 2004: 97).

Another important contribution of the HRSDPs vis-à-vis governance in the health sector has been the establishment of a functioning and fully Timorese administrative structure in the health sector. Initially dependent on international NGOs to deliver basic health services, the country has proceeded rapidly to self-administration in the health sector, notwithstanding the fact that it went through a lengthy period during which there were delays recruiting health sector personnel (Tulloch et al 2003: 16). By July 2004, the government of Timor-Leste could boast the following in relation to the system’s administration:
The Ministry of Health is now fully staffed and has a relevant structure. The Organic Law for the MoH has been approved by the Council of Ministers. District Health Management Teams have been recruited in all districts and have the responsibility to manage district health services providing management support to health providers. Recruitment of senior staff (level 5, 6 and 7) has been successfully completed. Many important vacancies have been filled, such as Director-General, Inspector of Health and several Heads of District Health Services. This has already contributed to a better organisational stability. Recruitment of level 2, 3, and 4 positions has been concluded. A total of 455 permanent positions were advertised and candidates are now being selected and will take up their positions. The number of civil servants in the health sector is within the recommended range in accordance with the Government staff policy (Ministry of Health 2004: 13).

Furthermore, this administrative structure was characterised by clear backward and forward linkages between the central administration in Dili and local health clinics. As one informed source pointed out, the Ministry of Health is relatively internally coherent—all parts of the health administration make decisions on the basis of the same health indicators and work according to the same planning and budgeting systems and vision. In addition, the Ministry has made an effective effort to mobilise local feedback as part of its planning mechanisms. Every year, Ministry of Health officials make field trips to the districts to collect information to be used in the formulation of the Ministry’s annual action plans. The Ministry of Health is also relatively effective at spending the resources at its disposal, having one of the highest budget execution rates in the government.

While the development results achieved by the government and donors through the two health sector projects have arguably been impressive on the whole, they have been weak in certain specific respects. First, while the projects have served to re-establish a system for delivering a basic package of health services in the country, demand for these services has remained weak. As the World Bank (2004: 90) has pointed out, average annual outpatient visits—at around 2 per capita—are low by international standards—the corresponding figures for East Asia, Latin America, the Caribbean and sub-Saharan Africa are 5, 6, 6, and 4 respectively. Second, while, as noted above, there has been a marked improvement in the key performance indicators listed above, several of these indicators appear to have stagnated or even fallen slightly in recent months (see Table Two). The reasons for this are unknown. Finally, little progress has been made in terms of rehabilitating the hospital system, in part because of delays in securing European Union funding for HSRDP II. Nor has much progress been made in relation to improving hospital management, something that is generally regarded as very poor and a serious obstacle to the provision of good health hospital care (Program Management Unit 2004: 9).

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5. Explaining the Contribution of the HSRDPs to Timor Leste’s Development

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2 Interview, Dili, September 2004.
How can we understand the HSRDPs’ contribution to Timor Leste’s development? I would argue that it has reflected ten factors, five of which relate to the way in which the program was designed and implemented, and five of which relate to the nature of country’s political economy since independence. These factors are as follows.

**Design and Implementation Factors**

First, the HSRDPs were based on a good understanding of the health problems facing the territory after the Indonesian withdrawal, in large part because the joint donor health mission teams that designed the projects were able to draw on the findings of several detailed studies of the health sector prepared during 1999-2000. The Joint Assessment Mission had examined the territory’s health status as part of its broader assessment of the country’s development situation in October/November 1999 (Joint Assessment Mission 1999). In December 1999, the ETHPWG conducted a workshop to discuss the country’s health situation and undertook a review of the country’s health infrastructure. On this basis, the JHWG ‘identified the most pressing needs in healthcare service provision, the measures that would rapidly address them, and the minimum short-term requirements for the fulfillment of these needs’ (La’o Hamutuk 2000). Finally, after its establishment in February 2000, the IHA conducted ‘team visits to all of the districts to gather information to inform the mission that designed the first HSRDP in the first part of 2000 (Tulloch et al 2003: 9).

Second, the HSRDPs involved simultaneous efforts to conduct health sector rehabilitation work and policy and institutional development. A potential problem with rehabilitation work in any sector is that it can constrain future policy choices—if rehabilitation work serves to simply rebuild the previous (deficient) system, it can then be very costly to change the system, forcing a country to inherit its deficiencies. The HSRDPs reduced the potential for this sort of outcome by trying to incorporate planning processes through policy and institutional development into the projects’ designs.

Third, there was considerable flexibility in terms of the way in which the projects were implemented. As one informant explained, the projects was designed very quickly—the Is were not dotted and the Ts were not crossed. This made it possible for the projects to respond quickly and effectively to changing circumstances. For instance, the first project was able to take over funding of international NGOs when ECHO funding ran out, ensuring that they could continue to provide emergency health services. Another example is that the project was able to operate as financier of last resort for medical students who were studying abroad, covering fees, per diems, air fares, and any other costs related to their education, a role not originally envisaged but which was subsequently seen as necessary in order to address the severe shortage in qualified health personnel faced by the country.

Fourth, the projects provided a mechanism for donor coordination, one that by most accounts proved successful. As noted above, donors employed a SWAP approach in the health sector, holding joint-donor meetings every six months at which strategic decisions
on health issues were taken. This has not prevented individual donors pursuing health interventions of questionable priority vis-à-vis Timor Leste’s health needs. A number of informants, for instance, were highly critical the priority given by the World Health Organisation to an anti-smoking campaign and AusAID to oral and mental health programs. But in general informants were positive about the extent to which these regular meetings provided for effective donor coordination. Tulloch et al (2003: 30) concluded that the SWAP approach was ‘the best option for ensuring the coherent development of the health sector’.

Fifth, the projects were characterised by a relatively high degree of local ownership on the part of East Timorese senior health professionals and administrators. As noted above, East Timorese health professionals were involved from the start in the design of the territory’s health system through the ETPWG. Many of those in the ETPWG continued to play a role once the IHA was formed by assuming senior positions in that organisation. In contrast to other sectors, there was considerable scope for East Timorese to influence the development of the health system under the UN because health was the only sector to have an interim authority and, as just noted, East Timorese held key positions in this organisation. In this respect a useful contrast can be made with the education sector. Millo and Barnett (2004: 14-15) have argued that ‘while there was considerable success in reconstructing East Timor’s education system, the opportunity to begin the transformation that Civil Society and CNRT desired was missed’. This outcome, they say, reflected in large part the inability of the World Bank and UNTAET to ‘construct appropriate partnerships that could have facilitated empowerment of the local community’. The CNRT and other East Timorese representatives, they say, did not trust UNTAET and the World Bank, leading to ‘the creation of parallel systems instead of real partnership’. Arguably, the situation in health was characterised by a more effective partnership.

It seems likely, however, that the extent of local ownership of the activities performed through the HSRDPs has been constrained by the lack of institutional capacity within the Ministry of Health and its predecessors. The Ministry of Health is generally regarded within the donor community as one of the more capable ministries within the government. However, like other ministries, it is short on skilled staff, both in relation to policy development and medical issues. With many Timorese health officials lacking adequate expertise and experience, the Ministry has had little choice but to rely heavily on foreign advisers to formulate policy ideas as well as author policy documents. It has apparently become common practice for foreign advisers to leave the room at Ministry of Health meetings when policy decisions are being made to maximise the discretion exercised by Timorese officials. But the fact that these decisions are taken on the basis of information and analysis provided by foreign advisers and that the capacity of Ministry officials to critically evaluate this information and analysis is limited means that foreign advisers continue to exert significant influence over policy regardless of whether or not they are physically present at these meetings. One foreign health consultant who has worked on East Timor’s health sector for several years suggested that it was difficult to talk about full ownership of the policy-making process in the health sector when, in conversations between that person and Ministry of Health officials, many of the latter
were unable to clearly explain the rationale underlying policy decisions or articulate government policies. The Health Ministry is reportedly able to make more strategic use of international advisors than a number of other government ministries because, notwithstanding its human resource problems, it is better staffed, both in terms of quantity and quality, than many other departments. But the fact that it is so dependent on foreigners to do key parts of the ministry’s work nevertheless constrains the extent of local ownership.

A further constraint on local ownership of the two health projects has been the fact that many health sector policies and laws have been formulated through non-participatory mechanisms. Indeed, the government and the World Bank have been criticised by some groups for not taking on board sufficiently the views of local communities and international NGOs in designing and implementing health projects (see, for instance, La’o Hamutuk 2000).

**Contextual Political Economy Factors**

Sixth, the government had at its disposal relatively large financial resources to promote the rehabilitation and development of the health sector, reflecting in large part relatively generous levels of donor financing. As Figure Two illustrates, East Timor received relatively generous donor funding between 1999 and 2002 across the board—aid per capita in East Timor was over $300 in 2000 and between $250 and $300 in 2001 and 2002, significantly higher than many other LICUS. The health sector, in particular, benefited from the high level of aid flows—according to the World Bank’s *Public Expenditure Review* for 2004, combined sources expenditure on health in Timor-Leste was around $27 per capita, much higher than the average of just under $6 per capita for low income countries as a whole (World Bank 2004: 93). This level of funding had a downside—it was too much for the country to productively absorb. As Tullock *et al* (2003: 29) have pointed out, ‘some funded entities, not wanting to be left with unspent funds, [found] creative ways of using them within stipulated guidelines but with little relevance to the true needs’. At the same, however, it ensured that the government had the resources it needed to achieve what it could—unlike in some other contexts shortage of funds was not a problem.

The high level of funding for the health sector reflected the nature of the country’s political economy. Tullock *et al* (2003: 29) suggest that donors were able to mobilise relatively large sums of money for East Timor, and health sector rehabilitation and development in particular, because of the ‘relative political attractiveness of emergencies and the undeniable health needs in such situations’. Arguably, however, the high level of funding also reflected public pressure on Western governments to make amends for effectively abandoning East Timor after the Indonesian invasion in 1975. For instance, it is difficult to understand the Australian government’s relatively generous aid program for

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4 An important exception in this respect is the Health Policy Framework which was produced through a consultative process involving two large-scale public workshops.
East Timor/Timor Leste—compared to say, its aid programs for Indonesia, Laos, and Thailand—in any other context. In addition, the high level of funding for the health sector also reflects political decisions taken as part of negotiations between donors and government over the Transition Support Program—a program of general budgetary support funded by various donors that is designed to help the government implement the National Development Plan. Specifically, it reflects the government’s and donor’s joint decision to allocate at least 35 percent of the government’s core budget to health and education (Rosser, this volume).

Seventh, the Ministry of Health has benefited from relatively good, technocratic, leadership. Timor-Leste’s human resource base is extremely weak and the leaders of Fretilin, the dominant political party, have generally appointed individuals with strong political connections to top government positions rather than ones with good technical skills or senior management experience. In the health sector, however, they have appointed someone with strong technical qualifications to the top job. The Minister of Health, Rui Maria de Araujo, has spent many years working as a doctor in East Timor and holds a Masters degree in Public Health from a New Zealand university. His appointment to the top job has apparently not stopped political appointments from being made within the Ministry and, as in other Ministries, there is a general dearth of well-qualified and experienced staff. But the personal ability of the Minister and some other senior Ministry staff has, according to most informants, given the Ministry of Health greater capacity than most other government departments.

Eighth, there is a strong imperative for the government to cooperate closely with donors and make a reasonably earnest attempt to produce results, not just in the health sector, but in general. This imperative stems from two aspects of Timor-Leste’s political economy. The first is the fact that the government of Timor Leste has lacked access to an alternative source of government finance or investment capital besides aid since independence. Government revenues from the oil and gas sector and other domestic sources have not been sufficient to fund the government’s expenditure program during this period, although recent oil price rises and the likelihood of future development of oil and gas projects in the Timor Sea mean that they probably will be in the future. Highly dependent on aid, the government has not been able to ignore donors as, for instance, a number of oil-exporting countries did during the oil boom years (Winters 1996). This dynamic has been reinforced by the second relevant aspect of the country’s political economy—the fact that the country is vulnerable in security terms, both externally and internally. Beyond needing donors to fund its expenditure program, the government also needs them to help maintain political and social stability. Donors have helped in this respect by funding security-related activities such as those incorporated into the TSP and by funding troops on the ground (Rosser, this volume). Dependent on donors for finance and security, the government has had every reason to act in manner likely to maintain their support over time.

Ninth, decision-making authority within the government of Timor-Leste has been concentrated in the hands of the Council of Ministers, a body equivalent to a cabinet. Fretilin has a large majority in parliament, having won 55 out of the 88 seats up for grabs
at the 2001 election. Furthermore, it has remained fairly unified, with parliamentary representatives rarely challenging decisions made by the Council of Ministers. There are signs that Fretilin members of parliament are becoming increasingly assertive vis-à-vis the Council of Ministers. The most notable example in this respect is the parliament’s recent rejection of the government candidate for Ombudsman, a position that constitutes one of the main accountability mechanisms in the government (Suara Timor Lorosae 2004). Despite these signs, however, the general pattern has been for Fretilin members of parliament to fall in behind the Council of Ministers (Holloway 2004: 9). At the same time, CSOs have generally been ineffective in carrying out advocacy work, partly because of their own weaknesses and partly because of a lack of channels through which NGOs can access the policy-making process (Holloway 2004). In this context, the only real veto point in the whole policy-making process has been the Presidency. Under the Constitution, the President has the authority to veto any statute up to 90 days after its passage through parliament (Shoesmith 2003: 244), so long as the legislation is adjudged to contradict the constitution or endanger stability. In so far as there is some prospect that he may exercise this veto power in relation to health sector legislation, there is a possibility that it could interfere with the HSRDPs. Thus far, he has not done so. This situation has meant that the government has been able to produce health sector policies and laws, have them enacted or approved reasonably quickly and easily, and begin the process of implementing them. This has made the policy and institutional development work that has been part of both HSRDPs much easier than it might have been if the political system was more fractured.

Finally, although Timor-Leste is vulnerable in security terms, it has remained stable. Indeed, as the Joint Assessment Mission in 1999 noted: ‘East Timor is different from other post-conflict situations in one very important aspect. There is no apparent need for pacification between different ethnic, cultural or religious segments of the population…..In a way it would be most useful to treat the problem as a post-natural-disaster situation, where a vicious hurricane destroyed all buildings and most crops and removed all records and institutional memory’ (as quoted in World Bank 2002: 5). The fact that Timorese society has remained relatively cohesive in the post-occupation period and more specifically that the country’s political leaders have not been distracted by ethnic, cultural or religious fighting has allowed them to focus on the task of development. At the same time, stability has meant that there has been relatively little prospect of rehabilitated health centres being razed to the ground again. This has doubtless facilitated the process of rehabilitation and development, not just in the health sector, but in other areas as well.

6. Conclusion

It has been argued here that the HSRDPs contributed to improved basic service delivery to the poor, reduced negative spill-over effects from disease, and poverty reduction through the restoration of basic health services and the re-establishment of a functioning health system more generally. It has also been argued that the projects contributed to improved governance through the development of a policy and institutional framework
for the health sector. This in turn, it has been argued, reflected a variety of factors related to the design and implementation of the program as well as contextual political economy factors.

To what extent do the projects serve as a model for similar interventions in other contexts? I would argue that it does so in two respects. First, the HSRDPs demonstrate the benefits of conducting health sector rehabilitation work and policy and institutional development simultaneously. As noted earlier, the HSRDPs reduced the potential for a simple recreation of the old dysfunctional health system by incorporating policy and institutional development into the projects’ designs. Second, the HSRDPs demonstrate the benefits of a sector-wide approach to health sector reform. As noted above, this did not prevent individual donors from pursuing their ‘pet interests’, but it did help to limit duplication of effort and to focus donor attention on the achievement of the same basic set of performance indicators. It also served to reduce pressure on the government of Timor-Leste, an important consideration given its low level of administrative capacity, by concentrating negotiations with donors into a particular time period and a particular forum, the joint donor health mission.
Figure One
Basic Health Indicators, 1999 and 2001

### Table One

**Key Performance Indicators**

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>June 01</td>
</tr>
<tr>
<td>1.</td>
<td>Children Under 1-year immunised (in each district) more than:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) DPT3</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>b) Measles</td>
<td>20%</td>
</tr>
<tr>
<td>2.</td>
<td>Births with skilled attendance at birth more than:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) nationally</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>b) in each district</td>
<td>4%</td>
</tr>
<tr>
<td>3.</td>
<td>Population with access to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) basic health services within two hours more than:</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td>b) inpatient services within two hours from a source of basic health services more than:</td>
<td>40%</td>
</tr>
<tr>
<td>4.</td>
<td>Health services in district plans appropriately utilised: number of outpatient visits per capita per annum more than:</td>
<td>1</td>
</tr>
<tr>
<td>5.</td>
<td>Health facilities reporting no stock outs of essential drugs lasting more than 2 weeks in the previous quarter</td>
<td>60%</td>
</tr>
<tr>
<td>6.</td>
<td>Draft health sector policy paper discussed with stakeholders and completed by June 02</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Revised regulations on pharmaceuticals:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) draft prepared by June 2002</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) regulations issued by June 2003</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Human resource management and development plan adopted by June 2002</td>
<td></td>
</tr>
</tbody>
</table>

Source: World Bank (2001a: 2)
Figure Two
Aid Dependence in Selected ‘Low Income Countries Under Stress'

Source: World Bank, *World Development Indicators CD ROM.*
References


