Rehabilitating the health system after conflict in East Timor: a shift from NGO to government leadership

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Efforts to rehabilitate health systems after periods of prolonged conflict have often been characterized by poor coordination of external actors – multilateral agencies, donors and non-governmental organizations (NGOs). This paper describes the process and analyses the roles of the different stakeholders in the establishment of a government-led district health system in East Timor, between 1999 and 2002, after decades of chronic conflict and Indonesian occupation. Future East Timorese policy-makers and health professionals began to mobilize in May 1999, in preparation for independence. During the emergency phase, from September 1999, when violence erupted, to March 2000, NGOs played a major role in the provision of relief to the population, coordinated by United Nations agencies. An Interim Health Authority, led by local Timorese, was established in March and the major donors began to shift funding from NGOs to the newly established Ministry of Health. A rapid phasing-out of NGOs, accompanied by a sequence of steps to build the capacity of Timorese to manage the new district health system, was implemented. Early evidence shows that health service utilization continued to grow during and after implementation.

Key words: post conflict, health systems rehabilitation, East Timor, NGO

Introduction

There is growing awareness of the need for timely and appropriate support for post-conflict rehabilitation (Lanjouw et al. 1999). Complex political emergencies are characterized by long duration, violence directed towards civilians, social discord – often manipulated by power-seeking groups – and absence of normal accountability (Hallam 1998; Goodhand and Hulme 1999). Typically, they seriously impact on the health status of affected populations (Bornemisza and Sondorp 2002). The World Bank’s Conflict Prevention and Reconstruction Unit established a Post-Conflict Fund in 1997 and in January 2001 adopted a ‘Development Cooperation and Conflict’ policy to enhance its capacity to respond and provide transitional support in such settings (World Bank 2001). The Department of Emergency and Humanitarian Action at the World Health Organization (WHO) has boosted WHO’s operational role since its 1995 operation in the former Yugoslavia (WHO/EHA 2002).

The post-conflict and rehabilitation arena often involves numerous external actors, including multilateral agencies, bilateral donors, non-governmental organizations (NGOs), military forces and the media; as well as internal ones – politicians, civil society groups and religious leaders, among others. Fifty bilateral donors and multilateral agencies were actively involved in the West Bank and Gaza in 1999, and 60 in Bosnia-Herzegovina during the same period (Balaj and Wallich 1999). The wide range of actors increases the need for strong coordination mechanisms (Buse and Walt 1997). The period after the formation of the National Resistance Army government in Uganda in 1986 was characterized by uncoordinated interventions of donors, including United Nations (UN) agencies, NGOs and bilateral donors. Their fragmented project approach has been cited as responsible for delaying the development of a comprehensive policy for sustainable and equitable health development (Macrae et al. 1993).

To understand the essence of aid coordination mechanisms Walt et al. have argued the need to consider and analyze ‘institutional characteristics, the distribution and nature of influence among the actors, and the interests which they pursue through the aid regime’ (Walt et al. 1999). During the immediate post-conflict phase, NGOs are often best placed for rapid intervention and relief work, providing logistics, emergency services and relief for basic needs. After the emergency phase, continued provision of goods and services by NGOs can hinder the development of indigenous health and governance systems (Buckland 2000). Despite being different, relief and development strategies are related. Some authors recommend a developmental approach to relief as a major basis for further development of health systems affected by conflict (Macrae 2001). The path taken by East Timor since September 1999 provides some lessons in this regard; although the specific characteristics of post-conflict East Timor – population size, rapid restoration of peace, strong social cohesion towards the
goal of independence – impose some limitations to transferability of this experience to other post-conflict settings.

This study draws on participant observation by the lead author, while being an adviser on Policy and Management to the Ministry of Health of East Timor during the early years of health system reconstruction (2000–02), supported by a review and analysis of unpublished reports (2001–03). Together, these provide a description of the evolving policy environment, with insights into the processes of policy development and the roles of the different stakeholders. Data from quarterly monitoring reports, covering the same period, illustrate the early effects of policy change on service outputs. The analytical framework used is adapted from Walt, focusing on an analysis of the context, actors and decision-making processes (Walt 1994). A review of relevant literature helps to situate the Timorese findings within an international perspective.

The paper continues with a description of the historical context, the political and health systems development, leading up to independence. It proceeds to describe and evaluate the roles of the main national and international agencies and stakeholders; the development and early implementation of national policies; and the early effects on service delivery. The paper concludes with lessons, distinguishing between those specific to the Timorese context and those transferrable to other settings.

The context

East Timor, renamed Timor Leste after independence in May 2002, is a half-island country with a territory of 18,900 km², sharing borders with Indonesia to the west and north and Australia to the south. The island is mountainous, with an average height of 2500 metres in the central area. The state of East Timor also includes an enclave (Oecusse) located within West Timor’s borders, as well as two small islands (Atauro and Jaco). Tetum and Portuguese are the two official languages, while Indonesian and English are also used. The most recent census, conducted in July 2004, revealed a population of 924,642 inhabitants with a gender ratio of almost 1:1 (Statistics Directorate 2004).

Historical overview

In November 1975, after more than four centuries of Portuguese colonization, a civil war broke out in East Timor, as political parties fought for power in anticipation of independence from Portugal. The Revolutionary Front for an Independent East Timor (FRETILIN) declared the country independent on 28 November 1975. Nine days later, Indonesia invaded, leading to the integration of East Timor as its 27th province. Indonesian sovereignty was neither recognized by the majority of the East Timorese nor by the UN (Molnar 2002). Occupation under Indonesia’s one party political rule was characterized by terror and human rights violations, resulting in the death of 200,000 East Timorese (25% of the population), either killed or victims of starvation and disease (Amnesty International 1994). Despite the strong repression, an active underground clandestine structure, led by the FRETILIN, resisted the invaders, while the Catholic Church provided leadership and protection to the population. As a result of international pressure, a referendum on independence was held on 30 August 1999. A turnout of 98% resulted in 78.5% of the registered electorate voting for independence.

In September 1999, the announcement of the results triggered a violent outbreak by militia, supported by the Indonesian army, which resulted in the destruction of 70% of infrastructure and displacement of two-thirds of the population. Over 35% of health facilities were completely destroyed and more than 40% seriously damaged. Most physicians and senior management staff from central and district levels left the country and virtually all medical equipment and supplies were looted or destroyed. In the aftermath of the conflict, GDP declined by almost 40% and prices rose by around 200% (Valdivieso et al. 2000).

On 15 September 1999, UN Security Council resolution number 1264/99 set the stage for deployment of a multinational force to restore peace and security in East Timor; and a second resolution (1272/99) established the United Nations Transitional Administration for East Timor (UNTAET), which had a mandate to administer the country, exercise legislative and executive power, coordinate humanitarian assistance and support capacity building for self-government. The response from the international community resulted in an inflow of aid of more than US$500 million by June 2002 (Rohland and Cliffe 2002). A transitional cabinet was established in July 2000 with eight departments and staff appointed by the Special Representative of the UN Secretary General, following consultation with Timorese groups.

The transitional government actively promoted ‘timorization’, a term used to describe a process of strengthening the sovereignty and control of the East Timorese people over East Timor. At the end of August 2001, the ‘timorization’ process made a major advance when 88 democratically elected members formed the first Constituent Assembly of East Timor, which immediately started to draft a constitution. The assembly, composed mainly of members of FRETILIN, appointed a cabinet of 10 ministers, three secretaries and seven vice ministers. An independent Ministry of Health (MoH) was established, to which a physician was appointed as Minister and a nurse as Vice Minister. The new Constitution was signed into force in March 2002. On 14 April 2002, Kay Rala Xanana Gusmao, leader of the Timorese resistance, obtained 83% of the votes in the presidential elections as the final crucial event that preceded East Timor’s independence on 20 May 2002.
Development of the new health system

In April 1999, when it had become apparent that autonomy or even independence would be considered by the Indonesian government, a meeting of East Timorese – including members of the diaspora, some who managed to temporarily leave East Timor and others who were coincidentally out of the country for other reasons – was held in Melbourne, Australia. There, a Strategic Development Plan for East Timor was elaborated and the outline of a new health system was defined, based on principles of equity, acceptance of cultural diversity and accountability to the Timorese people (ETDA 1999). The Melbourne meeting was an early seminal and catalytic event for the future development of the health system. Some of those who participated subsequently established the East Timor Health Professionals Working Group (ETHPWG), which became the focus for the development of the new health system.

Based on recommendations from the Melbourne meeting, the principles and structure of a national health system for an independent East Timor were further developed and ratified at a workshop organized by the ETHPWG, held in Dili in December 1999. The workshop was attended by national and international NGOs, the UN and members of the National Council of Timorese Resistance. From this meeting the Joint Working Group on Health Services was constituted.

In March 2000, the international agencies declared the end of the emergency phase and recommended that all efforts be directed towards sustainable development (Heijden and Thomas 2001). An Interim Health Authority (IHA) was established, composed of national (local Timorese) and international UNTAET staff, responsible for coordination of all health sector activities. One Timorese member of the IHA was nominated in each district as the focal person for health, to work closely with the social services international officer, with international agencies providing technical assistance for decision-making.

Following the initial emergency phase, some of the NGOs left the country. From those that remained, one was assigned by the IHA to each district as the lead agency for management and provision of health services. The NGOs, with limited participation of local counterparts and following guidelines and standards established by the IHA, designed health plans for each district. They were intended to be suitable for rapid implementation and to promote efficient use of available resources. The operational priorities were to ensure maximum coverage of basic services and to build the capacity of East Timorese staff. The plans were approved centrally after discussion and agreement between the IHA and each district-based NGO.

The new health system rationalized the previous Indonesian network, limiting the number of health facilities and staff to the minimum necessary to ensure provision of basic services to the population; also planning their distribution according to administrative, geographic and accessibility criteria. One health centre with inpatient facilities was rehabilitated in each district capital and one centre with an outpatient department in each sub-district. Health posts, each staffed by two health workers, were established to provide basic services in more remote areas. Outreach (mobile) clinics were organized, providing minimum services to the most inaccessible locations twice per week. The initial aim was to provide outreach on a temporary basis as a way of exploring the demand for services that outreach triggered in each location, so as to assist in planning the location of additional fixed health posts. After withdrawal of NGO support, this strategy was resisted by local health staff and implemented unevenly. Transport of patients requiring referral was initially done using NGO vehicles or ambulances located in the two referral hospitals; and sporadically by UN planes and helicopters for patients referred from very remote areas, or when cases required urgent attention.

During the early reconstruction period (2000–01), East Timor’s health system had a staff complement of about 1500 as compared with approximately 3540 during the Indonesian occupation (Joint Assessment Mission 1999). From 135 doctors working before the crisis, only 20 remained after September 1999. International medical staff were recruited as a temporary measure while Timorese doctors were being trained abroad through scholarships sponsored by donors. Nurses and midwives were allocated to every health facility. Hospital service configuration was re-assessed in November 2001 and January 2002 through two in-depth rationalization studies, leading to the current composition that was approved by the Parliament in April 2002. The plan comprised four small 20-bed hospital units, one regional hospital with 110 beds and a national referral hospital with 220 beds.

The main players

Donors and funding

The main sources of funding for the reconstruction of East Timor (non-emergency funds) were the Humanitarian Consolidated Appeal, UN agency reconstruction programmes, bilateral assistance (NGOs), the assessed contribution budget of UNTAET and two trust funds: the Consolidated Fund for East Timor and the Trust Fund for East Timor (Rohland and Cliffe 2002). The Consolidated Fund for East Timor, managed by UNTAET, represented more than US$54 million by December 2001. It contributed mainly to national institutions like the East Timor Transitional Administration and paid for government running costs (e.g. salaries).

The Trust Fund for East Timor, managed by the World Bank, had accumulated more than US$112 million by December 2001 and had paid mainly for reconstruction
The decision to publicly fund and provide health care, rather than implement a public/private mixed strategy, appeared to be related to the economic context of the country, political forces and the influence of the different actors involved in the reconstruction. The absolute poverty, with a high proportion of the population living on less than US$0.55 per day, was perceived by Timorese authorities as a strong reason to support free universal access as the only option acceptable. The great availability of resources during the first years of rehabilitation and the prospects of significant future economic growth through oil revenues from the Timor Sea supported this preference. Later, the National Health Policy Framework would establish the intention of the government to accept private initiatives, but only after the government was able to provide a basic package of care to the whole population. Despite that, by August 2002 private health facilities such as pharmacies, outpatient clinics and laboratories were already offering services in Dili. A USAID-supported coffee cooperative provided primary health care services to associated farmers and their families (around 120,000 beneficiaries) in coffee-growing areas (USAID 2003).

**UNTAET**

The role that UNTAET played in the reconstruction of East Timor was critical. The rapid deployment of a Peace Keeping Force to re-establish security and the rapid deployment of technical, financial and logistical assistance were key steps in the rehabilitation process. The work done with local counterparts and the progressive withdrawal of international technical assistance as capacity was growing in the Timorese staff were key to providing legitimacy to the emerging institutions. Especially in the health sector, where the input of UNTAET was initially restricted to providing some international staff and assets, the strategy of fully involving Timorese counterparts in the decision-making process promoted the legitimacy of the emerging MoH. However, the complex and sometimes inefficient UN bureaucratic system delayed interventions, mainly due to their strong centralization and weak processes of procurement.

**The World Bank**

The World Bank was the manager of the Trust Fund that was the financial base for the reconstruction of the health system. Its involvement since the assessment phase and its leadership and support for a comprehensive approach helped with the first steps towards reconstruction. As was the case with UNTAET, on one hand the process of procurement in the Bank was too rigid at times to deliver at the rapid pace required in a post-conflict situation. On the other hand, its approach was often too aggressive in forcing expenditure as a visible measure of achievement to report to the Trust Fund contributors when institutions and staff did not have enough absorptive capacity.

**Bilateral actors**

The main bilateral donors who had contributed aid by the end of 2001 were: Japan, with more that US$81 million in non-emergency aid; Portugal, with almost US$80 million; the European Union, more than US$65 million; Australia, US$45 million; the USA, US$43 million; and the UK, with almost US$16 million (La'o Hamutuk Bulletin 2001). Among all bilateral actors, Portugal was, despite not being the largest donor in financial terms, the most influential due to its historical relation with the emerging country and the political interest of the Portuguese government in responding to a very popular issue among its constituency.

**Issues faced by international aid actors**

The role of aid in post-conflict reconstruction is an essential one. Some of the dilemmas that international aid actors face during their interventions have been well identified and described in the literature. These are issues of legitimacy of the decision-making process, the sustainability of the rehabilitation work and the coherence of the intervention (Macrae 1997). In the case of East Timor, as in many other post-conflict settings, the three issues were interconnected. Widespread acceptance of the legitimacy of the decision-making process and the trust placed by external actors in local institutions constituted the base for a sustainable re-development of the system. The process of legitimization and trust is a circular one whereby local institutions grow in legitimacy as the international actors learn to trust them; and trust increases as legitimacy is established. Coherence is often tackled through appropriate coordination mechanisms. In East Timor, early implementation of a sector-wide approach (SWAp) (Cassels 1997) was the cornerstone for ensuring appropriate coordination and increasing legitimacy. It placed Timorese at the centre of the process, with the international actors supporting them with technical and financial assistance.

**Donor coordination**

During a joint donor multi-sector assessment mission led by the World Bank and supported by technical members of five donor countries, UN agencies, the European Commission and the Asian Development Bank, a general country assessment in November 1999 identified the overall needs for health sector rehabilitation. The findings
of an in-depth health facilities and service needs assessment done by the ETHPWG between December 1999 and January 2000 and a health-sector-specific Joint Donor Mission led by the World Bank and the IHA later in April 2000 resulted in the first Health Sector Rehabilitation and Development Programme (HSRDP I). The project aimed to restore access to basic services and to develop health policy and systems for the future (Tulloch et al. 2003).

The HSRDP I programme was funded through the Trust Fund for East Timor, which was established in June 2000 for an initial period of 3 years, through the pooling of US$12.7 million from several donor countries and organizations, and managed by the World Bank. A management unit for the HSRDP was established within the structure of the IHA to ensure its implementation as a programme rather than as multiple health projects. This was followed in mid-2001 by the HSRDP II, funded through a second phase of the Trust Fund for East Timor with an additional US$12.6 million. The objectives of this second programme were to support ongoing service delivery, improve their quality and scope, and to develop policy, regulations and administrative systems.

While it can be contended that all elements of a SWAp were not yet in-place, East Timor, with the support of its international partners, was perhaps the first country to adopt this approach with some success from the beginning of the post-conflict rehabilitation. This approach minimized duplication of efforts and facilitated targeting of funding towards priority health sector activities. Under coordination of the health authority, biannual Joint Donor Missions constituted the main forum for negotiation between donors and the government and an appropriate mechanism to monitor the progress.

NGOs as transitional health service providers

There is limited evidence in terms of effectiveness and equity about the adequacy of different alternatives for health care delivery in post-crisis settings. Historical background, politics and the overall environment and context in which the health system is to be rehabilitated are important determinants. In post-conflict Afghanistan, the government, supported by donors, decided to adopt a publicly funded and privately provided health service delivery option, relying on a performance-based partnership with NGOs under state regulation and monitoring (Strong et al. 2005). Factors influencing this choice were: variable or low levels of security and consequent low service accessibility to the population, the low trust of the population in the emerging state, societal fragmentation, poor infrastructure, and probably donor agendas, with a different spectrum of donors to those in East Timor.

The decision to use NGOs, almost all of which were international, as health service providers in East Timor during the first months after the violence of September 1999 was not part of a blueprint, but more the result of these organizations being in place at that time. Some of them entered East Timor in May 1999 when negotiations on the status of the province started between Indonesia and Portugal. Catholic missionary orders and other religious organizations were already working in the area. In September 1999, all NGOs left the country as security deteriorated. Immediately after the violence subsided, emergency NGOs entered or returned to East Timor. There was great variation in their resources and expertise, ranging from skilled and highly specialized to less experienced.

The contribution of NGOs from October 1999 to February 2000 greatly contained the negative health consequences of the crisis. During this phase, the main health care activities focused on the re-establishment of minimum primary care services, provision of drugs and organization of emergency referrals. The provision of safe water supply, sanitation, food and nutrition, shelter, control of communicable diseases and emergency immunizations all contributed to control mortality. NGOs were relatively autonomous in their operations and were able to work in remote areas under sometimes volatile security conditions. Their close collaboration with the emerging health authority and the strong commitment of their staff towards the health of the Timorese were important strengths that helped in the initial stages of the reconstruction.

After March 2000, when the emergency phase was declared over, some of the major emergency NGOs left the country. Following guidelines and standards from the health authority, each NGO then started to work on the definition of a plan for one district to which it was assigned. A memorandum of understanding between each NGO and the Division of Health Services (previously IHA) was signed between August and September 2000, by which each organization assumed the responsibility to implement the District Health Plan for one year.

East Timorese members of the IHA were eager to take control of the situation from NGOs as soon as possible. This determination was probably a reaction to their history of domination and disempowerment and their long struggle for independence from foreign powers. External technical assistance provided a temporary means to support policy implementation and complement decision-making capacity within the existing workforce. NGOs were accepted as temporary health service providers while the system’s capacity was being strengthened to deliver care using local human resources. The need to define a strategy to hand over the responsibility of district health services to the government was already on the IHA’s agenda by January 2001.

At that time, the lead author of this paper was commissioned to explore the role that NGOs were playing and the perception of that role among the local IHA members. This idea gained momentum after some internal meetings where discussions about the future strategies for the development of the MoH were held. Long-term development strategies were to be fully adopted in order...
to support a sustainable consolidation of the emerging health system. These discussions revealed the limited role that the existing NGOs could play in the new plans for health system development. Most NGOs in the country were specialized in emergency work, with limited capacity to adopt a developmental perspective. International staff working for these organizations were often inexperienced in issues related to health systems development.

Most NGOs were initially funded directly by the European Commission Humanitarian Office (ECHO). The decision by ECHO, on demand from the MoH, to shift funds and assume the responsibility for funding five of the NGOs, from April to September 2001, made Timorese senior managers in the IHA more aware about the opportunity cost of funding NGO operations and provided them with the power to take independent decisions in this regard.

The policy process

Planning during the first months after September 1999 was mainly through ad-hoc decisions by NGOs, either based on their previous experience and mandates, or through information gathered during coordination meetings. During the early months, decision-making by the new IHA used information produced by the different assessment missions, including those conducted by individual NGOs in the districts assigned to them. External consultants were commissioned to assess different areas of the health system: drug supply, possible financing strategies and hospital services configuration. Some of these consultancies contributed to decision-making, while a major limitation in others was that they often did not take into account the limited absorptive capacity of the system to implement their recommendations. Often limited Timorese interaction with consultants resulted in complex reports, poorly understood by local counterparts.

A formal policy formulation process was initiated in February 2001 so as to develop a comprehensive health policy framework for East Timor. A major challenge was to involve Timorese professionals who had little previous experience of policy and decision-making. Participation of actors external to the Ministry of Health in the definition of the policy framework was achieved through formal stakeholder consultations in February and May 2002. The process took 16 months, resulting in the publication of the first Health Policy Framework for East Timor in June 2002. The last chapter of the document dealt with policies for managing external aid, including NGOs.

A call for NGOs to work in close coordination with government institutions and follow priorities established by the MoH was included in this document (MoH 2002). However, the decision by the government to transfer responsibility for district health service provision from the international NGOs to the newly established health authority was made before the publication of the Health Policy Framework, and the document only reflected what had already been decided some months before. This decision encountered some resistance but essentially the driving factors overcame those of opposition (see Table 1).

Different actors had different interests around allowing NGOs to continue playing a major role as health service providers. NGOs, often with limited strategic vision, were reluctant to leave this role in the hands of the government, arguing lack of capacity in their local counterparts. Some bilateral donors directly funding NGOs had an interest in their continuation, as this often constituted an

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<th>Table 1. Facilitating and resisting factors for policy implementation</th>
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<td><strong>Facilitating factors</strong></td>
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<td>Early ‘timorization’ in the health system.</td>
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<td>The perception of senior management staff in the MoH that NGO costs were unjustifiably high, especially in their indirect costs.</td>
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<td>The belief among senior MoH staff, supported by a formal stakeholder analysis, that NGOs would have a limited role in the new district health system.</td>
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<td>The assumption of funding of several NGOs by the MoH in mid-2001, using the Trust Fund for East Timor, in place of direct donor funding.</td>
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<td>The willingness of most Timorese managers to assume responsibility for their districts.</td>
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<td>The burden of coordination of DHMTs, assumed by the MoH, was no more than that of coordinating NGOs.</td>
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<td>Completion of the recruitment process of civil servants including DHMTs. Initially, slow staff recruitment had a negative impact on the morale and credibility of the new administration (Tulloch et al. 2003).</td>
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<td>District level tensions, engendered by the presence of full-time expatriate staff once DHMTs had been formed, accelerated the change process.</td>
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excellent means for political visibility and increased accountability. Resistance to loss of control by multi-lateral actors was also evident during the months after the decision was made public. ECHO expressed hesitation about the new system being capable of delivering a minimum standard of care without the support of NGOs. The European organization thought that a longer and more gradual withdrawal process would have been a better option. Despite resistance from almost all quarters, the government held firm on its decision and implemented the new policy of timorization.

As a first step for the implementation of the new policy, the MoH, together with the NGOs, conducted an in-depth participatory assessment to identify areas where potential gaps could disrupt health service delivery after the NGOs withdrawal. Some of the areas identified were: availability of physicians, logistical support for outreach activities, pharmacy management and drug distribution, ambulance services, communications and information systems.

The process of phasing-out of NGOs and phasing-in of government means was continuously monitored through periodical on-site assessments using tools specifically developed for this purpose (follow-up matrix). Phasing-in of the MoH’s inputs was done in a coordinated way, to ensure timely overlap with the withdrawal of NGO support.

The MoH recruited physicians through international competitive procurement procedures. Specialists were allocated to hospitals and general practitioners were based in district facilities. At least one car was allocated to each district and motorcycles were distributed to every facility responsible for outreach activities. The referral system was supported by provision of a fleet of ambulances staffed with trained drivers and nurses. An essential element of the new referral and communication system was the establishment of a radio network covering all district and sub-district facilities, ambulances, referral hospitals, central medical stores and central MoH structures.

After the emergency phase, in which drug and medical supply was managed by an NGO and later by the IHA, the establishment of an autonomous medical supply system to ensure regular and efficient purchase, storage and distribution was initiated. The aim was to establish a self-sustaining, non-profit entity operating on commercial principles, managed by Timorese under a board of directors composed of representatives of the MoH, Ministry of Finances, private business sector, civil society and church. National supply of drugs was fully assumed by this system after the withdrawal of NGOs.

Information provided by the ‘health service monitoring system’ on a quarterly basis was also used to assess the impact on service delivery and health care coverage of the new strategy during and after the complete withdrawal of NGOs in December 2001.

One of the main problems faced by the new health system was the low capacity of the staff in managerial positions at district level. As a short-term strategy for capacity building, all DHMTs were provided with basic training in health management by the School of Health Services Management of the University of New South Wales, Australia, funded and supported by WHO. For longer term managerial support, an innovative mentoring programme was introduced: five public health specialists with field experience in the area of district health management were recruited through international competitive procedures, each to be responsible for mentoring DHMTs in several districts. The rationale was that part-time technical support would stimulate assumption of responsibilities by the DHMTs, whereas full-time presence of often non-specialist expatriate staff in districts was believed to have hindered the development of DHMTs during the NGO period. It also enabled greater attention to specific areas where DHMTs were experiencing difficulties. The initial benefits were reflected in the second round of annual district health plans (the first having been prepared by NGOs with limited local participation), based on situation analyses prepared by the newly formed DHMTs with the support of the mentoring team. A thorough problem identification and needs assessment was undertaken in every district. Results from this assessment, together with information from the existing health service activity monitoring system, constituted the basis for the second district health plans.

Together with the decision to discontinue the role of NGOs as service providers, the government issued, in December 2001, a policy document containing the MoH’s preferred future role for NGOs, as well as areas in which their support was still required. A new procedure to assess NGO proposals at the MoH was established, with a committee created for this purpose. Assessment criteria were agreed, including project relevance, sustainability, technical and financial feasibility. Proposals were requested to be in accordance with principles underpinning the MoH’s mission, such as equity, gender and cultural sensitivity.

Impact on the health system
After the first years of reconstruction, East Timor remained one of the poorest countries in the world, with 46% of rural dwellers and 26% of urban dwellers having an income below the national poverty line established at US$0.55 per person per day (UNDP 2002). In a late 2002 survey conducted by UNICEF, about 12% of children under the age of five were found to be moderately or severely wasted, 47% stunted and 43% underweight (UNICEF-ET 2003). The same survey revealed that only
5% of children between 12 and 23 months of age were fully immunized. According to the Human Development Report 2004, life expectancy at birth is 49.3 years, the adult literacy rate (older than 15 years of age) is 58.6% and the total fertility rate is 3.8 children per woman (UNDP 2004).

While East Timor’s district health system was still at an early stage of development, some evidence of impact, mainly positive, was already evident in its early years (see Figure 1). This included an incremental growth in service utilization in 2001 that was maintained and sometimes accelerated during 2002 after withdrawal of NGOs. Service utilization, while still low compared with other developing countries, continued to grow in outpatient, inpatient and maternity services attendance; while the performance of the immunization programme improved, as shown by a continued decrease in drop-out rates between DPT antigen 1 and 3.

Further judgements on the impact of the new policy adopted are still subjective, pending systematic evaluations and the availability of data produced by the health management information system, currently being implemented. However, increases in efficiency are plausible, given the sustained growth in health service outputs and the belief, which needs to be substantiated, that the new strategy was less costly than individual NGO-supported activities. Consolidation of district financial management processes into one structure, in place of fragmented individual NGO systems, also helped to increase efficiency. Gains in geographical equality are likely to have occurred, through standardizing of health services and provision of the same basic package of care throughout the country, in place of different standards depending on the different levels of performance due to the specific background, experience and resources of individual NGOs. Workforce motivation is believed to have increased, through MoH-managed DHMTs taking responsibility, following decades of control by external actors. The Timorese for the first time had taken control of their own destiny. Strengthening of stewardship in the system is likely to have led to increased system responsiveness.

**Figure 1. Health service output indicators (East Timor Ministry of Health, unpublished)**
Despite these improvements, the introduction of changes may initially have created some gaps, which the system needed to adapt and correct in order to benefit fully from the new approach. The system was initially benefiting from resources that were not sustainable in the long run, including external logistic support and technical expertise in specific areas like logistics, water or sanitation. Adaptation to a leaner and probably less costly system resulted in a temporary reduction in some activities. There were disruptions in the drug supply, as the development of the autonomous medical supply system took time to implement fully. Some districts reported interruption in the supply of some essential drugs for two or more consecutive weeks. Reasons included logistical weaknesses and gaps in the management system at the central medical stores and facility level. These problems gradually declined during 2002, with five districts reporting problems at the end of 2001 and only two at the end of 2002.

The presence of NGOs provided a form of control – but also disempowerment – over the performance of the health staff. District level staff disciplinary problems were often detected and reported to the central level by NGOs. After implementation of the new policy, sporadic supervisory visits by managers from the central level to the districts revealed persistent problems of low staff attendance in some facilities, especially in outlying areas. Initial delays in reporting of epidemiological and service activity information from peripheral to district and central levels resulted in lower response capacity during the months immediately after the NGOs withdrawal. Increased capacity and the development of a radio information system helped to improve this area, as demonstrated when a measles outbreak was detected early and controlled in Ermera District in mid-2002. Full implementation of the health information system will help to consolidate surveillance and monitoring at both district and central levels.

Discussion

NGOs, having played an important role during the emergency post-conflict phase, had a time-limited contribution to further support the development of the system. Given their limitations, they could have hindered the assumption of responsibilities by local actors if allowed to remain for longer in that capacity. In many respects, the model of post-conflict health systems rehabilitation in East Timor has been, in its initial phase, remarkably successful. However, the experience of East Timor’s health system rehabilitation should be viewed cautiously when trying to transfer lessons learned to other similar settings. Favourable preconditions existed before the reconstruction, including widespread recognition of the legitimacy of the transitional administration, social cohesion within the state, small size of the country, and coordination facilitated by a high level of consensus among all actors. Such positive preconditions are often not present in other post-conflict situations.

A major obstacle to report on the East Timor rehabilitation experience – and hence a limitation in this study – has been the scarcity of published evidence. Participant observation (by one of the authors) and internal documents that could not be directly cited, which form the bulk of the findings reported in this paper, are together – we believe – a valid source of evidence. They have formed the basis of the policy analysis, which focused on the roles of the different actors and provided a framework for understanding the complex processes of post-conflict health systems development.

An important study bias is that the lead author was a participant, rather than a disinterested and neutral observer, in the rehabilitation process. While no longer having an affiliation with any of the main stakeholder institutions, the interpretations and level of importance given to events are inevitably coloured. This study, therefore, is not a substitute for an independent external analysis of the rehabilitation processes, which should include primary data collection and analysis, open access to secondary source material, as well as interviews with the key players. However, in justification, participants who have been involved in policy processes are likely to have insights not readily available to external commentators years after events have begun to unfold. Also, rapidly evolving contexts are not easily captured, some years later; and international agencies and other major stakeholders involved in post-conflict rehabilitation often place a low priority on, or may even place obstacles in the way of, public dissemination of lessons learned.

Contextual analysis suggests that there were many factors that predisposed positively to post-conflict health system rehabilitation, which distinguish East Timor from less favourable settings. Once the colonial power agreed to withdraw (under pressure from the international community), a broadly accepted indigenous political authority rapidly emerged, which was contested for only a limited period through externally fomented violence. Important lessons have emerged, notably regarding the positive role of the donors and multilateral agencies in promoting a rapid shift of responsibility and decision-making power from NGOs to the government; and a series of decisions and capacity-building measures adopted by government, with the support of international agencies. A less obvious but noteworthy factor that set the ground for an indigenous, district health systems approach was the 1999 Melbourne meeting of future policy-makers, 5 months prior to the violent upsurge, and the resultant formation of a group of Timorese health professionals willing to assume responsibility for the future development of a health system for East Timor.

The external actors – UN agencies, donors and NGOs – and the nascent East Timorese leadership can all be credited for their contribution to the rapid transition from relief to development, and to the birth of an indigenous health system. The early definition of a phase-out strategy and close monitoring of its implementation were
important for the success of the policy, as they allowed the government of East Timor to detect areas of potential risk after the withdrawal of NGOs. For some NGOs, among those who chose to remain after the end of the emergency phase in early 2000, the enforced phasing out of their role may have been a painful experience. However, the way it was managed has helped clarify the transient role for NGOs in some post-conflict settings. Equally important was the decision by the MoH to recruit experienced district health specialists to provide technical support and build the capacity of the locally recruited DHMTs to take responsibility for planning and managing district health services.

**Conclusion**

This paper describes and analyzes the evolution of policy-making and the initial phase of implementation of a district health system in post-conflict East Timor. Post-conflict rehabilitation and the process of establishing a sustainable health system can be a more complex challenge than is health systems development in stable settings, not least because of the plethora of external actors including UN agencies, multilateral and bilateral donors; and frequently, a large number of different NGOs with different levels of expertise and resources. Unlike many other settings, where civil strife and contention of rival ethnic and political groupings for power are an obstacle to rehabilitation, East Timor has been a fertile setting for showing how it can be done in a more cohesive environment. Those who have been centrally involved have succeeded in contributing to a remarkably seamless transition from conflict to relief, to development, committed to a process that enabled the East Timorese to become the owners and controllers of their health system.

**References**


Acknowledgements

We would like to thank Professor Gill Walt for her comments on this manuscript. This article represents the viewpoints of the authors alone, not those of the Ministry of Health or other institutions involved in East Timor.

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