DEVELOPMENT AND IMPLEMENTATION OF TIMOR-LESTE HEALTH POLICY FRAMEWORK 2002: A GOVERNANCE ANALYSIS

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ABSTRACT

This thesis examines the role of the central and local administration (the Ministry of Health and District Health Service) and their development partners who are tasked with the implementation of health services with the attendant relevant health policies within the bounds of the Timor-Leste’s Health Policy Framework 2002. This study explores and analyzes how health policy actors, decision makers and implementers engage with policy processes and elements of governance. The elements include: structure, power, equity, ethics, cooperation, responsiveness, transparency, accountability, effectiveness and efficiency, and participation.

The research explores structures and processes that are in place, the way they operate, and their legitimacy. It compares these arrangements in two districts, where one district has good performance and one district has poor performance in terms of achieving Ministry of Health identified health indicators and objectives. The study identifies that these elements of governance are essential to strengthen local health governance and to improve the health status and well-being of the Timorese people.

The overall design of this study followed mixed-methods, qualitative and quantitative approaches with case studies. NVIVO 8 computer software program was used to facilitate data analysis and assist with interpretation. It was identified that the two districts have similarities and differences in history and experience of governance, as well as geography, demography, socio-economic and human capital background. These have contributed to differences in performance and differences in the achievement of health indicators and objectives. It was found that the development of health policies and procedures was dominated by those with power, including donors and leaders of the political parties, which disempowered the local administration and communities. Lack of responsiveness on the part of the central and local administration and partners is the foremost concern of both districts. This lack of responsiveness jeopardizes the implementation of health programs.

Key words: health policy process, system and governance
Figure 1: Map of Timor-Leste. Source: [http://upload.wikimedia.org/wikipedia/commons/7/7/d/Un-timor-leste.pmg](http://upload.wikimedia.org/wikipedia/commons/7/7/d/Un-timor-leste.pmg) (accessed 9/09/09)
DECLARATION

I hereby declare that the work herein, now submitted as a thesis for the degree of Doctor of Philosophy at Charles Darwin University is the result of my own investigations, and all references to ideas and work of other researchers have been specifically acknowledged. I hereby certify that the work embodied in this thesis has not already been accepted in substance for any degree, and is not currently being submitted in candidature for any other degree.

Signature of the candidate: __________________  Date: __________

Ana Isabel de Fátima Sousa Soares
DEDICATION

This thesis is dedicated to the memory of my parents, João Mateus da Costa Soares and Úrsula de Jesus da Silva e Sousa Soares. My parents instilled in me the values of the Catholic religion, hard work, good attitude, honesty, firmness and courage, unity of the family, loyalty to culture, service to humanity, and the importance of education. They worked hard to support their eight children and spared no effort to provide the best possible environment for us. They fostered connections among all our families, and encouraged us to respect and love each other, collaborate with and take part in Catholic Church events and attend school.

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ABBREVIATIONS

4WD – Four Wheel Drive
ADB – Asian Development Bank
AIDS - Acquired Immune Deficiency Syndrome
AMP – Aliança Maioria Parlamentar
ANC – Ante Natal Care
ASDT - Associação Social Democrática Timorese
BEOC – Basic Emergency Obstetric Care
BSP – Basic Service Package
CCT - Clinic Café Timor
CCV - Centro Celebração da Vida
CDTL - Constitution of the Democratic of Timor-Leste
CHC - Community Health Centre
CNRT - Conselho Nacional de Reconstrução do Timor
CNRT - Conselho Nacional de Resistência Timorense
CPD-RDTL - Conselho Popular pela Defesa da República Democrática de Timor-Leste
CSO – Civil Society Organization
DHC - District Health Centre
DHMT - District Health Management Teams
DHP - District Health Plan
DHS – District Health Service
DOTS – Directly Observed Treatment Short-Course
DPHO - District Public Health Officer
DPT3 - Three Doses of the combined Diphtheria/ Pertussis/ Tetanus Vaccine
MDG - Millennium Development Goals
MMR - Maternal Mortality Rate
MoH - Ministry of Health
MoJ - Ministry of Justice
MoSS - Ministry of Social Solidarity
MoU - Memorandum of Understanding
MSATM - Ministry of State Administration and Territorial Management
NCHET - National Centre for Health Education and Training
NDP - National Development Plan
NGO - Non Governmental Organization
NHS - National Health System
PD - Partido Democrático
PDC - Pastoral das Crianças
PHC - Primary Health Care
PMTCT - Prevention of Mother to Child Transmission
PMU - Project Management Unit
PSD - Partido Social Democrata
PSF - Promotor Saude Familian Nian
RDTL – República Democrática de Timor-Leste
RTL - Rádio de Timor-Leste
RTP – Rádio e Televisão de Portugal
SAMES - Servico Autonomo de Medicamentos e Equipamentos de Saude
SDHC - Sub-District Health Centre
SISCa - Serviço Integraddo da Saude Communitária
SMS – Short Message Service
SPK - Sekolah Perawat Kesehatan
SSPGE - Secretary of State for the Promotion of Gender Equality

STD – Sexual Transmission Disease

TB - Tuberculosis

TLHPF - Timor-Leste Health Policy Framework

TT - Tetanus Toxoid

TVTL - Televisão de Timor-Leste

UDT - União Democrática Timorense or Timorese Democratic Union

UN – United Nations

UNDERTIM - União Nacional Democrática de Resistência Timorense

UNDP – United Nations Development Program

UNFPA - United Nations Fund for Population Activities

UNICEF - United Nations International Children’s Fund

UNTAET - United Nations Transitional Authority in East Timor

UNTL - Universidade Nacional Timor-Leste

USAID - United States Agency for International Development

VCT - Voluntary Counselling Test

VIP – Very Important Person/ People

WFP - World Food Program

WHO - World Health Organization
CHAPTER 1: INTRODUCTION

This study addresses the development and implementation of the Timor-Leste’s Health Policy Framework 2002 (TLHPF). It explores the role of the government and Ministry of Health, as well as the operational staff in the districts who are tasked with the implementation of health policies and services within the bounds of the Health Policy Framework.

The research recognises that improving the health status of the people of Timor-Leste has the highest level of priority for the Government of Timor-Leste, with many of the determinants of health and well-being lying within the responsibilities of the different sectors of government. The improvement of the health and well-being of the Timorese involves an inter-sectoral approach to governance that is sensitive to the history, geography, physical settings, ethnic diversity and colonisation of Timor-Leste. The resilience of the Timorese, evident in their experience and history, plays a crucial part in the processes of governance.

CONTEXT: TIMOR-LESTE AS A POST-CONFLICT STATE IN TRANSITION

Timor-Leste is a fragile, post conflict state, which like other such states, faces the ongoing task of preventing violent conflict while reconstructing the capacity of the society to solve conflict without the use of force. The essence of post conflict peace-building involves political responsibility, including development cooperation, humanitarian assistance, protection of human rights, institution building and ensuring security. International development agencies have programs for assisting and supporting post-conflict transitions, socio-economic rehabilitation, and humanitarian and emergency responses (Brinkerhoff, 2010). These programs were relevant in Timor-Leste especially from 1999 to 2002, but also thereafter until the UN force terminated its mission in December 2012.

Kauzya (2007) recognises that international assistance for post conflict and fragile societies is transitory. The “New Deal for Engagement in Fragile States” appreciates that transition is not without ongoing fragility (International Dialogue on
Peacebuilding and Statebuilding, 2012). In this regard, it is significant that violence erupted in Timor-Leste in late April and May 2006 when the UN Office in Timor-Leste was initially scheduled to end. This threw the state into a crisis during 2006 and 2007 that shock the foundation of the new nation. The crisis revealed a number of fundamental weaknesses in the Timorese state, including deep divisions among the nation’s senior political leaders, critical institutional weaknesses and rivalries as manifested in the police and military, a propensity for violence among some elements of the population (particularly young, unemployed males), and the mobilization and amplification of regional differences (Brady & Timberman, 2006).

The crisis required international intervention and support.

Government is the key focus of capacity building by international agencies because the state’s authority is usually weak (Debiel & Terlinden, 2005). The government often lacks legitimacy by failing to provide security and other essential public services such as health and education. Accordingly, international agencies seek to enhance the knowledge and skills of the local military, police and other public officials during the transitional phase as a basis for fostering and maintaining reconstruction. Eventually, local officials have to demonstrate their capability to take over and administer programs to rebuild society independently of international assistance and support and with a clear focus on reducing capacity deficits and overcoming the lack of trust by citizens (Brinkerhoff, 2010). Public service values such as impartiality, transparency, accountability, integrity and dedication to serving the public effectively and efficiently are crucial elements of governance that need high consideration by international agencies and national governments in the transitional phase to avoid re-emerging conflict and violence (Debiel & Terlinden, 2005; International Dialogue on Peacebuilding and Statebuilding, 2012; Kauzya, 2007). These values are particularly relevant in Timor-Leste as policies and programs are developed and implemented across the whole range of public services, with health services being one of the most essential areas of need and concern.
RESEARCH FOCUS, OBJECTIVES AND QUESTIONS

Research focus

This study recognises that the TLHPF 2002 created a system designed to improve health services delivery in Timor-Leste, but that progress has been slow, such that nine years later in 2011 many things remain to be done and achieved for the framework to be fully implemented effectively and efficiently. The reasons for the lack of progress need to be addressed and responded to in the historical, cultural and political context within which health policies and services are framed and delivered. Hence, the importance of this study as a basis for identifying where developments have enhanced the health and well-being of the community, while also appreciating where new or adjusted policies, programs and action are still required for progress to be better than it has been to-date.

Research objectives

In accordance with the focus, the objectives of the study are:

1. To investigate the significance of governance and power in relation to the development and implementation of health policies, structures and processes in Timor-Leste as prescribed in the TLHPF 2002; and

2. To analyse the significance of health governance and policies in terms of the delivery of health services in Timor-Leste, with particular reference to;
   a) the structures and processes that have been established, and
   b) the extent to which the structures and processes have enabled the delivery of health services and the achievement of health outcomes in practice.

Research questions

The research questions, in accordance with the objectives of the study, recognize that the development, implementation and impact of policies are essential
components of governance, as addressed in the overview of the analytical framework and expanded on in Chapter Two. The questions are:

1. On what bases was the TLHPF 2002 developed – including, what were the drivers, who were involved, and what factors were central to their deliberations?

2. On what bases has the TLHPF 2002 been implemented – including, what strategies have been adopted, what barriers have been encountered, and what has been done in seeking to overcome these barriers?

3. What have been the results of the development and implementation of the TLHPF 2002 – including, what governance structures and processes have been established, how has legitimate power been distributed and exercised, and what improvements have been made in the health and well-being of the community?

These questions are significant because governance, policy and service delivery should ensure that health services are equally available to all people, without discrimination on the basis of gender, age, and place of residence or socio-economic status. Access to health services in Timor-Leste is a basic human right of every citizen, as documented in the Constitution of the Democratic of Timor-Leste (CDTL) sections: 57.1 and section: 57.2:

The State shall promote the establishment of a national health service that is universal and general. The National Health Service shall be free of charge in accordance with the possibilities of the State and in conformity with the law (Democratic Republic of Timor-Leste, 2002a).

**OVERVIEW OF THE ANALYTICAL FRAMEWORK AND METHODOLOGY**

The analytical framework and methodology are addressed in detail in Chapter Two and Chapter Three, respectively. Health governance and policy are studied
using an exploratory analytical framework that addresses governance definitions, concepts and ideas; policy structures and processes; and the nature and significance of health governance, power and policy. These matters are all interrelated. They begin with the broad notion of governance, leading to an appreciation of policy and a more specific consideration of health governance and policy.

Governance definitions, concepts and ideas are addressed with reference to the dynamics of public policy. The elements of governance include structure, power, equity, ethics, cooperation, responsiveness, transparency, accountability, effectiveness, efficiency and participation.

Broad notions of governance lead into a more specific appreciation of power and policy in relation to health policy. This approach recognises three interrelated aspects of policy structures and processes, namely their establishment, their operation, and the bases of their legitimacy.

The analytical framework is used to guide and inform an analysis of the development and implementation of the Timor-Leste Health Policy Framework 2002, with particular references to health governance and policy in relation to the delivery of health services in Timor-Leste.

Methodological approaches used in this study include mixed methods of exploration involving qualitative and quantitative data collection and analysis, with particular emphasis on qualitative data and information obtained through case studies. Data was collected in two districts, one referral hospital, one national hospital, and the offices of Ministry of Health and its partners. NVIVO 8 software program was used to facilitate management and data analysis. Quantitative data was collected from the Ministry of Health 2009 Health Statistics and analysed in order to compare the selected districts in terms of their geographic, demographic and health circumstances. The fieldwork was conducted in two phases: phase 1 was the scoping phase and phase 2 was the interactive phase. Ethical considerations were significant and appropriately addressed.
CHAPTER OUTLINE

This thesis is divided into nine chapters. This first chapter provides an introduction to the study. An analytical framework with an emphasis on elements of governance, power and policy is established in the second chapter. The third chapter presents the methodology used in this research, including data collection and analysis techniques. The fourth chapter describes Timor-Leste society and governance, providing the social and economic profile of the country, the cultural and historical context, the political and administrative structure, and the health system in Timor-Leste during three historical periods. The fifth chapter describes Timor-Leste’s Health Policy Framework 2002. This leads into a detailed analysis of data and related findings from the case studies of the two districts in chapters six and seven. A comparison and contrast of health governance and service delivery in these two districts are presented in chapter eight. The last chapter highlights the main findings and provides recommendations and suggestions for further research.
CHAPTER 2: ANALYTICAL FRAMEWORK

INTRODUCTION

This thesis addresses governance and policy in the context of health policy development and implementation in Timor-Leste. The emphasis is on the role of government at the national and district levels. The study addresses elements of governance, power and policy in terms of structure, power, equity, ethics, cooperation, responsiveness, transparency, accountability, effectiveness and efficiency and participation. These elements are all interrelated and are used to develop an analytical framework to guide and inform the empirical analysis in subsequent chapters.

The development and implementation of health policies in Timor-Leste are studied in terms of this analytical framework. Governance definitions, concepts and ideas are addressed with reference to power and policy. Broad notions of governance lead into a more specific appreciation of the structures and processes of health policy and service delivery.

The framework is more exploratory than explanatory. It draws on an array of literature on governance, power and policy both in general and more specifically in relation to health services. The aim is not to critique the literature, but rather to bring together key elements of it that have particular relevance to governance and policy dynamics. The elements are addressed in such a way as to establish a comprehensive and integrated lens through which to explore and assess important aspects of health governance, policy and service delivery in Timor-Leste.
GOVERNANCE: DEFINITIONS AND CONCEPTS

Definitions of governance

Definitions and interpretations of governance are quite indistinct. Most international organizations and bilateral agencies have developed their own definitions of governance. Therefore, it is important to understand and consider definitions and concepts of governance before examining particular aspects of governance, policy and service delivery.

Governance is often used without presenting a logical underpinning for the word, and without conceptual rigor. It is probable that people who use the word in their speeches or writings know what they mean by governance, but prefer not to explain it because they assume that all attendants know the intended meaning. People who use the word governance to mean public administration may appreciate the emotive power of the word but may not have given serious consideration to its fundamental meaning (Committee of Experts on Public Administration, 2006). The first and most evident meaning of governance in the public sphere is that it describes a wide range of organizations and institutions that are linked together and engaged in public activities (Committee of Experts on Public Administration, 2006; Organization for Economic Co-operation and Development, 2001). Western governance structures and processes were introduced to developing countries by the World Bank, donor agencies and agencies of civil society, as part of capacity building (Committee of Experts on Public Administration, 2006). The aim of this was to support policy reform, to increase good governance and decrease poor administration. The aim was also to strengthen the processes of decision-making and implementation, and to improve access to quality public services. This was done by developing government capacity for measuring and mapping governance challenges within the public sector; conducting public affairs; and managing public resources.

Governance is the exercise of political, economic and administrative authority to manage a nation's affairs. It is the range of complex mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights and obligations, and mediate their differences (United Nations Development Programme, 1997). Significant ideas are that:
Governance is the manner in which power is exercised in the management of a country’s social and economic resources for development (Asian Development Bank, 1997, p. 1);

Governance is … the traditions and institutions by which authority in a country is exercised for the common good. This includes (i) the form of political regime; (ii) the process by which authority is exercised in the management of a country’s economic and social resources for development; and (iii) the capacity of governments to design, formulate and implement policies and discharge functions (World Bank, 1996, p. 1);

Governance … encompasses the role of public authorities in establishing the environment in which economic operators function and in determining the distribution of benefits as well as the relationship between the ruler and the ruled (Organisation for Economic Co-operation and Development, 2009, www.oecd.org/dac/);

Governance is … the manner in which public officials and institutions acquire and exercise authority to shape public policy and provide public good services (World Bank, 2007, p.i, para.3); and

Governance is the application of rules and processes through which authority and control are exercised in a society, political decisions are made the rules for the scope of action of state and society are structured, and resources for economic and social development are administered (Debiel & Terlinden 2005, p. 3).

While there are many definitions of governance, central to all of them is the distribution, exercise and efficacy of power. In this study governance is a key determinant of economic growth, social improvement, and the system of managing the development process involving the power of government to formulate and implement policies. Governance covers power and decision making in and through institutions and organizations. Governance also includes the active cooperation and engagement in policy processes by numerous stakeholders, including citizens. There is also people centred governance, which can be characterized as a partnership between government and society in which consultation is a key issue.
In post-conflict developing countries, there is a need for a strong state to underpin the competence of the governing authority (Rondinelli, 2006). This is necessary not just to provide security, protect human rights, and generate economic development, but also to extend basic services, control corruption, respond effectively to emergencies, and combat poverty and inequality. Experience in some developing and post-conflict countries shows that the most important requirements are political stability, legitimacy, respect for law, and the reinforcement of the legislative, executive and judicial systems (Rondinelli, 2006). The crucial requirement is to build and rebuild governance to form, or to make stronger, mechanisms for widespread participation in governance and public decision-making. This is essential to fulfil community needs and basic functions, to ensure credible governance, and to foster and sustain trust, peace and development (Agborsangaya-Fiteu, 2009; Brinkerhoff, 2010; Debiel & Terlinden, 2005; Grindle, M, 2007).

**Governance concepts**

There are different ways of thinking about the concept of governance. Governance can be used descriptively or prescriptively (Doornbos, 2003) as a broad set of interrelated concepts and ideas that delineate areas of concern within policy systems and processes. One of the original intentions of the good governance agenda was to enable donors to question the systems and processes of aid recipient countries and to get them to make adjustments according to universal criteria and conditions established by the donors. The idea was ultimately to try to transform what donors perceived as ‘bad governance’ into ‘good governance’ (Doornbos, 2003). Often though, the way to achieve ‘good governance’ is not articulated. Governments were not always provided with clear guidance about, for example, how they should structure their policy making processes, which policy initiatives should be a priority, and how they should handle any issues that arise (Doornbos, 2003).

Pierre and Peters (2000) identify that the concept of governance is very broad. Aspects of governance, and concepts central to an understanding thereof, include hierarchies, markets, networks, communities and processes. In addition, each of these components has sub components. For example, social interaction is a sub component of community, and market control is a sub component market.
Hierarchy is a mechanism for facilitating communication between organizational and functional structures within systems (Pierre & Peters, 2000). The processes involved may vary according to internal rules and regulations (Pierre & Peters, 2000). They can be applied vertically within integrated structures and also horizontally through means of coordination. They allow the implementation of policies to achieve organizational interests, while being bound by rules and regulations. The critics of bureaucracy suggest these processes remain too subordinated to a single decision maker or makers within an organization. Hierarchy is a vast and complex concept with implications for the regulation of a variety of economic resources and political actions (Pierre & Peters, 2000).

Market regulations refer to how interactions between economic actors are oriented and coordinated (Pierre & Peters, 2000). They concern well-created economic activities and cooperation between actors in order to provide goods and services. It is well understood that market actors for governance are not new. Governments have often used market actors to govern when they could not govern themselves. Historical examples include Britain’s use of companies to govern India, Canada and the East Indies (Peters, 2010). There are also examples of governments ceding authority to markets in implementing projects in a manner perceived to be more efficient and effective, and of governments involving major private actors in strategic planning in the public sector (Peters, 2010).

Pierre and Peters (2000) point out the difference between markets as a governance mechanism and the governance of markets. Markets as a governance mechanism describes demand and supply processes and procedures, whereas the governance of markets is about coordination between companies and other institutions in controlling market products in terms of demand and supply.

Networks consist of a wide range of interconnected systems working collaboratively for a common outcome. Governance as networks comprises a number of main and supplementary actors (Pierre & Peters, 2000). They create and share ideas (Rogers, 1995). Policies are generally developed for the collective interest of a wide array of actors and implemented to deal with complex and interconnected issues using existing resources. Issues may vary from the simplest to the very complex. The policy process facilitates interactions between government bureaucracies and the general public involving the market and civil society to
accomplish government objectives. Governance has increasingly comprised networks of actors to develop and implement government policies in response to the public interest.

Governance as community is a key pillar of good governance (Pierre & Peters, 2000). It is a complex phenomenon. Governments need to give more attention to the power of community actors and structures. The interaction between governments and communities is frequently and sensibly driven by local social, economic and political pressures.

Although community governance may be built up from simple ideas and consensus, it has considerably high value in the decision making process because it is practiced by communities (Pierre & Peters, 2000). It is acknowledged that the community as a regulator and facilitator of public action requires intensive support from the state to be truly empowered in the process of reallocating resources to the benefit of the people.

Anthropology is a key aspect that should apply in community development, as well as being a support to changing perceptions of the role of the development process concerning culture and norms (Panayiotopoulos, 2002). It involves participatory practices that aim to ensure community empowerment and reduce poverty, particularly in developing countries. Booth (1994) records that the spreading out of international NGOs in development in the 1980s and 1990s generated significant change in community development systems (Booth, 1994). Experience in the 1980s shows that conservative community development practices that linked state and donors were confronted by a new market-led orthodoxy (Panayiotopoulos, 2002). In essence, communities are a valuable component of governance because most social, cultural and economic issues emerge from communities (Panayiotopoulos, 2002).

Governance as process is related to strategies to achieve organizational objectives (Panayiotopoulos, 2002). Governance processes are essential for ensuring all the components of governance are working within a system and are guided and synchronized to achieve common purposes (Panayiotopoulos, 2002). Processes increasingly comprise means of policy consultation requiring public participation in which engagement is predicted to minimize contradictions and misunderstanding in the development and implementation of policies (Panayiotopoulos, 2002).
Governance can take place at various levels including international governance, national governance and local governance (Thynne, 2000). One of the actors in governance is government, but governance is not the business of government alone. The actors involved in governance change depending on the level of government. For example, in a rural area the actors could include influential landlords, NGOs, research institutions, religious leaders, political parties, and the military. In all areas, the media, donor agencies, powerful (and/or corrupt) families other entities can influence decision-making or can play a role in the decision making process.

The World Health Organization Regional Office for Europe has introduced governance for health in the 21st century through a “whole of government” and a “whole of society” approach (figure 2). This is known as “smart governance for health and well-being” (World Health Organization Regional Office for Europe, 2011). Countries in Europe and other parts of the world are practicing it. Smart governance for health and well-being comprises five aspects: collaboration; engagement; a mixture of regulation and persuasion; independent agencies and expert bodies; and adaptive policies, resilient structures and foresight (World Health Organization Regional Office for Europe, 2011). These reveal how governments address health challenges strategically, and society chooses and decides to engage when, and how they are working together. Smart governance for health and well-being aims to promote joint action on health among different groups including civil society organizations, communities and the private sector (World Health Organization Regional Office for Europe, 2011).
Figure 2: Smart Governance for health and well-being
Source: WHO 2011

How people construct health in terms of their everyday lives requires a new perspective on governance aimed at enhancing health and well-being. Figure 2 shows that smart governance for health comprises contextual drivers of change, interdependence among interest groups, and co-production involving the state and society in addressing health needs (World Health Organization Regional Office for
Europe, 2011). It requires the dynamic altering of health governance to make it collaborative rather than state-centred. Fundamentally, it is based on democratic principles, public accessibility and shared values, with health being considered a human right, a key component of well-being, a global public good, and an issue of social justice and equity (World Health Organization Regional Office for Europe, 2011).

Smart governance is identified by Nye as relating to ‘smart power’, which has a combination of hard power and soft power of the persuasion and attraction (Nye Jr, 2011). For example, hard power uses military intervention and economic sanctions, whereas soft power uses diplomacy, economic assistance and communication. The concept of smart power includes evaluation. World Health Organization Regional Office for Europe (2011) argues smart governance for health and well-being recognised that states are engaged in numerous interactions with societal actors using both hard and soft power as central resources of governance.

GOVERNANCE AND POWER

Concept of power

Power is one of the fundamental issues in any study of human relations, particularly in government and governance. Scholars have long debated the nature and processes of power, with several definitions of power being addressed.

The Merriam-Webster's Dictionary defines power as “the ability to act or produce an effect; legal or official authority, capacity or right; possession of control, authority or influence over others” (Merriam-Webster's Online Dictionary, 2010). As defined by (Thynne & Goldring, 1987), “power is the capacity of a person or persons (A) to achieve a result, normally a desired result, in the form of action or inaction on the part of another person or others persons (B)” (p.2). Dahl (1957) argues “A has power over B to the extent that he can get B to do something that B would not otherwise do” (p. 2). The basic interpretation is that power involves an unequal connection of reliance between the object and the subject of power in human relationships.
Power depends on certain preconditions: the presence of personal capacities such as health, strength, knowledge and skill; the possession of material resources; and space or scope in the sense of freedom from control (Beetham, 1991). Beetham appreciates that these preconditions are interrelated, with legitimacy based on rules, shared beliefs and consent being particularly important.

In essence, the exercise of power can range from passive influence, through the manipulation of people’s interests and preferences, to active forms of domination, with varying levels of acceptance (e.g., Lukes, 1974; Ham, & Hill, 1984). Often, events occur in which people act in a way which is not in favour of their interest. There is also the possibility of poorly informed or misconceived consent affecting the decision making process (Dahl, 1957; Ham & Hill, 1984).

The nature of power, public administration and policy processes in developing countries has been influenced particularly by international factors (Turner & Hulme, 1997). These factors have involved the activity of colonial powers, with power vested in the hands of a small number of people - usually a white elite; the functions or operational systems of international development agencies - such as the World Bank and the United Nations agencies; the promotion of market forces; and, in the last two to three decades, various forms of privatization (Turner & Hulme, 1997).

**Power and elements of governance**

Power underpins the various elements of governance that assist and guide how structures and processes of government are arranged and operate in a state. Power as the capacity to act and as the right to act are exercised by politicians and officials undertaking work within and through institutions and organizations. Citizens are influenced by the policies and regulations that governments formulate and implement. Governments provide and control public goods and services such as schools, community health centres, hospitals, post offices, and so on (Guttman & Willner, 1976; Kettl, 2002; Stoker, 1998). These activities are performed through a network of structures. The structures can be organizations or committees capable of delivering a good or service. The networks of structures are important in influencing
relationships aimed at avoiding conflicts of interest and ensuring sound management (Calderini, Garrone & Sobrero, 2003).

Power is dependent on an ability to manage various resources such as people, money, equipment and land. Resources come from public and private sectors and are shared in good governance. Peters and Pierre (1998) recognise that government institutions remain a part of the network of governance, but they depend on other actors as well. Thus it is a case of mutual dependency whereby those actors also depend on the government.

Public and private sector resources interact with one another, with people in both sectors ideally having a common commitment to helping each other to promote the overall good. Cooperation involves a team of people who share the same ideas for doing something together towards a common objective (Myers, 2003). Participation becomes a key element. In representative democracies, communities participate in government through the electoral process, and governments are accountable to the electorate. At the community level, participation implies that government structures are flexible enough to give communities - as the beneficiaries of goods and services - the opportunity to improve the design and implementation of policies and programs such as health programs and projects (World Bank, 1996). The effectiveness of policies and institutions is dependent on the support and cooperation of communities and other stakeholders.

Ethical standards are essential. They relate to the responsiveness, equity, transparency and effectiveness of governance and policies. Ethics reflect personal and professional standards it is values that define what health professionals’ sight as right and guide the actions and performance of values like morality and attitude (United Nations Economic and Social Council, 2006). The image of public services can be revived and enhanced when ethical standards are valued. The behaviour of civil servants is affected by the political leadership (Hyden, Court & Mease, 2003). Thus, if the elected politicians are corrupt, dishonest and have poor moral principles, this tends to permeate the entire civil service. Administrative ethics and professionalism are crucial. Codes of professional conduct in public services have contributed to the rise of modern administration (Farazmand, 1997).
Goods and services should be available to, and easily accessible by, communities. In the process, it is essential that everyone be treated equally, regardless of race, ethnicity, gender, religion, disability, age, sexual preference, and colour. Debates on equity and fairness are growing in the area of social policy and justice policy (Birkland, 2005). Equal access to public services by citizens is an important indicator for legitimacy of the civil services and development outcomes (Hyden, Court & Mease, 2003). These are affected by various factors such as geography, demography, social stratification, and economic status. When public goods and services are distributed, access is frequently limited for people. In underdeveloped countries, significant problems exist in terms of access to public services (Schaffer & Wen-hsien, 1975). Three conditions are usually required: first, people have to demonstrate their eligibility for the services; second, people have to obey all rules once they have been admitted; and, third, people have to accept they are in a queue as the next to be dealt with (Schaffer & Wen-hsien, 1975). Frequently, particularly in developing countries, people have to resort to paying bribes to get access to public services (Hyden, Court & Mease, 2003).

The weakness of bureaucracy is often the cause of poor development performance in many countries (Blunt, 1983; Hyden, 1983). Bureaucratic performance needs significantly to be improved (Kaufmann, Kraay & Zoido-Lobaton, 1999). Therefore the reform of the bureaucracy is usually needed, including changes in civil servants’ attitudes, bureaucratic procedures, performance criteria, career incentives systems, and levels of corruption (Hirschmann 1981, 1999).

Transparency is important. It refers to the availability of information to the general public and clarity and openness about government rules, regulations and decisions (World Bank, 1996). It concerns how individuals, groups, civil society organizations and the media receive and transmit information on how efficiently services are delivered and the effectiveness of those services. All activities of governance should be in response to the public interest. This refers to the common well-being or public welfare, including the happiness, health and good fortune of citizens. The lack of transparency and honesty, including in the decision-making system and consultation with the public, is very pronounced in many developing countries (Hyden, Court & Mease, 2003).
In achieving good governance by governments and their partners through the exercise of power, accountability is needed. Accountability is a key requirement for transparency in good governance. Accountability for their policy implementation and achievements is a vital principle of good governance (United Nations Development Programme, 1997). Accountability to the public is required not only from governmental institutions, but from private sector and civil society partners as well. Systems of accountability are important to overcome corruption, collusion and nepotism, and misuse of public office (World Bank, 2004).

Post-conflict and fragile countries such as Timor-Leste are not capable of offering basic services or maintaining public order, let alone assume anticorruption work (Blunt, 2009). Patronage-based systems of governance are often defended strongly and therefore there is not immediate support for technocratic reform (Blunt, 2009). Consequently, while the establishment of governance institutions such as an Anti Corruption Commission and an Ombudsman is relatively easy, it is quite difficult for them to work effectively (Blunt, 2009).

The elements of good governance are an ideal, which are hard to realize. Very few countries and societies have come close to achieving good governance in its entirety (Peters & Pierre, 1998). Nonetheless, to guarantee sustainable human development, action must be taken to work towards this ideal with the intention of making it a reality. How well people, structures and processes perform functions has a direct effect on the strength and well being of a community. Governance occurs through interactions among power, people, work, structures and resources, with processes, traditions, participation, responsiveness, equity, transparency, effectiveness, efficiency and accountability all very important. How power is exercised, how decisions are taken, and how citizens and other stakeholders have their say are essential questions to be addressed in governance.

Governance is about power, relationships and accountability. An institution is accountable to those who will be affected by its decisions or actions. It cannot be enforced without transparency and the rule of law (Birkland, 2005). In essence, governance comprises a number of elements, which underpin the notion of good governance. The elements serve to guide and inform the study of governance and policy in practice. How governments (at central and local levels) and their partners
use their power to formulate, implement and evaluate public policies is a central concern of governance.

**GOVERNANCE, POWER AND POLICY**

People exercising power in the formulation, implementation and evaluation of policy bring the various elements of governance together. The exercise of power in governance occurs through an array of policy structures and processes, whatever the contexts. In analysing the arrangements, it is useful to recognise three interrelated aspects: their existence, their operation, and their legitimacy.

**Policy structures and processes**

The state is central to the way policy structures and processes are arrayed. In Montevideo Convention, article 1, it is defined that a state has some fundamental features, including a defined territory, a permanent population, a functional government, and a capacity to enter into relations with other states (Government Representative of Twenty Countries, 1933). There are two broad activities within the processes of government, namely politics and public administration, which have strong interrelationships. The process of politics needs to include administration. Political activities are found both beyond and inside the processes of public administration. In essence, politics involves activities, which decide and achieve desired objectives of the state through various policies, whereas administration comprises activities for meeting those objectives.

A state includes institutional and organizational structures and the functions these structures perform. State institutions consist of legislative, executive, and judicial bodies (Ham & Hill, 1993). The relationships between these institutions are affected by the separation of powers, accompanied by forms of overlapping power and appropriate checks and balances.

State institutions and organisations exist at national, regional and local levels. The levels result from the distribution and delegation of power and functions within a state. There are varying degrees of centralisation and decentralisation. An underlying
aim is usually to ensure that policies are developed and implemented in the most appropriate jurisdictions and arenas, ideally with opportunities for a wide range of inputs and engagement, including the direct involvement of particular communities and the public as a whole.

Relevant structures and processes need to exist to facilitate the development and implementation of policies in practice. Such arrangements inevitably comprise various interrelated elements, which are sometimes portrayed as policy cycles with networks of contributors and patterns of interaction suited to the sectors for which the policies are especially relevant. The networks can, and do, involve or intersect with hierarchies, markets and communities in line with the governance definitions and concepts addressed earlier in the discussion.

Dye (1972) defines public policy basically as “whatever governments choose to do or not to do” (p. 2). Cochran, Mayer, Carr, and Cayer (1999) similarly refer to it as being “an intentional course of action followed by a government institution or official for resolving an issue of public concern” (pp. 1-2). The “public” feature of policy recognises that policy making is public, that the public is the source of political authority, and hence policy can affect all members of a state (Birkland, 2005). Public policy should respond to and reflect relevant needs, principles and values of a society. It should have moral and ethical meaning and be geared to the protection and promotion of human rights, peace and dignity.

Broadly, there are official and unofficial actors (Birkland, 2005). Official actors include parliamentarians, judges, government ministers and various categories of government employees, all of whom contribute to policy in the exercise of power and the discharge of responsibilities in accordance with a constitution and/or legislation and related legal instruments. Unofficial actors are participants who are involved in policy deliberations exclusive of any explicit legal authority but with the aim of influencing what is decided and done. Such actors include numerous individuals, groups and organisations in the market and civil society. They have the right to identify policy problems, to express their desires for action, to suggest solutions, and in other ways to make a contribution.

The relations between actors and policy processes, agenda-setting issues and the ways in which problems and possible solutions are analysed and addressed are particularly important. Accordingly, appropriate mechanisms need to be in place and
be maintained to ensure that inputs are made, considered and responded to as effectively as possible. This requires communication, consultation and coordination.

Communication is an essential factor which bridges and links decision makers in government and people in developing and implementing policy to achieve desired results (Althaus, Bridgman & Davis, 2007). Communication is a part of policy consultation and coordination. Consultation should aim to provide a voice for people and allow those who are affected by policy and its implications to provide advice and feedback (Althaus, Bridgman & Davis, 2007; Jones, 1977). It is expected that the advice will be taken into consideration and hence affect decisions and influence outcomes. Jones (1977) asserts that if a public policy is enacted without consultation, the objectives of the policy will often not be met.

Communication is also crucial to coordination (Althaus, Bridgman & Davis, 2007; Birkland, 2005; Dye, 1972). Coordination is needed to harmonize activities towards a common goal with the aim of obtaining integrated and effective policy outcomes. Communication, consultation and coordination are required to establish interaction between government and other people, agencies and management. They are central elements of policy formulation and implementation.

Policies should be appropriately shaped, funded and directed in order that their implementation occurs within a clear framework of expectations about what the objectives are and how they should be pursued (Althaus, Bridgman & Davis, 2007; Birkland, 2005; Dye, 1972; Rhodes, 2000). A requirement for the effectiveness of policy implementation is that those who are responsible for carrying out a policy must be familiar with what they are supposed to do and the means by which they are to do it. Included in the means are laws, regulations, funding agreements and information strategies.

The developmental record of countries indicates that both good policy choices and effective policy implementation are very important variables (Dye, 1972; Turner & Hulme, 1997). People expect that policy will be made and implemented by governments, with consultation and assistance from non-state actors to achieve policy goals. Ongoing action is necessary to ensure improvements in policy-making and policy outcomes to enhance the competence and capacity of the state (Grindle & Thomas, 1989; Turner & Hulme, 1997).
Operational arrangements

The operational aspects of policy are aimed at determining and achieving policy objectives in practice, with appropriate account being taken of citizens who have their own social and cultural values. Policymaking strategies are important in the pursuit of good, valuable, well-considered and useful policy. The strategies can involve a mix of contributions from official and unofficial actors.

The ways in which policies are actually or potentially determined are addressed by several models of policy-making. They include the rational-comprehensive model, incremental model, mixed scanning model, systems model, and institutional model, among others (Birkland, 2005; Dror, 1970; Dunn, 1981; Dye, 1972; Etzioni, 1967; Jones, 1977; Lindblom, 1959; Smith, & May, 1980; Soenarko, 2003).

The rational-comprehensive model assumes that decision makers have complete information on problems, causes, solutions, social values and contexts (Birkland, 2005). Decision-making involves comprehensive analysis, the clarification of objectives and detailed assessments of relevant courses of action (Birkland, 2005; Dunn, 1981). The emphasis is on significant societal and economic factors in terms of values and of costs and benefits (Dunn, 1981; Lindblom, 1959).

The rational-comprehensive model comprises problem identification, the setting of objectives and criteria, the development of policy alternatives, the identification and analysis of the expected impact of various alternatives, the ranking of alternatives according to established criteria, and the choosing of the best policy alternative (Dror, 1970). It assumes that there are few, if any, time constraints, that there are sufficient and capable policy specialists and advisors, and that there is a clear awareness of political, economic and social values. These and other conditions of rationality are seldom present in practice to the extent the model requires.

In response to the perceived weaknesses of the rational-comprehensive model, Lindblom (1959) formulated the incremental model. This model involves policy makers commencing the decision making process, not with a selected ideal goal in mind, but with reference to current policy problems, goals and contexts. Policy change occurs through small incremental steps rather than in large jumps.
Key information includes what is known about present circumstances and established policies. It provides a basis for adjusting policies to meet immediate problems and emerging issues in the light of actual experience and the lessons learnt from it (Dye, 1972; Lindblom, 1959).

The rational-comprehensive and incremental models of decision-making have given rise to, and been complemented by, other models which seek to facilitate and explain how decisions are made. In essence, they describe how decision makers try to proceed as rationally as possible in circumstances in which there are limitations of resources including; time, information, and human capacity and to be aware of all aspects of a problem of public significance.

Analyses of the 1980s remain pertinent to the issues addressed here. They include discussions by Anderson (1984), Dye (1987), Hogwood and Gunn (1984) and Edwards (1984). The matters examined are particularly significant in terms of the operational demands and dynamics of policy making and implementation.

Anderson (1984) addresses six factors that normally influence policymaking. First, everybody has values and personal convictions. Second, there are political party affiliations, with opinions and viewpoints being expressed according to party principles. Third, there are constituency interests with various groups having and voicing interests and concerns. Fourth, there is deference by someone to another person, which can influence a person when they make a decision. Fifth, there are decision rules, which structure and guide the making of decisions. Sixth, there is general public opinion, which has a major influence on policy making (Anderson 1984). Thus, policy making is affected by an array of factors and is complex.

Walt et al (2008) summarize the stages of policy analysis that divide policy making into four stages: agenda setting refers to the notes and ideas that rise to the attention of decision-making; policy formulation in importance of the development of policies and decision to enact them; implementation, the central and local government including its partners also put the policies into practice; and evaluation reflects the function, impact, achievement of objectives and consequences of the policy to the public community. The achievement of policy objectives requires that a government establish rules and regulations as policy instruments to administer or regulate a variety of activities and operational aspects of government. Policy instruments are the tools, which can be chosen and used to overcome problems and
achieve policy objectives (Bemelmans-Videc & Vedung, 1998; Salamon, 2002; Schneider & Ingram, 1997). Some examples of policy instruments are regulations and standards, taxes and charges, voluntary agreements, subsidies and other incentives, research and development, and information strategies (Dye, 1972; Ringeling, 1983). Without policy instruments, decision makers would not be able to turn political discussions and policy statements into concrete social action (Ringeling, 1983).

Once policies and associated instruments have been decided on, their implementation assumes immediate importance as steps are taken to turn policy into action. The processes of policy implementation can often be as complicated and demanding as those of policy development. Various matters require close and serious attention, with ongoing communication and coordination being essential. Edwards (1984), for example, recognises the significance of these and associated matters. He begins with the questions: What are the preconditions for successful policy implementation? What are the primary obstacles to successful policy implementation? He addresses these questions with reference to four variables in policy implementation: communication, resources, dispositions or attitudes, and bureaucratic structure. The four factors operate simultaneously and interact with each other to aid or hinder policy implementation. The relationships between the four factors are outlined in Figure 3.

![Diagram showing the relationships between communication, resources, dispositions, bureaucratic structure, and implementation.](source: Edwards (1984, p. 148).)

Figure 2: Direct and Indirect Impacts on Implementation
Edwards (1984) argues that communication that is too detailed may lower the morale and independence of implementers, leading to the waste of valuable resources such as staff skills, creativity and adaptability. The impact of communication on implementation is linked to resources, dispositions, and bureaucratic structures. Important resources include adequate and capable staff with necessary expertise; appropriate information on how and by whom policies are to be implemented; the authority to ensure that policies are carried out as they are intended to be; and facilities such as buildings, equipment, land and supplies which are necessary for the provision of services. The dispositions of implementers influence how they understand policy communication, and whether and how they work to implement policies through and beyond bureaucratic structures. Even if sufficient resources to implement a policy exist and implementers know what to do and want to do it, implementation may still be unsatisfactory because of the bureaucratic structures involved. Too many sites of communication can cause fragmentation, which means a message can be distorted too easily. Good communication is essential to successfully implement a complex policy.

Hogwood and Gunn (1984) articulate that what happens in the policy implementation phase has a strong impact on policy outcomes. This led them to consider the preconditions for “perfect implementation”, which include:

1. that the circumstances external to implementing agency do not impose constrains;
2. that adequate time and sufficient resources are made available to the program;
3. that the required combination of resources is actually available both generally and for each phase in the policy implementation process;
4. that the policy to be implemented is based upon a valid theory of cause and effect;
5. that the relationship between cause and effect is direct and that there are few, if any, intervening links;
6. that dependency relationships are minimal;
7. that there is an agreement on objectives to be achieved from the outset and throughout the implementation process;
8. that tasks are fully specified in the correct sequence for all participants;
9. that there is perfect communication and co-ordination between various participants involved in the implementation process;

10. that those in authority can demand and obtain perfect compliance.

In reality, while not all policy implementation is complex and dynamic, these preconditions are seldom if ever met, which means that perfect implementation does not occur (Hogwood & Gunn, 1984). In implementation, policies often drift from their original objectives or their goals are only partially realised. The dynamics of policy implementation can consist of a variety of actions, including issuing and enforcing directives, disbursing funds, making loans, signing contracts, collecting data, disseminating information, creating organizational units, and reporting to relevant authorities (Cochran et al., 1999; Edwards 1984).

Policy evaluation is an important aspect of the policy process, which aims at determining whether or not policy goals have been achieved and what the implications are for society. Policy evaluation can be both the final and the new starting stage of policy development and implementation. It provides valuable information and gives guidance to policy implementers which can be used to ensure improved policy and program performance. It assists governments to set priorities and contributes to improving good governance issues such as responsibility and accountability to parliament and the public (Birkland, 2005; Edwards, 1984). It also helps decision makers to reformulate a policy if needed.

Policy operations and dynamics vary considerably from state to state. They depend on the capacity of the state to manage and control human resources, finances, the environment, and political contexts. Some states, for example, are society-centred and focus on the interaction between societal actors, while others are state-centred and emphasise the interplay of actors within key state institutions. Both approaches can be relevant, depending on stages of political, economic and social development (Turner & Hulme, 1997).

**Importance of legitimacy**

Policies are usually promulgated through official written documents as laws, regulations and declarations (Birkland, 2005). These documents legitimize the policy
and express that it has been considered officially, soundly and systematically (Baldwin & Sunkin, 1995; Birkland, 2005; Soenarko, 2003). It is the product of the exercise of power in the form of an official articulation of the intention to act in the public interest.

Legitimacy is an important issue that requires consideration when designing public policies (Baldwin & Sunkin, 1995; Birkland, 2005; Soenarko, 2003; Walt & Gilson, 1994). Legitimacy is also relevant when addressing the long-term success or failure of a public policy (Baldwin & Sunkin, 1995; Birkland, 2005; Soenarko, 2003; Walt & Gilson, 1994). Birkland (2005) identifies that to acquire and maintain legitimacy entails a primary level of public approval and acceptance. Legitimacy is affected by the content, processes, outputs and outcomes of policy. There are three interrelated requirements: conformity to established rules; the justifiability of the rules by reference to shared beliefs; and the express consent of a subordinate in a specific power relationship (Beetham, 1991).

In post conflict and fragile societies the legitimacy of government is often especially problematic. To strengthen a government’s legitimacy, all citizens need to feel represented and secure (Debiel & Terlinden, 2005). Public distrust in government and abuse of power by officials will undermine the legitimacy of the government (Debiel & Terlinden, 2005).

The legitimate authority of government to formulate and implement policy is a fundamental characteristic of governance, which needs to be supported by policy and administrative capacity (Pierre & Peters, 2000). Levels of capacity are affected by the relationships among the executive, legislative and judiciary bodies in government (Scott, 2007), as well as by numerous other factors within and beyond government.

Overseeing is an important task of the legislature to ensure that the policies, rules and regulations are being administered efficiently and effectively (Birkland, 2005; Cochran et al., 1999; Peters, 2004). Policies should be implemented in accordance with legislative intention, with consideration of good governance elements such as transparency, accountability, responsiveness and cooperation (World Bank, 1996). These are important to build and maintain public trust and policy legitimacy.
Policy outputs and outcomes are the principal results of policy implementation. Policy outputs are what governments do and achieve in particular policy areas (Cochran et al., 1999; Peters, 2004). Policy outcomes are the intended and unintended consequences of policy outputs. In analysing policy outcomes, it is necessary to examine whether or not outputs benefit society as a whole in line with policy objectives. Questions include: Have policy goals been met or not? Has the government been accountable for outcomes? How much money was expended? What were the unintended consequences? Has a policy improved the lives and well being of communities?

Governments need to have the legitimacy and capability to develop and implement policies. Carroll and Carroll (1999) recognise that there is a mutual relationship between policy capacity and legitimacy, particularly in developing countries. They argue that if a government has legitimacy but does not have sufficient capacity to formulate and implement policies effectively, its legitimacy will inevitably decline (Carroll & Carroll, 1999). A government with limited legitimacy will possibly use force to implement policies, resulting in its policy capacity being further diminished (Carroll & Carroll, 1999; Lane, 1987).

The development and maintenance of legitimacy in the policy process is crucial in developing countries. The policy process should involve not only individuals who have expertise within government, but also members of society, including interest groups and other stakeholders with some independence from government. This can assist in enhancing the capacity of the public sector to develop policies and seek to achieve desired policy outcomes (Carroll & Carroll, 1999; Cochran et al., 1999; Lane, 1987).

**GOVERNANCE, POWER AND HEALTH POLICY**

**Health Governance and Power**

Governance is a most important influence for health outputs and outcomes involving the complexities and interactions of various sectors and factors, not just the health sector alone. According to United States Agency for International Development (2008), there are three prime performers in health policy and services:
the government, the providers and the beneficiaries. Governance in health includes rules that prescribe the roles and responsibilities of actors and their partnerships, structures and interconnections (Walt & Gilson, 1994). Good governance in health involves accountability to beneficiaries and the public; transparent and accessible policy processes with opportunities for interest groups to contribute; state capacity and legitimacy to take and implement health policies; responsive service delivery; and the engagement of non state actors in both policy making and service delivery (Blakemore, 1998; Pierre & Peters, 2000; World Health Organization Regional Office for the Eastern Mediterranean, 2007).

Health governance means developing and implementing health strategies, policies and rules to achieve better health outcomes (Siddiqi et al., 2009). To ensure the success of health governance and service delivery in developing countries, the most important requirements are political stability, legitimacy, respect for law, and the reinforcement of the legislative, executive and judicial processes within states. These in turn involve the interaction of hierarchies, markets, networks and communities underpinned by the distribution and use of power.

In facilitating health governance, it is essential to consider the accountability of the actors involved, the adequacy of state capacity, and the nature of power and legitimacy, while also creating and maintaining relationships and networks with non-governmental actors. Health policies and processes are political, with competing interests and demands and determinations of priorities based on particular views of politics, power and the public interest.

A general issue is often whether interests of citizens are being provided for or whether the medical profession has succeeded in shaping people’s understanding of their health needs to the benefit of the profession. This concerns the persistent problem of determining what real interests are. It raises questions about whether people are communicating their real interests or whether their opinions and desires are or can be shaped by those who have power.

Health governance and policy can be structured and managed through a mix of centralized and decentralised arrangements. The mix depends on the government’s political and administrative structures and objectives, as well as on the model of health management existing in the particular country (Mills et al., 1990; Siddiqi et al., 2009). The arrangements comprise changing power relationships between levels
of government and political and administrative elites, as well as health providers, health administrators, consumer groups and the community. There are different political positions with significant influence on policy positions (Gardner, 1992).

Ministries of Health have a central role in providing health services and in setting the enabling conditions to increase accountability of health services to the public. They also have a role in establishing strong networks with partners, including nongovernmental organizations, community and other stakeholders. They are responsible for ensuring local health officers provide safe and quality health services to both urban and rural communities.

Paradigms in Health Policy

The preamble of the constitution of the World Health Organization states that “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (World Health Organization, 1946). A health system is defined as people or institutions (including resources) working together in accordance with established policies to improve the health of the population they serve, while also responding to people's legitimate expectations and protecting them against the cost of ill health through a variety of activities whose primary intent is to improve health (De Savigny & Adam, 2009; Islam, 2007; United States Agency for International Development, 2008).

In the late nineteenth century, the biomedical paradigm influenced health policy ideas (Lewis, 2005). The human body was perceived as similar to a machine that sometimes breaks down and needs to be repaired. In the 1970s, some experts observed that this notion of health services just focused on physiological conditions and had no interest in the social, psychological and behavioral dimensions of illness (Engel, 1977) nor in the reality that health was linked with income and inequality (Black, 1980). The focus of health policy was on individuals and curative care provided by medical professionals, rather than on health, influenced by social and economic factors.

In 1978, an alternative model or paradigm for health services delivery was developed. The Primary Health Care (PHC) model emerged in response to the Alma Ata Declaration (World Health Organization, 1978). Community health care policies
began to refer to community-based programs and a variety of approaches to health services delivery.

Health is influenced by various intersecting factors such as society, culture, history, spirituality and economic development (Blakemore, 1998; Cochran et al., 1999; Hill, 2000; Walt & Gilson, 1994). Improvements in the health status of citizens are influenced by the quality of life (Blakemore, 1998). Hence, a health policy approach should precede health delivery systems (Grindle, 2004; Siddiqi et al., 2009). Health policy requires clear objectives, alternatives strategies, and careful consideration of the social determinants of health. Health policy is a package of promises and commitments to pursue lines of action designed to achieve defined health objectives (Shariati, Farzadi & Akhlaghi, 2005), through which governments convert their vision into programs and action to deliver service and outcomes (Nutley, 2000).

In 1986, a new paradigm of health was introduced through the World Health Organization’s Ottawa Charter, which presented the significant impact of social issues on human well-being. The social determinants of health combine economics, sociology and psychology. As social beings, humans not only need satisfactory material conditions from early childhood onwards, but we also need friendships; to feel useful; to have specialized skills through formal education; and to find employment (World Health Organization, 1998). These social issues should be incorporated in health policy processes not only to improve health and well-being but also to reduce a range of other social problems, because poor social and economic conditions have an effect on health throughout life (Marmot, 2005).

In the twenty-first century, health goals are still far from being achieved and there is consensus that stronger health systems are a key to reaching better health outcomes. In 2000, the United Nations Millennium Declaration identified eight Millennium Development Goals (MDGs) for development and poverty eradication. The MDGs provide a general policy framework for consideration by all countries and governments. Three of the eight MDGs directly concern health: reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria, tuberculosis (TB) and other diseases (Travis et al., 2004; Vandemoortele, 2010). The MDGs’ targets are measurable outcomes which indicate whether that goal is achieved or not. According to (Pearson, 2007), the objective of a general governance
framework for health is to assist countries to upgrade their efforts towards the achievement of the MDGs.

**Policy Structures and Processes in Health Service Delivery**

Communication in health policy is a critical factor in linking health decision makers in government and their partners, including the wider community and other stakeholders. Consultation among ministries of health and their partners such as donors and UN agencies and with stakeholders and the community is essential. It ensures that the voice of the people is heard and allows those affected by health policies to give their advice and suggestions.

In health policy and service delivery, the importance of coordination is usually appreciated by health policy actors, but has often remained ill-defined (Buse & Walt, 1996). Coordination raises the questions of who is coordinating whom, why, and to what ends. Buse and Walt (1996) define health sector coordination in developing contexts as “any activity or set of activities, formal or non-formal, at any level, undertaken by the recipient in conjunction with donors, individually or collectively, which ensures that foreign input to the health sector enables the health system to function more effectively, and in accordance with local priorities, over the time” (p. 175). This definition draws attention to the need for a government or Ministry of Health to take the lead in managing and coordinating resources. The Ministry of Health should encourage multilateral and bilateral agencies, stakeholders and community participation in the formulation of national health policies and plans. The external resources should be managed and developed as part of a national health policy and plan. The donors and related agencies should provide technical assistance to facilitate the Ministry of Health’s activities, including staff to assume leadership roles and resources to achieve desired results in accordance with local needs and expectations.

Health policy analysts argue that health policy content operates on four main levels. The first is systemic where the fundamentals of health objectives are decided. The second is programmatic in which priorities for interventions are set and translated into operational guidelines and manuals. These guidelines and manuals
inform service delivery and are based on the burden of disease, cost-effectiveness concerns, political and societal values, and equity and human rights. The third is the organizational level, with organizations being responsible for policy implementation. The fourth level is instrumental which is concerned with generating information to improve the operation of health policies and service delivery (Buse & Walt, 1996; Dugdale, 2008; Gardner, 1992).

Analysts also use different models of policy making to investigate health policy processes. They often assume that the process of policy formulation is rational and based on accurate information, but in practice it is often not the case and policymaking of involves bargaining among distinct interest groups to choose priorities (Bornemisza & Sondorp, 2002). An important concern is to investigate how and why some problems are prioritized, and why national health policies achieve less than expected, perform differently from what is expected, or succeed in achieving their goals (Grindle, & Thomas, 1989). The focus is on understanding the forces influencing why and how policies are identified, initiated, formulated, negotiated, communicated, implemented and evaluated.

Other important considerations in health policy processes are the costs and benefits of each alternative, as well as planning and evaluation (Blakemore, 1998; Dye, 1972; Hill, 2000; Walt & Gilson, 1994). Cochran, et al. (1999) have argued there are two key factors affecting health policy: the high cost of health care; and the recipients of health care, in particular the poor and vulnerable. Evidence based and ethical national policies are needed to develop a long term vision for health, along with an institutional strengthening of ministries of health with improved capacity to regulate and set standards and to engage in leadership and coordination (World Health Organization Regional Office for the Eastern Mediterranean, 2007). Effective governance includes mutual accountability for the development of equitable policy outcomes, transparent and sustainable approaches, and health legislation, regulations and measures to increase effectiveness (World Health Organization Regional Office for the Eastern Mediterranean, 2007).

In health governance, as in other sectors, the authority and legitimacy of the state is often contested by both national and international actors. A particular challenge for post-conflict, transitional and fragile states lies in their capacity to maintain security, to foster economic development, and to ensure the basic needs of
their communities are met (Meagher, 2007b; Organisation for Economic Co-operation and Development, 2007). This focuses attention on their policy decisions, action and achievements, and the extent to which they are able to secure public consent and acceptance as bases of their legitimacy. These matters are especially relevant to health governance and policy given the fundamental importance of available and accessible health services for a community.

**CONCLUSION**

The concepts and elements of governance and the policy process are relevant to understanding health governance and health policy. Governance in health means developing and putting in place policies, programs and activities to achieve health objectives. Important questions include: Who does what? What are the obligations and responsibilities of Ministries of Health and their partners? What are the roles of local health officers involving forms of decentralization? Weak health governance can threaten to destabilize the effective utilization of resources and delivery of health services.

In practice, governance is complex and its effects are contingent on many factors. The analytical framework established here highlights the significance of governance and policy based on people, power, structures, equity, ethics, cooperation, responsiveness, transparency, accountability, effectiveness, efficiency, and participation. These elements of governance are relevant to all states, while having special significance in developing, post-conflict and fragile states. They are used in subsequent chapters to guide and inform the analyses of health governance, policies and service delivery in Timor-Leste.
CHAPTER 3: METHODOLOGY

INTRODUCTION

This chapter will outline the research design, methodology and research methods used to create the two case studies of health governance. Contextual secondary data such as health statistics, demographic indicators and policy analysis will also be described.

The investigation focused on development and implementation of Timor-Leste Health Policy Framework 2002; how the health policy framework was developed and implemented; what worked and what did not. The overall design followed mixed-methods and case studies approaches.

Mixed methods explorations involve qualitative and quantitative data collection and analysis in this study. The combination of qualitative and quantitative data generate a more comprehensive analysis than the use of a single type of data on its own (Creswell, Fetters & Ivankova, 2004). Case studies provide a lot of information and in depth description of an organization (Somekh & Lewin, 2006). Phase I of the Fieldwork was conducted between October 2009 and May 2010, and Phase II in November 2010.

Data was collected in two districts, one referral hospital, one national hospital and the Ministry of Health Timor-Leste and its institutions, Ministry of Social and Solidarity, Ministry of Infrastructure, National Parliament and two local NGOs, two international NGOs as well as three UN Agencies. Participants were recruited through purposive and snowball sampling. All interviews were transcribed verbatim and imported into NVIVO 8 computer software program to facilitate data analysis and to assist with interpretation (Schutt, 2006). Thematic analysis was conducted using memoing and coding as well as captivation and crystallization in combination with revisiting relevant literature.

This chapter will describe in detail these methodological approaches and data collection methods and discuss the theoretical considerations of qualitative and
quantitative research, the use of two case studies, sampling and their limitations in this research.

**METHODODOLOGICAL APPROACHES AND DATA COLLECTION: THEORETICAL CONSIDERATIONS**

**Mixed-methods**

Creswell, (2003) defines mixed methods as collecting, analyzing, and combining both qualitative and quantitative data in a single study or among several studies in a continued program of inquiry. These two sets of methods can be used simultaneously or at different stages of the same study (Tashakkori & Teddlie, 2003). Creswell, Fetter and Yvankova (2004) argue that only studies, which contain both qualitative and quantitative data collection and analysis should be called mixed methods. If qualitative and quantitative data are merged, it yields a complete analysis and they balance each other. The results of both methods should be incorporated and linked at some phase of the research process (Creswell, 2003).

It is hoped that by using mixed methods a unique understanding will be found which otherwise may have been undetected by single methods. The assumption is that each method has particular advantages and disadvantages or limitations. By using mixed methods and their different perceptions, a complete picture can be gained, with limitations reduced.

Using mixed methods approaches in a study provides the opportunity to generate greater understanding from one method to another, as well as to converge or confirm findings from different data sources (Creswell, 2003; Traynor, 2007). Mixed methods are also keys to illuminating complex research problems (Branigan, 2003) such as health disparities. Mixed method approaches in social research can create better understanding than using only one method (Greene, 2008). In some cases mixed methods permits the researcher to generalise the results of data collection from a sample to a population and to obtain a deeper understanding of the event, context or phenomenon of interest (Hanson et al., 2005). Mixed methods can take action as a transformative process for vulnerable populations including ethnic
minorities (Beiser & Stewart, 2005) when they emphasize participation of the public over program planners, service providers and policy influences.

Morgan (1998) defined several criteria for choosing types of mixed methods strategies, but others have suggested other essential criteria that need to be considered when designing strategies for mixed methods (Greene & Caracelli, 1997). Creswell’s (2003) nominated criteria are informed by the following questions: What are the implementation results of the quantitative and qualitative data collection in the proposal of the study? What is the priority given to quantitative and qualitative data collection and analysis? At what stage are the methods integrated, combined or related to both quantitative and qualitative data? Does the study involve an overall theoretical perspective such as gender, race, ethnicity, lifestyle, and class? Mixed methods researchers should consider these criteria, to identify and design the study (Morgan, 1998; Somekh & Lewin, 2006).

Mixed methods, data is gathered in various ways including structured and unstructured questionnaires, observations and open ended interview (Somekh & Lewin, 2006). Quantitative data collection depends on structured instruments administered by telephone or face-to-face interviews (Creswell, Fetter & Ivankova, 2004) which are analysed by statistical methods such as correlation and regression. Qualitative data can be collected through open ended or semi-structured interviews and field observations including photographs, videotapes or emails.

The advantages of mixed-methods research are that each of them give a better understanding with stronger validity, and less known bias, than with the traditional approach of triangulation, developing a more complete understanding of our social world (Somekh & Lewin, 2006).

However, there are some challenges and limitations of mixed methods. The principal challenge of mixed methods is the description or delineation of qualitative research questions and quantitative questions or hypotheses which when integrated improve rigour. Additional challenges comprise a vast data collection, which is time intensive, as well as the complex analysis of both manuscript and numerical data (Creswell, 2003). These challenges necessitate intensive methodological training in interdisciplinary relationship and collaboration (Hviding, 2003).
Mixed methods have been used in health services research in United Kingdom (O'Cathain, Murphy & Nicholl, 2007) to detect the importance of understanding the impact of the health services delivered to the community. Mixed methods can also assist research aimed to understand the organisational systems of health services, including the coordination among all parts into a unit or structure, the relationship of components, the effectiveness of arrangements surrounded by the organization along with a focus on progression. Face-to-face, semi-structured interviews, documentary analysis of proposals and reports were all approaches used.

**Case study**

O'Leary (2005) defines case study as “a method of studying elements of the social through comprehensive description and analysis of a single situation or case” (p. 96). Case studies provide an in-depth examination of a single instance or phenomenon in an actual existing context (Walt et al., 2008). Furthermore, case study methodologists argue that the value of the study can be increased through asking some fundamental questions, such as: What are we finding here in this case? How is the health policy implemented? Does health policy network influence the agenda setting? (George & Bennet, 2004).

Yin (1999) concluded that case study methods are being rediscovered in health services research. For example, forty eight case studies were conducted on the topic of citizen participation and other modes of decentralized decision making in health services (Yin & Yates, 1975). Attig, Attig, Boonchalaksi, Richter, and Soonthorndhaha (1993) believe that a case study provides a range of information and in-depth description of an individual case for examining a person, an organization or an entity. A case study assumes that social reality is created through social interaction, although positioned in a particular context and history, and looks to identify and describe, before analysing and theorizing (Somekh & Lewin, 2006).

A case study approach makes it possible for stories to be told, informing how policies are implemented by government. Case studies can inform new improved social programs or policies (Somekh & Lewin, 2006). They can incorporate into policy the complicated realities and unintended consequences of implementation. Therefore, case study is specific, descriptive, inductive and eventually heuristic. It
aims to understand the difficult and complex process that is useful in problem solving.

Data collection in case studies includes documentary analysis of such documents as policies, clinical protocols, service specifications and audit outcomes. It can also involve individual interviews with key informants, group interviews, observation and critical incident analysis (Somekh & Lewin, 2006). Somekh and Lewin use Focus Group Discussion to encourage participants to imagine the future direction of their roles or organization as well as policies and practices. Critical incident analysis aims to support participants to be reflective about actual incidents in order to expand their understanding of significant issues retrospectively. Data analysis in case study is descriptive and may include transcribed taped interviews and extensive field notes on analytical memos.

An advantage of case studies is that there is a focus on one location which can minimize facilities, travel and cost (O'Leary, 2005). A limitation of case studies is that it may not be possible to generalise statistically from one or a small number of whole cases. However, many case study reports imply that their findings are generalizable because they illuminate more general issues and considerations (Somekh & Lewin, 2006). O’Leary (2005) challenges the claim that case studies are not representative or generalizable. Case studies contain intrinsic value, meaning cases maybe relevant, politically hot, unique and interesting. They can be used to debunk a theory by demonstrating that what is generally accepted as fact may be erroneous. Case studies can bring new variables to light. They can provide supportive evidence for a theory, and collectively can form the basis of a theory when used to inductively generate new understanding.

Thurston and team in 2003 used case studies to demonstrate their results: the study aimed to develop a theoretical framework for understanding public participation in the context of regionalized health governance, using document reviews, observations, semi-structured individual interviews, and focus group interviews to collect data (Trurston et al., 2005).
Qualitative methods

Qualitative research involves non-numerical data collection (Denzin & Lincoln, 2000). Holloway and Wheeler (1995) define qualitative research as data derived from observations, interviews, or verbal interactions and focuses on the meanings and interpretations of the participants. Qualitative methods produce information in many different academic disciplines, traditionally in the social sciences, in economic political or market research (Baum, 1995). This method aims to gather a deep understanding of human behaviour, motivation and interaction (Holloway & Wheeler, 1995; Silverman, 2006) and to explain why people are motivated in a way that they think is correct or polite and how people in groups behave and interact. Qualitative methods explore and investigate not just what, where, and when but pertain to who, why and how of human behaviour.

The interpretative process of the qualitative research method refers to the way that people interpret and give meaning to events and things. Rice and Ezzy (2002) argue that qualitative research is more adaptable in its approach than quantitative statistical methods. Qualitative methods allow understanding of the state of civil society, policy formulation, and development planning (Attig, et al., 1993). Qualitative methods are used in studies of health services and health policy research development (Sofaer, 1999) and illness (Wray, Markovic & Manderson, 2007). Baum (1995) suggests that in the context of health, qualitative data provide stronger and more effective understanding. Baum (1995) has used qualitative methods to explore communities’ interpretation and understanding of health issues including the social, cultural and political factors which influence communities’ health. She has used qualitative methods to explore such things as who makes up the workforce that deliver public health services and how they do it.

Similarly Rice and Ezzy (2002), recognise qualitative methods are particularly relevant to the new public health, because they can serve the need to describe and understand people’s behaviour. Qualitative methods are useful to gain rich explanations of complicated phenomena. These methods allow the discovery of facts. They uncover unexpected events and create new knowledge. They allow an understanding of events from the perspective of various participants including patients, families, communities and other stakeholders. Ultimately, a good qualitative
The researcher is someone who listens, thinks, and then asks probing questions to get to the next level of understanding. Thus the results of qualitative research depend on the creativity and patience of the insight of the researchers.

The data collection tools of qualitative research methods are predominantly the individual or paired interview, focus group discussion involving narrative analysis, and ethnography (Rice & Ezzy, 2002), each of which has its own advantages and disadvantages. The advantages of participant observation and interviews lie in their provision of rich and detailed information. Also the researcher’s intimate knowledge of the participant’s history and norms offers an interpretive framework from which to make sense of the action of participants (Adler & Adler, 1994). Tashakkori and Teddlie (2003) suggest that qualitative methods have various disadvantages, including observer bias and the challenges of translation into understandable forms for other researchers. For example, observers often present clear description for other researchers to see exactly how they make analysis from the field notes (Tashakkori & Teddlie, 2003).

**Quantitative methods**

Quantitative methods are used to obtain information dealing with either enumeration or anything that is measured within defined categories (Tashakkori & Teddlie, 2003). Quantitative research aims to develop and employ mathematical models, theory and hypotheses pertaining to a measurable phenomenon. Kuhn (1961) argues that the process of measurement plays an important role in this method, because it provides the basic connection concerning empirical observation and mathematical illustration of quantitative association or relationships. These methods use statistics, tables and graphs to present their results. Quantitative methods use statistical models to collect data and hypothesize and theorize (Kuhn, 1961). Quantitative approaches are relevant to social sciences because researchers rarely work with entire populations; and group comparisons involve statistical modelling of the interrelationship between variables (Shadish, Cook & Campbell, 2002).

Tashakkori & Teddlie (2003) suggest that quantitative methods can be used to verify hypotheses; develop theories and hypotheses; generate models; develop instruments and methods for measurement; control and manipulate variables; collect
empirical data; model and the analyse data; and evaluate results. Traditionally, quantitative methods have been the techniques of choice by organizational and management researchers. Because these methods handle standardized measures of variables through surveys, inferential statistics such as correlation regression coefficients can be compared across studies (Pedhazur & Schmelkin, 1991).

Forsyth (1990) warns that quantitative methods also have their disadvantages. Firstly, correlational studies like surveys provide limited information about cause and effect between variables. Secondly, the laboratory studies are highly unique activity and cannot be generalized to a population as a whole. Thirdly, the experiments are seldom used to conduct longitudinal research. The central strength of experiments - continuous rigorous control - can undermine the value of experimental findings since in the process of seeking control, the researchers may create extremely unnatural situations (Forsyth, 1990). Similarly (Van Maanen, 1979), believes that quantitative data techniques, such as sample surveys, interviews and laboratory experiments, in reality distort the phenomena they study.

**Sampling**

Sampling is the selection of elements (events, people, groups and settings) from the whole that is being investigated (Tashakkori & Teddlie, 2003; The Sage Qualitative Research Kit, 2007). The aim of sampling is to enable the researchers to competently draw conclusions from the sample to the population as a whole (Attig et al., 1993). The sample must contain all the main characteristics of the population to be investigated, or as many as relate to the research questions within a study. Sampling is necessary because researchers hardly ever survey the entire population. In most instances engaging directly with the entire population is prohibitively costly (Ader, Mellenbergh & Hand, 2008).

Sampling in qualitative research is different to quantitative research. The objectives of quantitative research such as survey, epidemiological studies or case control studies, is to guarantee that the sample is statistically representative and the results can be confidently generalized to the population from which the sample is taken (Rice & Ezzy, 2002). Quantitative sampling aims to obtain as large a sample as possible selected through probability techniques (Tashakkori & Teddlie, 2003),
which can then be representative and generalizable. O’Leary (2006) predicted that the majority of basic statistical analyses includes a minimum of about 30 informants or respondents. If anything smaller is used it can be difficult to demonstrate statistical significance.

The objective of sampling in qualitative research is not concerned with ensuring the findings can be statistically generalized to the whole population, but that sampling in qualitative research is *purposive* (Miles & Huberman, 1994). Participants are selected because they can offer a full and complex understanding of all aspects of the phenomena. Participants are selected using criteria relevant to the particular research questions and research objectives. The sample size may or may not be determined prior to data collection dependent on the resources such as funding, logistic support and time available. Purposive sampling is most successful when data review and analysis are done in combination with data collection.

O’Leary, (2006) offers two main strategies or categories for sampling. The first is random or probability sampling and the second is non-random sampling. The researcher will discuss non-random sampling as this was used predominantly in this thesis.

Non-random sampling (non-probability) is where the sample is not drawn at random. This is called purposive or theory sampling (Attig et al., 1993). Non-random selection presents the researcher with flexibility when working with populations that are difficult to define and access. A non-random approach is often used in qualitative research but can also be used in quantitative research, when investigators are not able to use probability selection methods.

Schutt (2006) suggests four non-random sampling methods. Namely:

1. Availability sampling: participants are selected on the basis of being easy to find and convenient to the study. Stopping someone on the street and inviting them to answer the research question is an example of availability sampling.

2. Quota sampling: the subjects are selected by convenience until the specified proportion of subjects for a specific subgroup is reached.

3. Purposive sampling: informants are selected by the investigator, to meet a specific purpose. The investigators try to obtain a sample that appears to be representative of the population and will usually try to ensure that a range from one extreme to other is
included (O'Leary, 2005). For example, a key informant survey may target individuals who are particularly knowledgeable about the topic of the study.

4. Snowball sampling: participants are recruited by asking informants for other people who may be suitable and willing to participate (Miles & Huberman, 1994). For example a sample where medical staff at a conference participate and then encourage colleagues to participate (Panacek & Thompson, 2007).

The advantages of non-random sampling include lower cost, faster data collection, smaller data sets ensuring homogeneity and to improvement to the accuracy and quality of the data (Ader, Mellenbergh & Hand, 2008; Miles & Huberman, 1994; Schutt, 2006).

**METHODOLOGICAL APPROACHES AND DATA COLLECTION: APPLICATION TO THIS STUDY**

The researcher was interested in the live experiences of a small number of people working within the policies and regulatory framework for health policies in Timor-Leste particularly on Timor-Leste Health Policy Framework 2002 and its implementation, both at the national and local administration levels. A mixed methods approach was considered the most appropriate because rich data were collected and analysed relating to a few cases, allowing for the development of deeper understanding of the particular phenomena of interest under study and development of greater theoretical understanding (Greene, 2008).

Other reasons for choosing mixed methods were because both qualitative and quantitative data were merged to yield a complete analysis. They also combined with each other in some phases during the research process. For example, during interview some informants said that they had not enough midwives to attend pregnant women in the health post. The researcher then asked them how many midwives were allocated per Community Health Centre or Health Post and how many pregnant women came or visited the health post per week. This descriptive (qualitative) account was compared with the maternal health outcomes (quantitative) across and between health services.
The researcher was also able to uncover some unique variance which may have been missed by single method research (Creswell, 2003). For example, during quantitative data collections, participants complained about logistic support and transportation for Community Health Centres and Health Posts. Participants stated that they were allocated funding in their annual plan to provide at least one 4WD for each Community Health Centre and two motorbikes for each health post among their area of services. The researcher interviewed, had informal discussions and observed people to gather accurate information with an opportunity to validate data about logistics and transportation in specific health services. Using only qualitative or quantitative methods would have been inadequate to produce the detailed information about the situation.

**Mixed methods**

This research gave priority to qualitative methods over quantitative methods because qualitative research methods are more suitable for the investigation of human behaviour than quantitative statistics (Rice & Ezzy, 2002). This study required a deep understanding of human behaviour which was largely gained through observation and interview methods (Appendix 3 guide interviews). For example, it was valuable to identify the ways in which good governance principles were neglected by the executive and senior managers in national and local government in Ministry of Health Timor-Leste and its partners when they developed and implemented health policies. The two case studies illustrated the phenomena of health policy implementation in the selected districts (Creswell, 2003; Somekh & Lewin, 2006; Yin & Yates, 1975).

The study started by identifying the criteria for designing a mixed methods study and reading reports in the social and behavioural science literature. The researcher adopted the criteria promoted by Creswell, et al, (2004) that involved both quantitative and qualitative data collection and analysis. This study also integrated, combined and compared both quantitative and qualitative data at all stages in the research process. The study examined the governance of policy makers, managers and staff at local and national levels and assessed gender equality and management styles. These criteria became a coding template for analysing data collected in this
study. Data collected was typed into full notes as transcripts. This study used NVIVO8 computer software to assist the data analysis. The researcher reviewed the transcriptions carefully, marked with codes, and then grouped codes into categories, and themes. A distinction was made between the research participants and data collected; recruitment techniques; number of research participants; research methods and analysis. These are reflected in Table 1: Overview of Data Collection and Analysis Plan.
<table>
<thead>
<tr>
<th>Phase I and Phase II (Iterate/Validation)</th>
<th>Participants</th>
<th>Sampling</th>
<th>Quantity</th>
<th>Research methods</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MoH: Headquarters</strong></td>
<td>Purposive</td>
<td>13</td>
<td>Semi-structured interviews</td>
<td>Thematic analysis</td>
<td></td>
</tr>
<tr>
<td>Managers and staffs</td>
<td></td>
<td></td>
<td></td>
<td>Conceptual framework</td>
<td></td>
</tr>
<tr>
<td>Local and international advisors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institution under MoH</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Snowball</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MoH’s Partners:</strong></td>
<td>Purposive</td>
<td>9</td>
<td>Semi-structured interviews</td>
<td>Thematic analysis</td>
<td></td>
</tr>
<tr>
<td>Parliament</td>
<td></td>
<td></td>
<td></td>
<td>Conceptual framework</td>
<td></td>
</tr>
<tr>
<td>Relevant Ministries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Stakeholders</td>
<td></td>
<td></td>
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<tr>
<td>Religious leaders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local and International NGOs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Snowball</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Secondary data MoH 2009</strong></td>
<td>Systematic search</td>
<td>1 year 2009</td>
<td>Numerical data Quantitative reports</td>
<td>Systematic analysis; Basic descriptive statistic; Graph and tables</td>
<td></td>
</tr>
<tr>
<td>Literature in multiple languages from 1910 to present</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phase I and Phase II (Iterate/Validation)</th>
<th>Case Studies – 2</th>
<th>District A and B:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Purposive</td>
<td>Semi-structured</td>
</tr>
<tr>
<td></td>
<td></td>
<td>interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focus Groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Observation 1 month</td>
</tr>
<tr>
<td></td>
<td>Snowball</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participants</th>
<th>Sampling</th>
<th>Quantity</th>
<th>Research methods</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>District A and B (health and other relevant departments)</td>
<td>Purposive</td>
<td>10</td>
<td>Semi-structured interviews</td>
<td>Thematic analysis</td>
</tr>
<tr>
<td>Health workforce</td>
<td></td>
<td></td>
<td></td>
<td>Conceptual framework</td>
</tr>
<tr>
<td>Communities Partners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thematic analysis</td>
</tr>
<tr>
<td>Conceptual framework</td>
</tr>
<tr>
<td>NVIVO8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic analysis; Basic descriptive statistic; Graph and tables</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thematic analysis</td>
</tr>
<tr>
<td>Conceptual framework</td>
</tr>
<tr>
<td>NVIVO8</td>
</tr>
</tbody>
</table>
Respondents and sampling districts

This study used non-random sampling.

Respondents

Respondents were sampled in two ways, either purposive or snowball. The respondents were from the Ministry of Health and its relevant ministries and partners, including stakeholders who had health governance knowledge and who were concerned with the development and implementation of the Timor-Leste Health Policy Framework 2002 (Ministry of Health Timor-Leste, 2002a) at the local and national level after the 1999 referendum. Other respondent were health workforce, communities including patients in Community Health Centres, referral and national hospitals. The following Table 2: Sampling Methods summarises how respondents were recruited to the research using both purposive and snowball sampling.

Table 2: Sampling Methods

<table>
<thead>
<tr>
<th>Purposive Sampling</th>
<th>Snowball Sampling</th>
</tr>
</thead>
<tbody>
<tr>
<td>District A</td>
<td>Two head of villages</td>
</tr>
<tr>
<td>District B</td>
<td>Two head of villages</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>One official staff and two international and local advisors</td>
</tr>
<tr>
<td>Personalized Services A</td>
<td>None</td>
</tr>
<tr>
<td>Personalized Services B</td>
<td>One leader and two health professionals</td>
</tr>
<tr>
<td>Personalized Services C</td>
<td>None</td>
</tr>
<tr>
<td>Members of Parliament</td>
<td>None</td>
</tr>
<tr>
<td>Civil society</td>
<td>None</td>
</tr>
<tr>
<td>Relevant ministries and their personnel</td>
<td>One national director and two head of programs</td>
</tr>
<tr>
<td>Local and International NGOs</td>
<td>One program manager</td>
</tr>
<tr>
<td>Advisors</td>
<td>None</td>
</tr>
<tr>
<td>Health professional associations</td>
<td>None</td>
</tr>
<tr>
<td>Communities/ patients</td>
<td>One community and one patient</td>
</tr>
</tbody>
</table>
Headquarters and its partners

In the Timor-Leste Ministry of Health the respondents were decision makers from the headquarters at a national level including Personalized Services\(^1\) or institutions within the Ministry of Health, which included the leaders from Personalized Services A, B, and C. Snowball techniques, were also used in both Ministry of Health and Personalized Services B. Some people in headquarters were interviewed who then recommended and advised other leaders for interview, including international and local advisors that knew about the topic of the study. They participated directly in the process of the development and implementation of Timor-Leste Health Policy Framework 2002. Whereas at Personalized Services B the leader recommended and identified other leaders and health professionals who knew about the general health system.

Individuals occupying a wide variety of roles were approached to ensure a diversity of perspectives were included. These included Ministry of Health partners, relevant ministries, members of parliament serving on the health commission, some international advisors, religious leaders, media, national and international NGOs, and other health organizations, representatives were recruited for interview.

Sampling districts

Districts were chosen purposively using the criteria ‘good’ and ‘poor’ performance. ‘Good’ performance was defined as meeting an acceptable standard of health outcomes for a given population. Whereas, ‘poor’ performance was indicated by lower than expected health outcomes. The indicators used to assess ‘good’ and ‘poor’ performance are presented in Table 3 below. Indicators include maternal health, immunization rates, and nutrition rates for each district population.

\(^1\) The Personalized Services are collective entities of public law attributed with legal personality and administrative, financial and asset autonomy, accordingly to the terms of the respective organic status. They have their own organic statute (Organic Statute of the Ministry of Health, 2007). They are neither fully public nor private legal entities and may be employed as both permanent government staff and/ or temporary contract staff.
Table 3: Indicators for ‘good’ and ‘poor’

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Good Criteria</th>
<th>Poor Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pregnant women who made 1\textsuperscript{st} Ante Natal Care (ANC) visit</td>
<td>$\geq 70.3%$</td>
<td>$\leq 42.6%$</td>
</tr>
<tr>
<td>- Pregnant women who made 4\textsuperscript{th} ANC visits</td>
<td>$\geq 26.7%$</td>
<td>$\leq 15.2%$</td>
</tr>
<tr>
<td>- Deliveries attended by health personnel</td>
<td>$\geq 58.3%$</td>
<td>$\leq 26.5%$</td>
</tr>
<tr>
<td>- Post natal related services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 week after delivery</td>
<td>$\geq 57.8%$</td>
<td>$\leq 20.8%$</td>
</tr>
<tr>
<td>1-6 weeks after delivery</td>
<td>$\geq 45.4%$</td>
<td>$\leq 16.1%$</td>
</tr>
<tr>
<td>Vitamin A and iron supplement</td>
<td>$\geq 60.6%$</td>
<td>$\leq 24.4%$</td>
</tr>
<tr>
<td>- Number of maternal deaths</td>
<td>$\geq 5%$</td>
<td>$\leq 12%$</td>
</tr>
<tr>
<td>Immunization for pregnant women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- TT 1</td>
<td>$\geq 43.5%$</td>
<td>$\leq 20.7%$</td>
</tr>
<tr>
<td>- TT2</td>
<td>$\geq 39.7%$</td>
<td>$\leq 17.5%$</td>
</tr>
<tr>
<td>- TT2+</td>
<td>$\geq 63.6%$</td>
<td>$\leq 40.8%$</td>
</tr>
<tr>
<td>Immunization among children &lt; 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- BCG</td>
<td>$\geq 105.7%\textsuperscript{1}$</td>
<td>$\leq 71.4%$</td>
</tr>
<tr>
<td>- Measles</td>
<td>$\geq 97.2%$</td>
<td>$\leq 59.0%$</td>
</tr>
<tr>
<td>- Polio 1</td>
<td>$\geq 109.2%$</td>
<td>$\leq 69.5%$</td>
</tr>
<tr>
<td>- Polio 2</td>
<td>$\geq 106.9%$</td>
<td>$\leq 63.8%$</td>
</tr>
<tr>
<td>- Polio 3</td>
<td>$\geq 102.9%$</td>
<td>$\leq 57.7%$</td>
</tr>
<tr>
<td>- DPT-HepB1</td>
<td>$\geq 109.2%$</td>
<td>$\leq 71.2%$</td>
</tr>
<tr>
<td>- DPT-HepB2</td>
<td>$\geq 106.9%$</td>
<td>$\leq 63.3%$</td>
</tr>
<tr>
<td>- DPT-HepB3</td>
<td>$\geq 102.9%$</td>
<td>$\leq 58.2%$</td>
</tr>
<tr>
<td>Nutrition, average number among children under 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Moderate malnutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-23 months</td>
<td>$\leq 15.9%$</td>
<td>$\geq 24.8%$</td>
</tr>
<tr>
<td>24-59 months</td>
<td>$\leq 16.5%$</td>
<td>$\geq 19.6%$</td>
</tr>
<tr>
<td>- Severe malnutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-23 months</td>
<td>$\leq 16.4%$</td>
<td>$\geq 25.3%$</td>
</tr>
<tr>
<td>24-59 months</td>
<td>$\leq 17.6%$</td>
<td>$\geq 49.1%$</td>
</tr>
<tr>
<td>- Moderate and severe malnutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-23 months</td>
<td>$\leq 32.3%$</td>
<td>$\geq 50.1%$</td>
</tr>
<tr>
<td>24-59 months</td>
<td>$\leq 34.0%$</td>
<td>$\geq 68.7%$</td>
</tr>
</tbody>
</table>

Source: Annual Health Statistics Reports January-December 2008, MoH-TL

$\textsuperscript{1}$ > 100\% where inflows of patients outside district.
**Districts**

Timor-Leste is divided into five geographical regions with 13 related districts. Purposive sampling was used to select two districts.

District A was identified as having good performance and district B as poor performance. District A and District B are located in different geographical regions. Assessment of performance was based on the Annual Health Statistic Report for the period January-December 2007 (Ministry of Health Timor-Leste, 2008b). The districts were selected because both are situated not far from the capital of Timor-Leste yet perform very differently.

The respondents in both districts were the district administrators, head of District Health Services, clinic staff, representatives of local NGOs, family health promoters (health volunteers), patients, communities, and other stakeholders. In both districts the heads of the Community Health Centres were interviewed. These individuals then referred me to village leaders conversant with the systems and impact of both public and private health services. Both districts were treated the same in research design, selection of participants, data gathering and data analysis.

**Case Studies**

Two case studies were employed in this research to describe and compare the development and implementation of the health policy framework (George & Bennett, 2004 cited in Walt et al., 2008). Case study approaches were used to analyse the health system and health services delivery (Trurston et al., 2005; Yin, 1999; Yin & Yates, 1975) within the bounds of the Timor-Leste Health Policy Framework 2002. Moreover, case study research design involved analysis at sub-unit level to present a complete image of the health system and health services in Timor-Leste, in both districts.

**Data collection**

During October 2009 and May 2010 the researcher collected data from two districts, four sub districts and eight villages plus one referral hospital and one
national hospital including Ministry of Health and its three institutions, two relevant ministries and six development partners (UN agencies and other stakeholders). Data included observations, interviews, general and Focus Group Discussions. The researcher attended high level and operational meetings in Ministry of Health and workshops regarding health issues and the implementation of Timor-Leste Health Policy Framework 2002. The second phase of the research was conducted between November 2010 and February 2011. In this stage researcher revisited participants and explored, observed and clarified more information.

Observation, interview and Focus Group Discussion (FGD)

Staff in headquarters and decision makers in Ministry of Health, representatives of relevant ministries, members of parliament (specifically those serving on the health commission), advisors, consultants, specialists, representatives of NGOs, religious leaders, district and sub district administrators, heads of district health services, managers of Community Health Centre (public and private), traditional community leaders were involved in this scoping study.

A total of 48 people were interviewed and four focus group discussions were held. Each focus group discussion contained 10-12 people. The majority of the interviews and focus group discussion were conducted in Tetum, with some conducted in English. All interviews were recorded on audio-tape. Informed consent was obtained from all participants prior to recording. Each interview was conducted in a private space within the respondent’s place of work. Interview guides were semi-structured and used open-ended questions. Each interview lasted approximately 45 minutes whereas focus group discussions (FGD) averaged 90-100 minutes.

Handwritten notes were made at the time of each observation, interview, discussion, and focus group discussion (Attig et al., 1993). Throughout interviews and focus group discussions the researcher noted the behaviour, gestures, facial expressions, and overall attitudes of participants. The researcher also observed participant behaviour in the field, when they delivered their services in Ministry of Health, District Health Services, Community Health Centre, referral hospital and national hospital. The researcher monitored the behaviour of community members in the field when they accessed Community Health Centre, SISCa (*Serviço Integrado...*)
da Saude Communitária), the referral hospital and national hospital. Observations were also made when staff consulted mangers and decision makers at headquarters (Ministry of Health and District Health Services).

Note-taking was constant during data collection. All notes from interviews, discussions, focus group discussions and observations were written up in full with the aid of the digital recording, on the same day of the data gathering.

**Analysis**

*Qualitative*

Field notes were recorded throughout fieldwork. Full interview records in both Tetum and English were read and the notes were used for cross checking when researcher typed the full transcriptions. Transcriptions were read and re-read and coded manually (Glaser & Strauss, 1967).

Data was analysed using NVIVO8 computer software to facilitate sorting and data management. Transcripts were entered into NVIVO8 computer software for analysis (Schutt, 2006). Codes reflected the key issues which emerged from the research questions, in-depth interviews, focus group discussions, observations, and also themes were identified during the process of reading and coding records (Charmaz, 2005; Glaser & Strauss, 1977; Markovic, 2006). To attain validity of this study researcher also used triangulation of data analysis techniques (Golafshani, 2003). Triangulation was used and provided validation for governance and health system in the field. For example the researcher examined participants’ understanding with the theoretical understanding of how governance and health system is constructed within two districts, which revealed parts of the analysis that had been overlooked.

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2 Integrated Community Health Services, the goal of SISCa is “population, who live in the city in the mountains or in the valley, must receive the same quality of health assistance” (Ministry of Health Timor-Leste, 2008), with a principle of “From With To the Community” (*ibid*, 2008).
Demographics, health workforce and health services were analysed in order to compare the selected districts through the Ministry of Health 2009 Health Statistics. This data provided information about performance in distinct health, and geographical areas, as previously described. Quantitative data was collected and analysed through constructed simple statistical models, tables and basic descriptive statistics in an attempt to explain what was observed and the data gathered (Kuhn, 1961; Tashakkori & Teddlie, 2003) and to classify key factors; for example the total workforce and qualifications, total population and logistical supports which influence the health policy implementation in Timor-Leste.

Limitation

Although the research was carefully prepared there were some limitations. The limitation related with the research primarily to my previous position as a senior staff in headquarter Ministry of Health Timor-Leste, this is described in the ethics section. The limitations of this research from a infrastructure perspective (road and bridge condition) are obvious and I did not presume to provide a comprehensive description of health system and governance in some peripheral areas. I could only conduct interviews and observations in areas reachable by public transportation, therefore the perceptions of peripheral communities are likely to be under-represented. This research was conducted only in two District Health Services and involved some participants from different levels from central and local government and might not represent the majority of the District Health Services. I acknowledge that a case study may not reflect the performance of health governance and system of most districts in Timor-Leste. However, based on my experience as a Timorese senior staff in Ministry of Health, and the majority of participants’ information, these two case studies described in Chapter Six and Seven are evocative of the performance of governance and health system of other District Health Services in Timor-Leste.

Another limitation was some secondary data (reports and aggregated statistic) collected at districts, sub districts, referral and national hospital including
headquarter was unsuitable for the purposes of research. For example the total professional and administrative staff, health equipments and other logistical support were incomplete and incorrect. Consequently I had to cross-check and verify directly from the field in peripheral areas. These incomplete data recording and reporting and aggregated statistics were major difficulties impeding the research process that required extra time in the field for proofing and correction, also hindering the quality and value of the health information system in both District Health Services A and B and Ministry of Health Timor-Leste.

HUMAN ETHICS

Ethics approval was granted for this study by the Human Research Ethics Committee, Charles Darwin University (HREC-CDU, reference number H09045, Appendix 4). All participants were provided written informed consent (Silverman, 2000) which all participants signed prior to participation (Appendix 5 Informed Consent Form for Headquarters, Appendix 6 Informed Consent Form for Community, and Appendix 7 Plain Languages Statement). Permission was obtained from local health authorities to interview staff in their place of work. Additional authorization and support for the research was gained from Minister of Health Timor-Leste (Appendix 8).

Complexities and confidentiality

As an individual well known in the Ministry of Health and among the population of Timor-Leste, particularly in both districts it was important for me to give due attention to ethical and confidentiality aspects of this research. The essential matter of human ethics is personal given my direct involvement in this research.

I was aware of my responsibilities when obtaining information from informants (Weber, 1946). I informed the participants about the investigation and reassured them that the information and names of people, places and organizations would be kept confidential. I assured people that identifying information would not be made available to anyone not directly involved in the study. However, this is a difficult task in small country like Timor-Leste. Families and communities are
strongly linked and it can be easy to identify those involved in the research. To limit this and thus to protect the research informants I have used pseudonyms and de-identified participants and place names.

**Difficulties and reflexivity**

There were some difficulties when conducting the fieldwork in Timor-Leste. My research base was my office at the Ministry of Health. The implication of this was that staff at Ministry of Health were both my colleagues and my research participants. Prior to engaging with this study I occupied the position within the Ministry of Health of national director for Health Services Delivery. In this role most of the Ministry of Health staff at both national and local levels including both A and B District Health Services reported to me through formal management structures. Thus I was in a position of authority. I was also in the privileged position of having a deep understanding of Ministry of Health policies and issues, including the relationships and friendships among Ministry of Health staff, district staff, community representatives, representatives of UN agencies, national and international NGOs and the private aid sector.

My position of power and influence within the Ministry of Health probably impacted on the fieldwork. Some participants may have seized the opportunity to promote family members, or raise concerns pertaining to their family. Others may have been apprehensive of my motives and reluctant to share some information and concerns. I needed to be continually aware of and reflect on these relationships in the processes of data collection and analysis.

In order to build trust I took time to engage with participants in my new role as researcher. I explained to them the reasons for and goals of the research and how the research findings will be used in both Ministry of Health and districts and peripheral areas. I decided my primary responsibility is as a researcher student and to maximize the objectives of the research improving the health outcomes, in a systemic and organizational approach for all Timor-Leste people. I believe that the way I interacted with participants helped build relationships characterised by trust, which was important in my study and gave me special access that perhaps an outsider could not have achieved (Rabe, 2004). Furthermore, I am like most Timorese Roman
Catholic and this personal faith influences my perception and analysis, however this makes this thesis a product of my culture and my country.

CONCLUSION

This chapter has presented the methodology used in this research. Mixed methods, qualitative and quantitative research approaches and data collections are described and critiqued. The case study approach is also described. The way in which this approach was used to analyze the implementation of the Timor-Leste health policies and systems at a national and local district level was presented. To ensure validity of qualitative research in this study triangulation of data analysis techniques also experienced. Sampling methods used in this research were also presented and justified. The criteria for health performance were also presented against which both qualitative and quantitative data were analyzed. Ethical considerations and my role as a researcher with a long history and senior role within the Ministry of Health Timor-Leste were presented and discussed.

The next chapter will discuss Timor-Leste society and governance. The researcher provides a social and economic profile of the country, cultural and historical context and political and administrative structure as it pertains to the health system in Timor-Leste during three epochs.
CHAPTER 4: TIMOR-LESTE
SOCIETY, POLITICS AND
GOVERNANCE

INTRODUCTION

This chapter addresses relevant aspects of the history of Timor-Leste with reference to systems of governance for each era – Portuguese (1515-1975), Indonesian (1975-1999), United Nations (1999-2002), and the period of Independence from 2002. The data for this chapter is from secondary historical sources, government documents and reports, as well as first hand reports of the experience of Timorese people.

The current health system in Timor-Leste was shaped by three periods of colonization in the country’s history. During the Portuguese era, before War World II there were no formal public health services, the health system was not defined and health infrastructure did not fully cover all districts, sub-districts and villages. The health care services were provided by missionaries, Catholic priests and nuns, and the military. After 1967 the health system, including public health care, was more formalized. But the experience of governance in health system during this epoch provided valuable learning to be applied the future of the health system in Timor-Leste.

The health system in Indonesia era was more fully developed. The health system and infrastructures were established from the national level down to the local villages including remote areas. In terms of governance, structure was generally well developed but responsiveness, transparency and accountability were significantly lacking and corruption increased in all government departments. Therefore, quality health care and health outcomes were lower than other provinces of Indonesia.

The major issue after independence in 1999 was to rebuild and reconstruct the health infrastructure and health system which was destroyed during the 1999 crisis. Health care services were provided by the international NGOs who brought their own systems and cultures. Timor-Leste’s health system was rebuilt and reorganized by the East Timor Health Professional Working Group with the assistance of World
Health Organization and UNTAET. A core aim has been to address deficiencies in governance and service delivery that have impacted negatively on health outputs and outcomes for all Timorese people.

Therefore, the current Timor-Leste governance in health system continues to face significant challenges. Governance principles are referred to in all official documents such as public policies and strategies but are poorly implemented. There are dissimilarities in the way governance principles were applied during the periods of Timor-Leste’s history and these have influenced health outcomes, system and performance, including community development and social determinants of health. This chapter considers these subjects.

CULTURAL AND POLITICAL CONTEXT

In the pre-colonial era the traditional power structure reinos (kingdoms) regulos (rulers) liurais (kings) and datos (tribal elders) were revered on the island of Timor. A kingdom controlled by a liurai (king) was defined by its language area (Nordholt, 1971). Freycinet (1817 in Gunn, 2005) observed that the kings exercised supreme power over their people. Rules of succession varied but were, in principle, hereditary and generally patriarchal. If a king passed away his position was taken by his oldest son. If there was no mature son, the eldest daughter or wife would take on the role. Examples of the latter include the Queen of Balibo and Queen of Cova (Freycinet, 1817 in Gunn, 2005). However patriarchal domination was strong and only the men were regarded as having rights. All decisions were made by men and women were required to submit (Gunn, 2005; Nicol, 2002). These systems still have influence in some parts of the country, and some men continue to disregard women’s capacity to serve in government in the present day. A participant in this research who serves as a middle level manager in Ministry of Health commented: “…Consequently some men still hold this understanding even in the office…” (Headquarter 11).

Timor Island was characterised by a diverse and complex culture and traditions. (Cinatti et al., 1987; Nicol, 2002). The son of a liurai could only marry the daughter of a liurai of another kingdom (Sousa, 2001) and arranged married also existed. Many traditions, myths and legends, and a long tradition of animism are also
part of the culture of this island. Traditional stories centre on the spirits, which materialize through, for example stones, animals, and other objects endowed with mysterious magical powers. These powers can be either good or evil and are described as *lulik* (sacred and mystical) (Gunn, 2005; Hicks, 1976; Nicol, 2002). Traditional and herbal remedies perceived to contain these powers are still used by some Timorese people, (Gunn, 2005; Povey & Mercer, 2002) impacting health indicators.

The opportunity to exploit Timor’s sandalwood attracted Chinese, Japanese and Indian traders to Timor Island. In 1225 the ‘Chinese Trade Foreign Inspector’ reported that Timor was rich in sandalwood (Gunn, 2005). In 1515 the Portuguese traders and Dominican missionaries reached the coast of Timor near Oecusse. Oecusse is now a district of Timor-Leste.

The Portuguese traders wanted to consolidate their monopoly of sandalwood supplies. The missionaries were engaged in Catholic evangelization and sought to attract traditionalists especially *liurai* to ‘civilization’. The first missionary to Timor-Leste baptized 5,000 Timorese (Lyon, 2011). The evangelization soon spread to Solor and other neighboring islands such as Flores in 1556 (Gunn, 2005). Efforts to convert local people began at the time of Portuguese colonization. The Portuguese occupied Timor Island, by gaining the trust and loyalty of the local people through missionaries. They did not use guns or force. By 1780 Portuguese-Timor had 50 churches spread throughout the territory (Lyon, 2011).

However, in the 16th century the Protestant Dutch also reached Timor Island. Conflict between the European superpowers split the island (Gunn, 2005). Eventually, West Timor was colonized by the Dutch and East Timor including the enclave of Oecusse was called Portuguese-Timor. Both colonizers destroyed the strong traditional power structures and culture systems that had existed in Timor (Gunn, 2005) with the intention of taking over.

In East Timor (Portuguese-Timor) on one hand the colonizers integrated traditional structures into the government structure by the *liurai* became *regulo* and *dom* giving them military ranks. On the other hand they created sub-districts that completed with the chiefs that had taken over of administration, thus, Ospina and Hohe (2002) analyzed that gradually the *liurai* and *regulos* become less powerful. But there was some level of cooperation between the government and the traditional
administrative structures. For example any implementation of the instruction from the central government required consultation with and approval by liurais (Pélissier 1847-1913 in Gunn, 2005).

Under Portuguese rule a governor served as the head of Timor supported by four staff and the territory was divided into ten districts (Gunn, 2005). However, there was a poor relationship between the Catholic Church missionaries and the government as the latter made decisions contrary to Catholic doctrine. This offended the local people through disregard for their traditions, culture and human values (Gunn, 2005), and because the Catholic Church as an institution defended indigenous human rights at that time. Another reason for the poor relationship was that the government forced the kingdoms to pay unreasonable fintas (tax in the form of goods).

Throughout the history of the Catholic Church in Timor-Leste there has been recognition of the traditional power structure liurais and the values of the local community. Therefore the Catholic Church knows who is the key person in a village, sub-district and district they should make contact with. This historical relationship has significance for Timorese and Catholic Church life today. A participant in this study who is a Timorese Catholic Leader said, “For the Timorese people, Catholicism is not just a religion but central to their Timorese identity. Therefore, since a long time ago our ancestors till present day, any government decision or policy that contradicts the Church and thus contradicts Timorese dignity and identity, they will fight against”.

In 1864 the government established a hospital in Lahane Dili and health services were provided by a military doctor. Three primary schools (Dili, Batugade and Manatuto) were also established with a total of sixty students. This school was exclusively for the sons of liurais (Gunn, 2005). However, the subjects taught were protested by Catholic Church through a Macau newsletter “A VOZ DE CRENTE” because the subjects did not include civilization, moral principles and human values (Gunn, 2005). There was also opposition to the lack of resources poured into Dili. “Dili was a part of Portugal but continued to be a poor town relative to the other Portuguese colonies. The colonizers spread only the stupidity” (Goulart, in Gunn,
2005, p. 196). Through a huge effort of Bishop Medeiros in 1877, the first formal education development resulted in the establishment of Jesuit colleges in Soibada and Lahane Dili, as well as Catholic schools in other places. A mission of Bishop Medeiros was to establish a school in every region with a missionary. At that moment Catholic and public schools prepared students (son of liurai) to become Catholic catechist teachers and future senior officials (Gunn, 2005). This strategy was aimed to install the value of Catholic religion, education and civilization to students, so after they could influence their parents and locals. The colleges also provided places for girls but at that time Timorese parents did not agree to send their daughters to boarding school. This tradition influences some parents today, as some parents remain unwilling to send their daughters to school. This directly affects women’s health and impacts on health outcomes, including the high maternal mortality rate.

After finishing their study some sons of liurai returned to their villages and replaced their parents as liurai. They governed with moral principles, respect for human value based on Catholic doctrine (A Timorese Catholic leader). They gained human capital and social development including leadership and were considered most advanced. Therefore, the education including the civilization of Timorese people during this period came from the Catholic Church, not government (A Timorese Catholic leader).

At the same time Bishop Medeiros also established a hospital called Casa de Beneficência in Dili where missionaries provided basic health services. In his book A mão D'Obra em Timor: breve memoria sobre o seu territorio, clima, producção, usos e costumes indígenas, industria, agricultura e commerçio, Montalvão notes that at that time the dominant diseases were Cholera and Smallpox including Malaria and Tuberculosis (Montalvao e Silva, 1910). The Catholic missionary activities came to be increasingly in the educational and political institutions of Portuguese-Timor such that by 1930 the total Catholic population numbered 19,000 persons.

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3 Pe. António Joaquim de Medeiros was the Rector of S. José Seminary in Macau appointed by Macau Diocese to Portuguese-Timor with the intention to reform and rehabilitate the Catholic Mission. Pe. Medeiros was later nominated as Vicar General in Portuguese-Timor.
During World War II (1942–1945) Australia and Japan fought each other on the island and Japan invaded Portuguese-Timor (Wray, CCH, 1987). By the end of the war, the province of Portuguese-Timor was destroyed and approximately 70,000 Timorese lost their lives (Simpson, 2005). In 1945, the Portuguese administration was restored and the government helped to recover but support was limited and progress was slow. Despite this benign neglect which characterised the five hundred years of Portuguese rule, the Timorese people still reminisce very fondly the Portuguese presence and their influences in Timor-Leste.

After the restoration of democracy in Portugal on 25 April 1974, it was decided to give Portugal’s colonies the right to self-determination. In May 1974 the government authorized the establishment of political parties in the province of Portuguese-Timor (Timor-Leste). Thus, for the first time Timor-Leste was given freedom to form political parties, and three main parties were formed. Timorese Democratic Union (União Democrática Timorense or UDT) was the first party to be established. This party was supported by the traditional elites. It initially supported continued association with Portugal, but later adopted a 'gradualist' approach to independence, promoting achievement of absolute independence over a period of 15 to 20 years. Eventually it supported a more rapid transition of independence within 3-5 years (Nicol, 2002). The second party was the Timorese Social Democratic Association (Associação Social Democrática Timorense or ASDT), which would later changed its name to Revolutionary Front for an Independent East Timor (Frente Revolucionario de Timor-Leste Independente or FRETILIN). ASDT/FRETILIN supported a rapid shift to independence (Nicol 2002). The third party was the Timorese Popular Democratic Association (Associação Popular Democrática Timorense or APODETI) which supported Timor’s integration with Indonesia as an autonomous province. APODETI had very little grassroots support (Nicol 2002). There were also two smaller parties: Sons of the Mountain Warriors (Klibur Oan Timur Asuwain or KOTA) and the Labour Party (Trabalhista) (Gunn, 2005; Nicol, 2002). KOTA sought to create a form of monarchy drawing on little local liurais. Neither of these two parties had any significant support.

In 1975, with the dissolution of the Portuguese colonial empire, local liberation movements increased. On 28 November 1975, FRETILIN unilaterally declared the independence of Timor-Leste. However, the declaration of
independence led to a civil war (Gunn, 2005; Sousa, 2001). Claiming the desire to protect Timorese citizens as the reason, ten days later Indonesia invaded the Eastern part of the island and declared the island as its 27th province, renaming it Timor-Timur.

In December 1975 when Indonesian forces invaded Portuguese-Timor, the colonial administration and traditional powers were dissolved. The only organized institution was the Catholic Church. Many foreign and native priests including the Bishop of Portuguese-Timor Dom José Joaquin Ribeiro stayed to protect their urban communities but some priests fled with the communities to the mountains. This strengthened and deepened the relationship between Timorese community and the Catholic Church. The percentage of the Timorese population who identified as Catholics more than doubled in the year of the Indonesian occupation to about 60% of the total population (Lyon, 2011).

During the Indonesian occupation 1975-1999, structurally Timor-Timur was a province of Indonesia and was under the same government system as other provinces of Indonesia. The Indonesian government used the traditional power structures tokoh masyarakat (members of society). The responsibility of tokoh masyarakat was as problem solvers. Moreover, history and experience inform us that rural communities are still strongly guided by representatives of the traditional structure and the people still trust the liurai system (Ospina & Hohe, 2002). Therefore, at the democratic election of xefe sukus (village leaders) people knew whom they had to vote for and mostly preferred to vote for a descendant of liurai or dato because they are widely trusted and respected.

Human rights abuses conducted by Indonesian military force and pro-Indonesia Timorese spread throughout the province of Timor-Timur. Regardless of ideological and political differences the Catholic Church worked together with the Timorese who were in opposition to Indonesian and against Indonesian occupation of Timor-Leste. Under the Indonesian occupation the Catholic Church was the only source of opposition to the Indonesian government and became a most important resource in the independence movement against Indonesia (Carey, 1999; Lyon, 2011). The Church was the only local institution that could communicate independently overseas and helped to inform the world about the real situation of East Timorese people. The Timorese resistance movement (against Indonesia)
continued for 24 years in the face of violent suppression by Indonesian forces. The most conservative estimates indicate that 150,000 to 220,000 Timorese were killed during the occupation by the Indonesian military (Gunn, 2000; Nixon, 2004; Staveteig, 2007).

Finally, on the 30 August 1999 through the referendum supported by the United Nations, 78.5% of the Timorese population voted to secede from Indonesia (Bureau of East Asian and Pacific Affairs, 2005). However, in an act of revenge, pro-Indonesian militias and Indonesian military killed an estimated 1,300 supporters of independence (Bureau of East Asian and Pacific Affairs, 2005; Gunn, 2000). Pro-Indonesian militias and the Indonesian military razed towns, slaughtered civilians and forced one-quarter of the population out of the province of Timor-Timur to West Timor. They destroyed more than 80 percent of houses including public buildings such as the Department of Health, hospitals, health facilities, schools and other public and private offices in Timor-Leste (Bureau of East Asian and Pacific Affairs, 2005; Dolan, Large & Obi, 2004; Gunn, 2000). Consequentially, the government administrative and economic systems were obliterated. On 12 September 1999 an international peacekeeping force led by Australia began restoring order to the destroyed region.

Before 25 October 1999, Timor-Leste was a non-self governing territory. Therefore according to article 73 (Chapter XI Declaration Regarding Non-Self-Governing Territories), the United Nation Security Council authorized the United Nations Transitional Authority in East Timor (UNTAET) to assume full administrative powers and sovereign authority over the country of Timor-Leste. The UNTAET in Timor-Leste was mandated to control, rebuild, restructure and administer the country for nearly three years. Another important responsibility of the UNTAET was to prepare Timorese people and country for independence. This unprecedented situation in state-building concentrated mostly on the national institutions. The UNTAET also established some fundamental institutions for governance and administration including a Constituent Assembly which was tasked with drafting a new constitution for Timor-Leste. In time, the Constituent Assembly became the parliament. As Hohe (2004) has identified, UNTAET embodied a centralized administration. This was transferred to the Timorese leadership which resulted in the under development of local government.
On 20 May 2002 the country’s administration was transferred from the UNTAET to Timorese control through a celebration of the restoration of Timorese independence. From that moment, the Timorese started rebuilding their own government system, including health, education, and the defence force.

As a post-conflict state Timor-Leste at independence was particularly vulnerable to state crisis and state failure (Shoesmith, 2008; United Nations Development Programme, 2010). In 2006 Timor-Leste succumbed to internal violent unrest. The root causes of the violence were complex and spread throughout the country. Consequently, government had to use state budget to address the enormous challenges of the aftermath of the crisis 2006. Moreover, the Timorese government faced challenges in planning and financial management that were based on the National Strategy Development Plan 2002, particularly in health, education, reform local government and infrastructure. Countries beset by military conflict and fragility make lower progress in terms of attaining the objectives of Millennium Development Goals and also remain vulnerably to external shocks such as the global financial crisis (United Nations Development Programme, 2010). This situation affects Timor-Leste today.

POLITICAL AND ADMINISTRATIVE STRUCTURES

The Constitution of the Democratic Republic of East Timor was implemented when Timor-Leste officially achieved independence on 20 May 2002, and established the basis of the new state. The Constitution provides for a Democratic Republic and adopts a semi presidential system that combines two-power centres, with the President as the Head of State and the Prime Minister as the Head of Government. The legislature is a unicameral Parliament that is modeled on the unicameral (having of a single legislative chamber) parliamentary system of its colonial ruler, Portugal.

Legislative Branch

The National Parliament was transformed from the Constituent Assembly in 2001 after the Assembly had developed the constitution. The National Parliament is
comprised of 65 seats elected by popular vote to serve five-year terms. All citizens aged 18 and older have the right to vote. The first parliament commenced with 88 members based on a party list system. There were 23 women out of 88 members, which constitutes 26% of the representatives. The electoral law required at least every fourth candidate on the party list to be women, in 2011 the amended electoral law raised this to three. The responsibilities of the National Parliament are stated in the constitution of Timor-Leste:

Pass relevant legislation in a timely manner; establish a multi party system and democratic rules through a productive dialogue; provide a counterbalance to the powers of the Presidency and of the Government; and establish and maintain proper, efficient and effective communication between the various branches of the government in order to ensure respect for the Constitution and constitutionally enacted laws, transparency within the public administration, and the independency and impartiality of the judiciary. (Democratic Republic of Timor-Leste, 2002a).

An important role of the National Parliament is to foster a functioning democracy and good governance. For example the parliament scrutinizes and amends drafts of legislation and bills; analyzes and presents their policy implications as well as communicates its work to the public. Shoesmith (2008) has pointed out that Timor-Leste needs a strengthened legislature that can scrutinize and oversee the executive. In growing democracies the executive branch tends to dominate the legislature. Morgan (2005) found executive dominance to be characteristic of the Melanesian parliamentary system. Political scientists suggest that parliamentary systems provide for the needs of developing states better than presidential systems (Henderson, 2006; Sartori, 1997; Stepan & Skach, 1994). Therefore, Timor-Leste needs a powerful parliament to prevent the breakdown of democracy and increase better governance in all government systems to ensure the establishment of mutual commitment, consideration, cooperation and trust between society and the state.

Another important responsibility of the National Parliament is to approve or reject the State Budget. According to the constitution, the State Budget shall be prepared by government, and then submitted to the National Parliament for debate, amendment, and enactment. The key element of this process is Committee C (Economy and Finance and Anti Corruption) of the parliament. The State Budget is
debated openly in National Parliament. The media (television, radios and newspapers) always have access to the process of debate. The media TVTL\textsuperscript{4} and RTL\textsuperscript{5} conduct direct transmission, so that every Timorese citizen and the broader public can witness the debates. During the debates, there are moments of intensity and of humor among members of parliament or between parliament and government. These processes are considered important, and interesting as indicated by the fact that many citizens, ministries, companies, civil servants, and organizations of civil society are keen to know the outcome of such debates.

The legislative power in Timor-Leste is vested in both government and the National Parliament. The FRETILIN\textsuperscript{6} party dominated the National Parliament in the period 2002-2007. Currently the Parliamentary Majority Alliance (AMP) is in power and is comprised of five political parties (CNRT\textsuperscript{7}, ASDT\textsuperscript{8}, PSD\textsuperscript{9}, PD\textsuperscript{10} and UNDERTIM\textsuperscript{11}), which form a coalition.

\begin{itemize}
\item TVTL (Televisao de Timor-Leste) is a national television station in Timor-Leste. This station broadcasts in Tetum and Portuguese and also provides retransmission of the RTP International from Portugal.
\item RTL (Radio de Timor-Leste) is the national radio station in Timor-Leste. It broadcasts in Tetum, Portuguese and Indonesia 16 hours per day.
\item FRETILIN (Frente Revolucionaria do Timor-Leste Independente) Revolutionary Front for an Independent East Timor was founded in 1974. The purpose was to pursue full independence for East Timor, led by Francisco Guterres (Lu Olo).
\item CNRT (Conselho Nacional de Reconstrução do Timor) Congress National for Timorese Reconstruction was founded in March 2007 in preparation for 2007 parliamentary election. It is currently led by former President of Timor-Leste, Xanana Gusmao who is the current Prime Minister 2007-2012.
\item ASDT (Associação Social-Democrata Timorense) Timorese Social Democratic Association is led by Francisco Xavier do Amaral. Do Amaral is an ex-Timorese President as well as the person who made the unilateral declaration of independence on 28 November 1975.
\item PSD (Partido Social Democrata) The Social Democratic Party was formally lead by Mario Carrascalão and is currently lead by Zacarias Albano da Costa who is Minister for Foreign Affairs 2007-2012
\item PD (Partido Democrático) Democratic Party led by Fernando Lasama who is the current President of the National Parliament.
\item UNDERTIM (União National Democrática de Resistência Timorense) National Democratic Union of Timorese Resistance is led by Cornelio Gama better known as Eli Fohorai-Bot a former FALENTIL commander, currently as a member of National Parliament.
\end{itemize}
**Executive Branch**

Separation of powers is defined in Section 69 of the Constitution and constitutes separation of the Parliament from the executive. The president is the head of the Timor-Leste state. Presidents are elected by an absolute majority vote to serve a five-year term and any given individual may serve no more than two consecutive terms. Under the constitution, the president is the symbol of East Timorese independence. The president has veto power over certain types of legislation. Normally in a semi-presidential system a president has many responsibilities including the ability to influence the appointment of cabinet ministers (Stepan & Skach, 1994), but in Timor-Leste the president does not have these powers (Shoesmith, 2008). The president is the guarantor of the smooth functioning of the republic’s democratic institutions, as well as the supreme commander of the defence forces, but he shares the responsibility for security police with the government and parliament.

The Prime Minister is the head of government and the leader of the majority party or majority coalition parties appointed by the President after elections. As the head of government the Prime Minister is in charge of the Council of Ministers (the cabinet) and executive power exercised by government. Ministers appointed by the Prime Minister are not simultaneously members of the legislature. This is similar to the presidential system (Mainwaring & Shugart, 1997). If a Member of Parliament is appointed as a minister, they have to leave their seat and be replaced by the next candidate on the party list. This is also the system used in Norway, Belgium and the Netherlands (Rommetvedt, 2005; Shoesmith, 2008). Therefore, as a result the Parliament cannot be both the judge and the jury.

The first government in Timor-Leste (2002-2007) was led by the FRETILIN party and the general secretary of the party, Mari Alkatiri, was the Prime Minister. The government adopted a centralized system and the parliament was marginalized (Shoesmith, 2008). This government gave the impression that the grassroots did not enjoy the rights of citizenship and development of the country as an independent country. Poor communities in remote areas could not fully access public services and economic development as promised in the Constitution and National Development Plan. For example they could not achieve the basic levels of capital development.
which underpin social determinants of health. Only a small portion of the population prospered under the new government and independence. It was reported anecdotally that some poor people never touch the dollar: they just barter their goods to survive. Nepotism, power abuse and corruption within the government system, and unemployment became a national problem (Assistant Secretary-General Hedi Annabi Briefs Council, 2004; International Crisis Group Working to Prevent Conflict WorldWide, 2007).

After the parliamentary elections in 2007, former President Kay Rala Xanana Gusmão (José Alexandre Gusmão) was appointed as Prime Minister and his cabinet was sworn in on 8 August 2007. Prime Minister Gusmão leads a coalition government called the Alliance of the Parliamentary Majority (*Aliança com Maioria Parlamentar* or AMP). This government is making some changes in government structure and systems to achieve the goals of an independent Timor-Leste. For example, the elderly and disabled have been provided with a trimesterly pension. However, the overall impression of the work of this governing coalition is that the government lacks commitment, discipline, transparency and honesty. For example Xanana stated in an open dialogue with CPD-RDTL that corruption has increased within AMP government (International Crisis Group Working to Prevent Conflict WorldWide, 2010; Movimentu Pro Komisaun Anti Korupsaun, 2011).

The government is scrutinized and monitored closely by the opposition, public and civil society. The performance of the government is debated in Parliament and the mass media. Throughout the period 2009-2011 there was intense media reporting of accusations of corruption, power abuse, nepotism and lack of responsiveness on the part of government ministers, directors and leaders. These issues of poor governance are often lamented by the public in the media, even though a range of institutions responsible for addressing poor governance, such as the Anti Corruption Commission and Civil Service Commission have been established by the current government.

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12 *Conselho Popular pela Defesa da República Democrática de Timor-Leste* or Popular Committee for Defence of the Democratic Republic of Timor-Leste. CPD-RDTL was established in 1999 to promote the view that independent East Timor should be based on the original Democratic Republic of East Timor, which was proclaimed by FRETILIN on 28 November 1975.
It seems that both Alkatiri (2002-2007) and Gusmão (2007-present) governments have modeled poor governance. To strengthen and guarantee effective democratic governance in Timor-Leste and cleanse Xanana’s government, he appointed judges to the Anti Corruption Commission and established civil society organizations such as the Ombudsman (Provedor dos Direitos Humanos e Justiça) though no high profile cases have been brought to trial. It is expected that Xanana Gusmão will make an effort to bring corrupt cabinet members to justice before the end of his term in mid 2012.

**Judicial Branch**

The constitution identifies the following courts: a judiciary composed of a Supreme Court of Justice and other courts of law; a High Administrative, Tax and Audit Court and other administrative courts such as the Military Courts (Democratic Republic of Timor-Leste, 2002a). The Court of Appeal will function as the Supreme Court until the latter institution is established. The president of the Supreme Court of Justice shall be appointed by the President of the Republic for a term of office of four years (Democratic Republic of Timor-Leste, 2002a). The president of the Supreme Court of Justice (in this case the Court of Appeal) is also the president of Superior Council of the magistracy, which plays a critical role in determining the judicial system in Timor-Leste. Other responsibilities of this body are to control management and discipline of the judiciary, to oversee judicial inspections and to propose to Parliament legislative initiatives regarding the judicial system. The Superior Council for the judiciary is comprised of one representative appointed by the President of the Republic, one representative elected by the parliament, one elected by the Government, and one elected by the judges of the courts of law from among their peers (Democratic Republic of Timor-Leste, 2002a).

Currently, there are two types of courts in Timor-Leste. There are four district courts located in Dili, Baucau, Suai and Oecusse. In addition, a Timor-Leste Court of Appeal is situated in Dili. This court’s role is to re-examine and reconsider any decision of the district courts.
The Legislative Process

Both Parliament and Government bodies have authority to make laws guaranteed by the constitution. It states that the National Parliament may authorize Government to make laws as set out in Section 96.

The Judicial System Monitoring Program recommended Parliament draft laws as members of parliament are elected democratically. Also parliamentary processes provide for the drafting of laws in a more open way making it easier for public to provide commentary on a draft. Legislation drafted by Government is not open to the public (Judicial System Monitoring Programme, 2006).

To ensure that the draft is appropriate and adapted to the Timor-Leste context (culture, tradition, socio-economic and political conditions) a consultative process is needed which also facilitates community and public participation in the process of development. Laws are published through “Jornal da Republica”, but it is very difficult for all members and agencies of society to access this document.

Shoesmith (2008) has commented that there are some uncertainties in the constitution in relation to what legislation is the sole responsibility of parliament and what can be enacted by the government. Elaborating on this he presented some examples from Section 115 and 116 of the constitution: “To submit bills and draft resolutions to National Parliament” (Democratic Republic of Timor-Leste, 2002a). Further, “The government has exclusive legislative powers on matters concerning its own organization and functioning, as well as on the direct and indirect management of the State” (Democratic Republic of Timor-Leste, 2002a), and competencies of the Council of Ministries empowers the Council “To approve bills and draft resolution” (Democratic Republic of Timor-Leste, 2002a, Section 116c). Through a careful analysis Shoesmith has concluded that it “is not made clear what statutes are not required to be submitted to the National parliament” (Shoesmith, 2008).

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13 Jornal da Republica is an official report periodically published by government.
Civil Service

Following the formal announcement of the results of Referendum on 19 October 1999, all government and administrative systems were totally destroyed. In rebuilding the government and administrative systems the National Parliament approved the Civil Service Act on 21 June 2004. The code of ethics and key performance indicators are emphasized to ensure the transparency, accountability and fairness in governing the process of recruitment, promotion, career progression and management of human resources in the public sector. Most public service employers work in health and education sectors. The largest public sector employers are the police force PNTL (Policia Nacional de Timor-Leste) and Timor-Leste defence force F-FDTL (FaleNTIL-Forças de Defesa de Timor-Leste).

Furthermore, a Civil Service Commission was established in 2009 to strengthen the overall capacity of the Timorese civil service. This aims to develop and deliver impartial and effective government services supported by high standards of professionalism to provide better public service delivery to the Timorese community. The Civil Service Commission is an independent statutory body that provides the framework for all human resource management and development activities across the civil service in Timor-Leste, in accordance with the provision of the Civil Service Commission Act.

Governance principles and processes are stressed in most official documents such as the Constitution, National Development Plan, public policies and strategies. However, not all of these principles of governance are implemented perfectly by implementers including civil servant in the field for a variety of reasons.

Local Government

The Ministry of State Administration and Territorial Management (MSATM) is the branch of Government responsible for the local and national administration, public service, territorial management, supporting elections, and publicizing and preserving public documents. Administratively, Timor-Leste is organized into five regions; 13 districts with each district managed by a district administrator; 65 sub-districts, with each sub-district managed by a sub-district administrator; 442 villages,
and 2,336 hamlets. The district administrators and sub-district administrators are appointed civil servants by central government through the MSATM, whereas villages and hamlets are managed by ‘village leaders’ through local community election. Constitutionally, the “local government is constituted by corporate bodies vested with representative organs with the objective of organizing the participation by citizens in solving the problems of their own community and promoting local development without prejudice to the participation of the State” (Democratic Republic of Timor-Leste, 2002a).

The Constitution also addresses the issues of local government and decentralization specifically: (1) On matters of territorial organization, the State shall respect the principle of decentralization of public administration. (2) The law shall determine and establish the characteristics of the different territorial levels and the administrative competencies of the respective organs. (3) Oecussi Ambeno and Atauro shall enjoy special administrative and economic treatment. (Democratic Republic of Timor-Leste, 2002a).

In addition, in Section 63, which covers participation by citizens in political life: (1) Direct and active participation by men and women in political life is a requirement of and a fundamental instrument for consolidating the democratic system. (2) The law shall promote equality in the exercise of civil and political rights and non-discrimination on the basis of access to political positions (Democratic Republic of Timor-Leste, 2002a). The constitution instruction on decentralization and local government is general. Legislation and laws are required to build and establish local government systems (Shoesmith, 2008).

An important aspect of decentralization is the establishment of municipalities. Both the previous and the current government considered decentralization high on their agendas. For example in 2003 an Inter-Ministerial Technical Working Group under leadership of the Ministry of State Administration and Territorial Management (MSATM), raised six options for decentralization. The Council of Ministries approved option 4 that the creation of new provinces or regions responsible for new municipalities based on the sub-districts. This option was planned to implement in 2006 by the first Constitutional Government of Timor-Leste headed by Alkatiri. However this plan was interrupted by the violent political crises. The fourth Constitutional Government (AMP) led by Prime Minister Xanana Gusmão re-
evaluated and reconsidered the six options. They decided on option 5b which required no regions or provinces. The thirteen districts would become thirteen municipalities with elected mayors and municipal assemblies and the sub-districts would disappear. All assembly members would be elected by universal, free, direct, secret, personal and periodic ballot (Shoesmith, 2008). Contrary to option 4, option 5b established a single level of local government between the central state and the sukus (villages) and aldeias (hamlets) (Shoesmith, 2008).

The local government reform program (Municipal Election) offers a possibility to engage the Timorese people in democratic governance. Shoesmith’s (2011) analysis suggests that the successful local government reform would present opportunities for local democratic engagement in governance and empower local communities for the first time in Timor-Leste. However, an inadequately designed, planned and mis-administered program of local government reform will perpetuate a centralized top-down system of governance, which will remain unresponsive to the local people. Even though it is not yet clear what the final model will be, an anticipation of the Indonesian experience of decentralization from 200114 should be considered by Timorese government, to avoid new local and national patronage network.

A Decentralization Policy including Decentralization Strategy Framework was approved in 2006. This was followed by a consultation process on decentralization policy and territorial division (December 2006 - September 2007) in all 13 districts and all sub-districts (Kuehn, 2011). However, the implementation of municipal elections has been postponed from its scheduled date of 2009 until after national election in 2012, by which time some regulation documents regarding decentralization will be revised.

14 There were cases of local elites jockeying for office in order to use local resources for their own enrichment and expand their power of political patronage. Indonesian experience also demonstrated that the decentralization included the decentralization of KKN (Korupsi, Kolusi and Nepotisme or Corruption, Collusion and Nepotism) (Shoesmith, 2011; Holtzappel and Ramstedt, 2009)
Civil society organizations

Another important structure recently developed in Timor-Leste is the East Timor NGO Forum that establishes, organizes and coordinates a network of national and international NGOs (Non Governmental Organizations) that give assistance to communities. In addition, there is a wide range of other organizations of civil society in Timor-Leste focused on women, youth, sport and professional networking, for example East Timor Nurse Association (ETNA), East Timor Medical Association (ETMA) and Rede Feto Timor-Leste (the Women's Network of East Timor) among others. Some Civil Society Organizations (CSOs) were established before the Referendum but most were established after the Referendum in September 1999. The CSOs such as religious orders, church congregations, women’s groups, youth organizations as well as NGOs have been central in the process of Timor’s development toward independence over the past decade.

TIMOR-LESTE’S COMMITMENT TO A HEALTHY COMMUNITY

Geography, demography and socio-economic factors

Timor-Leste is a small, fragile state with a population of 1,066,582. It has a land area of 14,610 square kilometres. Available data shows that 49.9% of the population live below the poverty line of US$1 per day consumption (United Nations Development Programme, 2008) and live in rural and remote areas at least two hours walk from a health facility. Timor-Leste has a young population with about 43% below 15 years old and 16% under the age of five years. The average life expectancy is 59.5 years (Timor-Leste National Statistics Directorate, 2007). Moreover, the Final Statistical Abstract Timor-Leste Survey of Living Standards (2007) reports that the adult literacy rate is 50.6%. Overall literacy and education levels are low, and are lower among women than among men. More than half the women and more than 40% of men in Timor-Leste are illiterate. However, literacy rates are higher among the younger generations, reflecting the spread of education with time.
Although it is expected that oil and gas resources will dramatically change the economic conditions of Timor-Leste in the near future, at present the country’s socio-economic indicators are very poor. Until 2010 Timor-Leste was considered a Low-Income Country (LIC). However due to the inflow of oil money which raised Timor-Leste’s per capita income above US$1,855, Timor-Leste moved into Lower Middle Income (LMIC) in 2010 (La’o Hamutuk 2010, updated 2011). Timor-Leste’s Human Development Index (HDI) is just 0.489, which gives the country a rank of 162 out of 182 countries (La’o Hamutuk 2010, updated 2011).

The Human Development Index provides a composite measure of three dimensions of human development: living a long and healthy life, measured by life expectancy; being educated, measured by adult literacy and enrolment at the primary, secondary and tertiary level; and having a decent standard of living, measured by purchasing power parity income (United Nations Development Programme, 2008). It is clear then that just a small percentage of the Timorese population partakes of the country’s wealth.

Timor-Leste has put huge emphasis on the development of the health sector and recognized health as a basic human right of every citizen. The Constitution of the Democratic Republic of East Timor (2002) provides general direction for its health services:

The State shall recognize the right of every citizen to health and medical care (Section: 57.1).

The State shall promote the establishment of a national health service that is universal and general. The National Health Service shall be free of charge in accordance with the possibilities of the State and in conformity with the law (Section: 57.2).

The National Health Service shall have, as much as possible, a decentralized participatory management (Section: 57.3).

It means everyone has the right and opportunity to access a standard of living adequate for health and well-being. The National Health Service should be comprehensive including primary, secondary, tertiary and rehabilitative care, and everyone must be treated equally regardless of race, ethnicity, gender, etc. Moreover, the health service should be free for the consumer where capacity of the state allows.
The management system of the health service should be decentralized to improve administrative and service delivery effectiveness and to increase local participation and autonomy, redistribute power and reduce ethnic or regional tension, as well as increase cost efficiency.

For the well-being of the people of Timor-Leste now and in the future, the Ministry of Health will play an important role in the process of development of health programs in this tiny nation. The long-term objective of health sector is summed up in this popular slogan: “Timorenses Saudaveis num Timor-Leste Saudavel (Healthy Timorese in a Healthy Timor-Leste)”.

This health objective will not be achieved unless there are sufficient skilled human resources capable and available to develop the existing health and medical workforce through education and system improvement. Therefore, Timor-Leste is committed to increasing the size and quality of its workforce through various strategies, policies and organizational structures.

The Timorese people and leaders now have the opportunity and the freedom to act, and to manage their own resources. The pressing issue for Timor-Leste is now the development of their own resources in health. This requires identification of both the obstacles to development of these resources as well as identification of the strategies, structures and activities that can mitigate or surmount these obstacles.

**Health system during the Portuguese era (1515-1975)**

During most of the Portuguese era there were no formal public health services. These began in the early 1940s. Since the arrival of the Portuguese at Timor Island the community health services were provided by missionaries, Catholic priests nuns and military. Catholic clergy focused on providing very basic treatment for diseases such as malaria, diarrhoea, leprosy and tuberculosis. The health system was not defined and health infrastructure did not fully cover all districts, sub-districts and villages. Before War World II in 1942 there was some small-scale activity but no significant initiatives were taken. There were few health services, even in urban communities. The traditional care available to the vast majority of Timorese, such as, detection and neutralization of sorcery, magical practices appealing to spirits, ancestors, saints, gods, and folk remedies such as herbal preparations were used
during that period (Hicks, 1976; Montalvao e Silva, 1910; Povey & Mercer, 2002). In 1948 there were four hospitals in Dili, Baucau, Lospalos and Maliana. These hospitals were operated by six Portuguese military and civilian medical doctors. There were about 3-5 Timorese nurses trained by the Portuguese and promoted to Dili and Baucau hospitals but it was not until the late 1960s the four hospitals were staffed by Timorese nurses and midwives. Health services were provided only in these four hospitals with limited treatment for malaria, tuberculosis, diarrhoea, leprosy and other common diseases (Gunn, 2000).

The way services were provided outside of these four centres is unclear but there is evidence that patients in rural and remote areas were reached by a referral system from the main hospital in these four districts. There was 24-hour ambulance standby at those hospitals. No shortages of drugs were found at that time as the drugs were provided by the Portuguese, English and Italian Governments.

In 1967 the structure of the health system including public health care was more formalized and expansion. There was a Repartição Provincial dos Serviços de Saúde (Central Office of Health Service) located in Dili. It managed health system functioning through its four divisions: Serviços de Estudos e Combate Endemias (Communicable Disease Service and Research); Farmacia (Pharmacy); Secção de Administração (Administration Section); Hospital Central (Central Hospital), Hospitais Regionais (Regional Hospitals) as well as Delegacias de Saúde (District Health Service) which included referral services. These regional hospitals were situated in the district capitals. In addition, the Repartição Provincial dos Serviços de Saúde directly oversaw and supervised quarantine service in airports and ports as well as Escola Tecnica de Enfermagem and Escola tecnico de Laboratorio (Nursing Technique School and Laboratory Technique School).

The regional hospitals provided public health care services in 12 districts. Aileu was not serviced by a regional hospital because this district was covered by Dili district. All sub-districts had Posto Sanitario (Community Health Centre), and some Posto de Tratamentos (Health Posts) under Community Health Centre were established in areas that had high or dense populations. All of those health facilities provided primary health care to the community.

The health workforce was one of the key challenges in the health system at that time. Most staff were located at the central hospital in Dili. A regional hospital
was served by just one medical doctor who was also the head of the hospital, two nurses - one *curso geral*\(^{15}\) and one *curso auxiliar*\(^{16}\). The *curso geral* also served as the secretary of the hospital. While delivering health services to the community they also functioned as the chief of administration that prepared and managed administrative matters.

Regional hospitals were supported by one midwife, one laboratory technician and between four to six *pessoal minor* (cleaning services, gardener included laundry and cook). The logistics, pharmaceuticals and transportation (one ambulance, one jeep and one motorcycle) were attended to by central office. A Community Health Centre had one nurse (*curso auxiliar*) and one *pessoal minor*. *A Posto Tratamento* had no health workforce. A medical doctor had regular weekly visits and urgent matters called to *Posto Sanitario* if required, while a nurse in *Posto Sanitario* also had regular visit to *Posto de Tratamento* twice a week, attended emergency calls from the community and provided weekly reports for communicable diseases and trimesterly report of health activities to the regional hospital. To overcome the shortage of staff - for example not all regional hospitals had medical doctor, it was intended that military doctors would serve neighboring districts. As well as the public health facilities there also existed a Military Hospital situated in Dili and health centres in some districts with military quarters. A senior nurse from the Portuguese era (now retired) commented:

… My job description was to deliver health care services to the community. This included *visum*\(^{17}\) in the case of emergency if there was no medical doctor. I was also responsible for quarantine and served as the secretary of the Regional Hospital or *Delegacia de Saúde*. As the secretary I prepared and processed *titulo*\(^{18}\) for all staff. Another responsibility was to compile a weekly report from community health centres (specifically pertaining to

\(^{15}\) The course authorized for candidates who have had completed senior high school and the course took four years (three years for theory and one year practice).

\(^{16}\) The course authorized for candidates who have had completed primary school and the course took three years (two years for theory and one year practice).

\(^{17}\) *Visum* is a medical official report or statement (for example *Visum et Repertum* about the result of medical examination that a person is alive or dead) for the use in the court.

\(^{18}\) *Titulo* is an official document that recording staff salaries, which staff could take to shops or banks to exchange for cash.
communicable diseases), as well as trimesterly, semesterly and annual reports of all health activities, logistics, pharmaceuticals, and expenses to the central office in Dili. I was responsible for putting in requests for logistics, pharmaceuticals and supplies to the central office and then for distributing these to all *Posto Sanitario* based on their trimesterly reports and requests. I also had a regular visit schedule to *Posto Sanitarios* (Community Health Centres) under my regional hospital where I carried out inspections. The regional hospitals were inspected by a medical doctor as the head of *Repartição Provincial dos Serviços de Saúde* (central office) every one to three months. I did not handle money and we had no treasurer. Sometimes I did handle the money (petty cash) when the chief of regional hospital was not in place… I just mostly dealt with papers…. I prepared the *título* for staff, which they took to the shops or banks to receive their salary. (Stakeholder 15)

The nurse also noted:

> A regional hospital had a “permanent fund” (petty cash) for everyday needs. It was twenty five thousand escudos for three months… The central office also provided the guidelines and procedures about how to utilize this money. The accountability and report had to be submitted to the central office every three months and… sometimes the inspector and auditor (from central office) came suddenly without any warning to oversee the expenditure of petty cash and health program implementation in our region… We could not manipulate the price of goods because the prices and level of salary were written and included in the *Boletin Oficial*19. … At that time a health professional had to have qualifications, capacity, ability, integrity, seriousness and high ethical standards. (Stakeholder 15)

The staff in regional hospitals did not participate in the development of plans and budgets. They were developed and finalized by the central office based on reports and result of visits and inspections. The requirements and plans of the regional hospitals and community health centres were included in the trimesterly or annual reports to the central office. Although health staff and communities did not

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19 *Boletin Oficial* was an official report published at regular intervals by the government for the public.
participate in health plan and budget development, their needs and concerns always received positive responses from the central government.

Accountability and transparency were strong at that time. For example the annual budget for each hospital, salaries for staff at various levels, and the price of goods were made available to the public through publication in the Boletin Oficial. This reduced the opportunity for manipulation of the price of goods and other dishonest practices. It seems then that the core values of governance; structure, power, responsiveness, monitoring and evaluation, transparency and accountability, effectiveness and efficiency, equity, ethics and cooperation permeated the processes of the health system at that time. Even though there was a shortage of health staff and other challenges, they continued to attend to the needs of the community as effectively and efficiently as possible. Informants from that era said that basic health care, health promotion and prevention including immunization was also conducted in villages, especially in the certain event such as recenseamento (census party). These activities were implemented in coordination and collaboration with local government district administrators, sub-district administrators and liurais.

There were several difficulties in delivery of public health care to the community. Road conditions in the rainy season resulted in constant damage to ambulances, which was lamented by the drivers. The rising and flooding of rivers also isolated some Posto de Tratamentos (Health Posts) during the rainy season for up to four months.

In 1974, health services were provided by a surgeon and a dentist and supported by a dozen Portuguese military and civilian medical doctors and a few Timorese nurses and midwives who had been trained by the Portuguese government (Gunn, 2000). By 10 August 1975, before the Portuguese left the Province of Timor, there was a total of 493 health staff: Two medical doctors, some nurses, midwives, other health technicians, and support staff (Stakeholder 15).

**Health system during the Indonesian era (1975-1999)**

The health system was more fully developed during the Indonesian era. Health centres, clinics and hospitals were established from the national level down to the local village. The numbers of health service providers increased significantly.
There were approximately 2,700 nurses, of whom 1,877 were registered Timorese nurses, as well as 400 midwives and 398 doctors providing services in hospitals, Community Health Centres (CHC) and Health Posts. About 60 percent of villages were covered by health facilities headed by a nurse, midwife, or doctor and provided with transportation, logistical support, equipment and pharmaceuticals.

Specialist doctors (for example, paediatricians, and gynaecologists) were located at the Dili, Baucau and Maliana Hospitals. Health promotions and prevention of disease activities were conducted for the general population; school health programs were facilitated; and family planning programs were introduced (Povey & Mercer, 2002). Public health care services were also provided by the private sector such as the Catholic Church and medical doctors (general practice and specialists) in their private clinics. Traditional medicine was also an alternative for the community if they could not access health facilities. This contributed to the progress and improvement of the Timorese society and provided alternative forms of health care for those who desired them.

However, there were some under-funded aspects of this system that hindered the provision of quality health services. For example, remote areas were served only by mobile clinics. Another problem under the Indonesian health system was the employment of a vast number of staff to perform a single task. For example one Community Health Centre had up to 25 staff, which was both unnecessary and costly.

In terms of governance structure the Indonesian system was generally well developed but responsiveness was significantly lacking by government. Only two percent of the budget was allocated to health development. Implementation was hampered by an unduly complicated bureaucracy with a high level of corruption in project leaders and financial managers. These limited the efficiency of the health system. The health system was also affected by the poor performance of other departments. For example, the disbursement of funds for infrastructure development (road, clean water and health facilities) took time and bribes, to ensure implementation. This was commonly known as uang rokok or cigarette money.

Consequently, the achievements of quality health care and health indicators were lower than other provinces of Indonesia and other countries with similar socio-economic profiles. For example life expectancy in East Timor was 51 years while
nationally across Indonesia it was 65.8 years. For the same period life expectancies in Cambodia and Bangladesh were 54 and 59 respectively. During that period Timor’s infant mortality rate was 85/1000, compared to Indonesia as a whole 35/1000 (Ministry of Health Timor-Leste, 2002a). Public health care covered almost all communities as, for security reasons, the Timorese populations tended to be more concentrated in one place (village or hamlet) during the Indonesian occupation but the quality of health care provided varied among communities. Another important factor contributing to poor health outcomes was the lack of trust in Indonesian people by Timorese.

Health system after the 1999 referendum and 2002 Independence

The major issue after independence was to rebuild the health infrastructure, which was destroyed during the 1999 crisis. More than 80% of all infrastructures including nearly 100% of health facilities were destroyed. Almost all physicians and senior health management staff from central and local administration left the country, and medical equipment and supplies were ransacked or seriously damaged. This left the central health administration and district health system dysfunctional and in ruins. The health profile of Timor-Leste in 2000 was similar to other poor developing and post-conflict countries. An East Timor Health Professional Working Group (ETHPWG) was rapidly established by the majority of senior Timorese health professionals, and with the assistance and support of World Health Organization (WHO) this group developed a future health plan.

At that time the emergency health services were provided by International NGOs. Through cooperation, coordination and collaboration between UNTAET and ETHPWG the Interim Health Authority (IHA) was established, which became the Ministry of Health in 2001. The main role of IHA was, in collaboration and with assistance from UNTAET (health sector) and WHO, to rebuild the Timor-Leste health sector and system. The first Joint Donor Mission for planning the rebuilding of the health sector was conducted in March-April 2000 (Tulloch, 2003). A team consisting of a variety of technical experts developed a framework for action that became the Health Sector Rehabilitation and Development Plan (HSRDP). The HSRDP had two major components; restoring access to basic services for the
population and development of health policy and system for the future (Tulloch 2003).

A network and cooperation agreements with the international NGOs were established to develop district health plans and the health services delivered by these NGOs in district and sub-district levels. After formation of the First Transitional Government of East Timor in August 2000, the process of recruitment of Timorese health civil servants was commenced, with 800 personnel working across the country although shortage of workforce was a concern.

The second phase of the HSRDP took place in the middle of 2001 and comprised three components: support ongoing health services, improve the scope and quality of services and support systems; and develop health policy, regulation and administrative systems (Tulloch, 2003). In early 2001 the District Health Management Teams (DHMT) were in place in each district and by late 2001 all Community Health Centres, including most of the Health Posts were staffed by Timorese personnel and functioning. Between late 2001 and middle 2002, all health infrastructures and equipments including vehicles (equipped ambulances, 4WDs and motorcycles) and the installation of a high-frequency radio network were in place to support the health system.

Over the past seven years Timor-Leste has made progress in rebuilding its health system. New policies including an East Timor Health Policy Framework 2002 were developed to establish and guide an appropriate health system. Other strategies, guidelines, and manuals are now also in place. One of the most important programs recently released by the Ministry of Health Timor-Leste is the Basic Service Package (BSP). The BSP aims to provide a minimum level of services at each service delivery level to contribute to achieving the objectives of the Millennium Development Goals (MDG) (Ministry of Health Timor-Leste, 2007a). The BSP addresses quality, management, training, administration, monitoring and supervision, health information and outlines the structure and functions of primary health care services, which serve as the first point of contact with communities and families. To
strengthen health service delivery in communities in 2008 a SISCa\textsuperscript{20} strategy was developed and implemented in all villages.

The Timorese government through the Ministry of Health is progressively reinstating its health system. It is seeking to rehabilitate health facilities, and redeploy staff by establishing health management systems at central and local levels. The Ministry of Health is the steward and manages the health system functions in Timor-Leste through its five directorates: Administration and Logistics; Planning and Finance; Human Resources Development; Community Health; and Hospital and Referral Services. The Ministry of Health also oversees the overall health program implementation within the country and supervises three institutions: Institute of Health Science (HIS) providing the pre-service and in-service training of the health workforce including nurses, midwives and other health technicians; \textit{Serviço Autonomo de Medicamentos e Equipamentos de Saúde} (SAMES) responsible for drug procurement, storage and distribution; and the National Laboratory responsible for surveillance, investigation and research on communicable disease in Timor-Leste.

Health facilities across 13 districts include the following. There is one National Hospital located in Dili. The National Hospital provides services only in response to referrals. There are five Referral Hospitals – one per region. These serve as the second level of referral and offer a comprehensive level of patient services. Patients are often referred from Community Health Centres. There are five District Community Health Centres located in the districts that do not have a hospital. They each serve an entire district and are responsible for providing outreach and referral services to all health facilities and mobile services to remote areas. There are 65 Sub-district Community Health Centres, which provide primary health care to between 5,000 and 15,000 persons. There are 183 Health Posts that serve as the primary entry point into the public health service. These posts are situated in the villages and serve 1,000-5,000 persons. The Health Post is the key to achieving MDG goals. There are 162 Mobile Clinics, which service communities that are over two hours walk from

\textsuperscript{20} SISCa (\textit{Serviço Integrado da Saúde Communitaria}): Integrated Community Health Service (MoH, 2008).

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the health facilities and health services delivered by Health Post and Health Centre staff. These Community Health Centres and Health Posts provide primary health care to community. They are linked with the referral hospitals, which provide secondary and tertiary care. In addition, the central government also promotes an Integrated Community Health System program (SISCa) that improves accessibility and acceptance of basic health services with stronger community participation in each village.

At the same time the number of health service providers continues to increase. The Institute of Health Science under the Ministry of Health has produced additional health workers (midwives, laboratory technicians, analysts and anaesthetists). The National University of Timor-Leste (Universidade Nacional Timor-Leste or UNTL) in cooperation with the Ministry of Health has established a Faculty of Medicine, where 80 medical students study, and a Faculty of Nursing with capacity for the enrolment of 40 students. Timor-Leste, in cooperation with Cuba is now providing a Family Doctor program qualification for 700 Timorese students in Cuba as a result of a Points of Co-operating Agreements between the Government of Republic of Cuba and Timor-Leste established in 2007. There is also a private university producing public health graduates.

Timor-Leste also has a number of international agencies supporting health areas, including World Health Organization (WHO), United Nations International Children’s Fund (UNICEF), United Nations Fund for Population Activities (UNFPA), United Nations Development Program (UNDP) and local and international Non Governmental Organization (NGOs), including Technical Assistants with specialization and general doctors (Ministry of Health Timor-Leste, 2002a). The Catholic Church and Cooperativa Café Timor/ CCT (Coffee Cooperative) are two of the most important partners of the Ministry of Health that provide basic health care services to communities in rural and remote areas. Through a Memorandum of Understanding between Cuba and Timor-Leste the Cuban Medical Brigade and their large-scale medical training program was introduced to Timor-Leste in 2004. They comprise a major component of the clinical workforce in health facilities including national and referral hospitals and support public health system that focus on primary and preventive services in community.
The government of Timor-Leste has also given more attention to health sector development (Democratic Republic of Timor-Leste, 2002b). The public health system is financed through the state budget and external resources. Development partners committed a total of US$236.4M for development assistance in Timor-Leste in 2008. The health sector is one of four main sectors supported by donors. Fifteen per cent of the total donations (US$31.1M) was dedicated to the health sector. Other priorities included Public Sector Management 15%, Education 14%, and Agriculture 14% (Ministry of Finance Timor-Leste, 2009).

Timor-Leste provides a free health service for all citizens (Democratic Republic of Timor-Leste, 2002a). However, out-of-pocket expenditure for health care does occur. Public expenditure of government on health has increased from 12% in 2000 to 19% in 2005 and per capita total health expenditure was around US$45 in 2005, and US$58 in 2008 (World Health Organization Country Office for Timor-Leste, 2009).

There are some constraints and challenges related to the current health system. There is a need for a substantial increase in resources to re-establish health facilities in remote areas. There is a shortage of staff including health managers, doctors, midwives and health technicians to work in remote areas. There is also a shortage of essential drugs and equipment. There are gaps in community awareness regarding availability of health services, particularly among those of certain backgrounds, education levels, cultures and traditions. There are problems with infrastructure including road and bridge conditions, potable water, electricity, and telecommunication systems, all of which influence performance of the health system.

In addition, there is a lack of trained personnel in ‘governance’ combined with poor inspection and auditing by independent teams. This constitutes a major constraint in the achievement of good health system performance. Another important constraint is the poor implementation of the decentralization of management of the health system.

Governance of the health system in Timor-Leste will be explored in detail in chapters six, seven and eight.
CONCLUSION

For more than 450 years Timor-Leste was under foreign rule - Portuguese, then Indonesian. After the referendum in August 1999 in which a majority of the Timorese population voted to secede from Indonesia the country was controlled by the United Nations for nearly three years. Throughout the years that Timor-Leste was under foreign rule, the traditional power structure at the local level particularly in the village level remain almost unchanged. Historically, and experiences showed that the Catholic Church preserved good relationships with the traditional hierarchy in Timor-Leste during the three periods of foreign leadership: Portuguese and Indonesian occupation and after independence.

The diversity of Timorese culture and tradition has affected governance and health outcomes both positively and negatively. Human development, particularly for women, was influenced by the traditions that made parents unwilling to allow daughters to travel for schooling. This limited their ability to participate in the education system. This also affected women’s health and health outcomes. Male domination is a part of the history culture and tradition, with implications for the health system and women’s health today.

After Timor-Leste gained independence, the government system was re-established across all sectors including health administration and infrastructure. Governance structures and processes have been put in place, but much remains to be done to ensure the efficacy of health policy and the delivery of health services. The developments and challenges are addressed in subsequent chapters, with Chapter Five setting out the key features of the Health Policy Framework 2002, leading into Chapters Six, Seven and Eight which examine in detail the health governance and service delivery experience in two contrasting districts.
CHAPTER 5: EAST TIMOR HEALTH POLICY FRAMEWORK 2002: AN ANALYSIS

INTRODUCTION

This chapter provides a content analysis of the East Timor Health Policy Framework 2002 (ETHPF-2002), which is the key document in the development of health governance, policy and service delivery over the last decade. The Framework sets out a wide range of policies and principles as a blueprint to guide the development of the Timor-Leste health care delivery system. It provides information on the Ministry of Health’s vision and strategy and addresses such matters as policy and service delivery problems and constraints, priority areas, human resources development, health financing, and the organisation and management of service delivery. It is considered here as essential background and context for the discussions in Chapters Six to Nine. Its main features are described rather than critiqued, leading into the subsequent analyses which consider the extent to which the principles and developments addressed in it have shaped present health policy and service delivery arrangements.

The East Timor Health Policy Framework 2002 was approved by the Council of Ministers in 2002. It provided the first comprehensive vision of the strategy direction of the Ministry of Health and established the basis of all future micro-policy development. It defines the key areas for policy development along with guiding principles upon which the health policy and system will be based. The strategic approach is based on the core principles of Primary Health Care which include: a multi-sectoral approach to health; community and stakeholder participation; addressing health issues and problems of women, children and other vulnerable groups; serving in a participatory manner; as well as affordability, accessibility and availability of services and interventions. The government’s (Ministry of Health) commitments to these are in order to increase health equity for all Timorese community.
These principles underpin a comprehensive primary health care system. A review of the East Timor Health Policy Framework 2002 document raises the following fundamental question: Is the East Timor Health Policy Framework 2002 actually a policy document or a long-term health development plan? There is a normative difference between those documents. A policy document generally emphasizes legal aspects and a set of decisions (Shariati, Farzadi & Akhlaghi, 2005) by which governments translate their political vision into programs and action to deliver outcomes (Nutley, 2000). A policy document also describes the basic policy of a health development program, policy network and community (Walt et al., 2008). However, a health development plan emphasizes arranging a strategic and long-term health development program. The researcher considers the East Timor Health Policy Framework 2002 as a policy.

THE CONTEXT OF HEALTH POLICY FRAMEWORK

The East Timor Health Policy Framework was developed and approved by government in 2002. The framework highlights the essential factors that affect health: for example, water and sanitation, transportation and food supplies. The framework also emphasises the importance of Primary Health Care services in improving the health of the population through health facilities in the districts and sub-districts.

Vision and mission

The vision statement of the Ministry of Health is “Healthy East Timorese people in a healthy East Timor”. That is, the Timorese community will enjoy a level of health that allows them to develop all their potentialities in a healthy environment. Healthy East Timor means that all parts of society, including the public and private sectors, should collaborate or adopt a multi-sectoral approach to health in order to achieve this vision. Linked to this is the emphasis in the East Timor National Development Plan 2002 on reducing the high rate of poverty in the country. Good health contributes to prosperity, and vice versa.
In order to realize the vision statement, three mission statements have been identified by the Ministry of Health Timor-Leste to inform their work: namely; availability, accessibility and affordability of health services; regulation of health services; and promotion of community participation. Availability signifies that one of the responsibilities of health sector is to guarantee the availability of qualified health services to all citizens. Accessibility refers to accessible health services to all citizens without discrimination regardless of place of residence (urban, rural or remote) and ethnicity. Affordability means that the Ministry of Health is responsible to ensure that quality health services characterized by good outcomes and professional standards are provided to all. Regulation of the health sector means involving the development of health policies and procedures, for example on the use of state resources for health. Promoting participation is to engage with all sectors, particularly local community including all stakeholders, public and private sectors in health development.

**Goals**

East Timor Health Policy Framework 2002 sets out the approach to be adopted by the government in the delivery of health services. Arising from the three components of its mission statement (ensuring availability, regulation and promotion of participation) the Ministry of Health expects to contribute to the overall goal of improving the health status of the Timorese people. An operational goal has also been identified for the Ministry of Health to improve the health status of Timorese. The operational goal is to provide “quality health care to East Timorese by establishing and developing a cost-effective and needs-based health system, which will specially address the health issues of women, children and other vulnerable groups, particularly the poor, in a participatory way” (p. 24).

**Values**

The Health Policy Framework also calls attention to the core values of equity and cultural sensitivity. Equity means the distribution of health resources according to population need. All citizens have the same right to access to quality health care and services including health facilities without discrimination based on geographic
location, ethnicity, occupation, income, gender, and so on. Cultural sensitivity refers to awareness that cultural differences and similarities exist and impact on values, learning processes and behaviours. Health services that are respectful of local history, culture and the environment, build trust and increase community reliance on the health system.

The Health Policy Framework (HPF) is consistent with the health section of the National Development Plan (NDP), but to some extent broader in scope. The NDP emphasises implementation of health programs by the public sector, whereas the Health Policy Framework emphasises financial issues and the appropriate mix of public sector and private sector service provision.

**Service values**

The Health Policy Framework 2002 articulates a commitment to providing good quality services, which are well managed, sensibly integrated, available, accessible, accountable, affordable and sustainable. The East Timor Health Policy Framework identifies the importance of visible and transparent support systems with regard to health information, communication, human resources, administration and finance. Strategic planning and priority setting in the East Timor Health Policy Framework are focused on achieving agreed Millennium Development Goals (MDGs) and improving quality.

**Guiding principles**

The East Timor Health Policy Framework outlines the guiding principles for development and maintenance of government health service through:

*Priority setting*

The Ministry of Health seeks to protect its citizens against sickness and provide high quality health care to all as part of health equity. The Health Policy Framework mentions that the Ministry of Health will not only ensure appropriate health care and interventions are available but also satisfy as much as possible the demands of the consumer. The Health Policy Framework also emphasizes the fact that political
influence shapes decisions in the Ministry of Health that cannot be ignored and should be taken into consideration. The Ministry of Health gives high priority to illness prevention and health promotion interventions rather than just curative care. This move away from focusing expenditure on cures enables government to invest in interventions that contribute to better health outcomes in the future in collaboration with Timor-Leste people and some providers.

**Human resource development**

The major problems confronting human resource development in Ministry of Health include: undersupply or oversupply of certain types of health personnel and skills; low morale of health staff; inadequate human resources management; and inadequate planning capacity within the Ministry of Health. The Ministry of Health will recruit staff according to needs, giving priority to Health Posts and Community Health Centres. The guiding principles are: training and staffing in underserved areas with implementation of Primary Health Care given priority; health services will be delivered by multi-skilled personnel at each level; and all training programs will be based on identified needs and should be delivered in the most cost-effective way.

**Health financing**

In accordance with the Timor-Leste Health Policy Framework, most health expenditure has been concentrated on primary and preventative health care services at the district level. The Health Policy Framework has designed a Basic Service Package that increases the quality and coverage of Primary Health Care and curative interventions. The Health Policy Framework provides up to 60% of health expenditure for Primary Health Care service in district and sub-district levels, 40% to be committed to hospitals and hospitals with specialised secondary and tertiary services and other support services.

The Health Policy Framework introduces financial strategies with regard to sustainability; efficiency; collaboration; and equity. Sustainability is manifest in the Ministry of Health implementation of alternative financing mechanisms to secure additional resources to finance health services. Efficiency refers to cost effective interventions and the targeting of areas of greatest need and highest impact on health
status. Collaboration refers to government working together with the non-governmental sector in health service provision through contracting out services to support health providers. Equity pertains to support of the poor to meet the cost of health care.

Basic service package

The Basic Service Package promotes priority setting of essential services in primary and secondary health care. The services arrangement makes an effort to ensure that basic health services are available within two hours walking distance from communities. Services nearest to the community at the sub-district level are provided by health posts that are staffed by a nurse and a midwife. The service includes regular mobile clinic visits to remote communities by motorbike. The Health Policy Framework also states that each district should be served by Community Health Centres, Health Posts and Mobile Clinics with some inpatient capacity, and some laboratory facilities. Community health centres are to have radio communications, and access to ambulance services with one ambulance per district. The Health Policy Framework defines a basic package of services that will be delivered by the Ministry of Health within the district health system. The basic package involves clinical, public health and rehabilitative services intended to address major health problems including low rates of immunisation; high incidence of malaria and communicable diseases such as tuberculosis; high rates of infant and maternal mortality; poor nutrition; and lack of health awareness in areas such as sexually transmitted infections and HIV/AIDS. The Health Policy Framework indicates the possibility of contracting out (public/private mix) primary health services such as health promotion to NGOs, as the public sector has limited implementation capacity. For example private doctors, cleaning services, and catering for patients in hospitals could be contracted.

Decentralization

The Health Policy Framework includes a policy objective of decentralising the health service to allow more effective participation by local level health workers and communities in the development and implementation of health programs.
Decentralisation will involve the strengthening of the management capacity of district health administrations, which will then become the focus of decentralisation within districts through the preparation and implementation of district health plans. There is also an important potential role for district health committees in increasing community participation in district health planning and implementation and studies are being undertaken to identify best option mechanisms that are most appropriate for a given community or population.

The pace and extent of decentralisation of the health system will be influenced by the approach adopted to decentralisation across the government administration as a whole in areas such as financial delegation and personnel management. The guiding principles are equity and community participation. Decentralization is a timely and appropriate movement towards transfer of responsibilities and authority from the national to the local level (District Health Services). These include planning, management and administration of finances, deployment of staff, discipline enforcement, delivery of public health care services, supervision, monitoring and evaluation. The Ministry of Health is committed to gradual decentralization but the process depends on the capacity and ability at the local level and commitment at the central level to transfer these responsibilities.

**Drug policy**

A system of classifying pharmaceuticals is noted including the development of an Essential Drug List and a list of importable non-scheduled drugs. The licensing of private pharmaceutical services and the establishment of an Autonomous Medical Supply System (SAMES) to administer drug importation, storage and distribution is foreshadowed. In order to strengthen delivery of health services, there is need for skilled health workers in adequate health facilities, supplied with drugs and consumables for the different health programs. They must be guided by clear policies and regulatory system.

**External assistance**

Several external sources of support for the health sector were identified by Health Policy Framework. These include multilateral, bilateral, charitable
organizations or NGOs. These agencies provide technical assistance (consultants, studies, research); capacity building (training and scholarship); equipment and commodities. External assistance is guided by procedures to develop an equitable, efficient and sustainable health system.

The structure and management of health services

The Ministry of Health central level has two roles: stewardship and health service provision. Stewardship refers to the development of policies, regulation, organizational monitoring and surveillance, intersectorial engagement, administration and financing of the public health care system. Health service provision refers to the delivery of diagnostic health care; treatment and rehabilitative services at primary, and secondary levels; development and implementation of programs of community engagement; disease prevention and control; and health promotion.

According to the Health Policy Framework, the focus of the Ministry of Health for the period of 2001-2007 comprised three directorates: Health Service Delivery; Finance, Administration and Logistics; and Policy and Planning. The senior civil servant in the Ministry of Health is the Permanent Secretary, while the Minister and Vice-Minister for Health provide strategic direction to the organization and assist in oversight on a daily basis. The health inspectorate’s role is to exercise disciplinary actions and audit institutions and services of the National Health System (NHS). The latter includes monitoring of the fulfilment of legal obligations and administrative regulations applicable to the NHS.

The Health Policy Framework recognises six national bodies: 1. National Council of Health, established at the central level Ministry of Health to provide stewardship of the health sector and advise Ministry of Health on policy matters regarding public health issues; 2. National Laboratory is to provide referral laboratory services with quality control for the country; 3. National Centre for Health Education and Training (NCHET) is to plan, develop, implement and evaluate continuing education and in-service training of the Ministry of Health. In 2005 the NCHET was changed to Institute of Health Sciences. The responsibility of this institution includes provision of short training for health staff. It also develops
academic programs and works with Universidade National de Timor-Leste (UNTL) or National University of Timor Loro Sae to provide graduate level training for Timorese health professionals; 4. Food and Drug Safety is responsible for inspection and regulation enforcement of food and drug safety, and for the implementation of appropriate measures; 5. Blood Transfusion Service will be nationally coordinated and promote blood donations. It will be managed as a national Blood Bank; 6. National Research Centre is not established yet. Some of these bodies have been modified and integrated into Personalized Services.

**Personalized Services**

There are four Personalized Services: 1. National Centre for Health Education and Training, which was changed to Institute of Health Sciences in 2005; 2. The National Laboratory; 3. The National Hospital Guido Valadares acts as the national referral hospital with only cases from referral hospitals and health centres; 4. Referral Hospitals are the second level of the referral and offer a comprehensive level of service for patients referred by health centres.

**Autonomous Institutions**

An Autonomous Drug and Medical Equipment Services is also recommended by Health Policy Framework 2002. This institution is also known as Serviço Autonomo de Medicamentos e Equipamentos de Saúde (SAMES). The legislation described SAMES as autonomous but the reality is that it is semi-autonomous in relation to the Ministry of Health. There are four major functions of this institution: (1) product selection; (2) procurement; (3) warehousing and distribution; and (4) prescribing and compliance.

**Consultation and Coordination body**

The Ministry of Health also established three Consultation and Coordination bodies. The first of these is the Council of Directors. This body consists of the Minister for Health as well as the chairperson, Vice Minister for Health, Health Inspector, Permanent Secretary, National Directors and other individuals or entities relevant to the working agenda that the minister invites. The Council meets weekly.
The role is to provide consultation about and support coordination of the implementation of health policies. Another important competence is the provision of technical advice on all the official approval and licensing process of the health system and pharmaceutical activities and all restrictive or correction measures taken in order to protect public health.

The second body is the Council of Coordination. This is composed of the members of the Council of Directors, directors of the Personalized and Autonomous Services and head of the District Health Services. One of the roles of this body is to evaluate final activities developed by the Ministry of Health and controls the execution of the activity plan. The third body is the District Health Council of which there are thirteen. District Health Councils consist of the head of District Health Service (DHS), who also serves as chair, deputy of the head of DHS, health professionals, other support staff and all directors of the community health centres within the district. The role of this body is to provide consultation for the heads of District Health Service who coordinate the delivery of Primary Health Care Services.

**The management structure at district level**

The Health Policy Framework defines the management structure for the district level (see Appendix 1). The Ministry of Health provides Primary Health Care services through health centres, health posts and mobile clinics. The District Health Service through District Health Management Team under the Ministry of Health direction implements health policies and strategies. They work to an annual action plan and have responsibility to ensure appropriate local service delivery and effective use of resources within the district.

The objectives of the District Health Services (DHS) through the District Health Management Team (DHMT) are to improve efficiency and quality of services as well as to ensure responsiveness of health services to the needs of the people in district level. The roles are to plan, supervise, coordinate, monitor, report and evaluate all health activities at the district level. The team will carry out administrative, financial, and logistical functions that fall under their jurisdiction. Community Health Centres, Health Posts and Mobile Clinics provide health care
service guided by the Basic Service Package provided by central level Ministry of Health.

In line with decentralization policy, more local involvement is required. District Health Councils (DHC) should be established by each District Health Service, but during the period of fieldwork (2009) some District Health Services including DHS B had not yet established this body. The role of the District Health Council is to provide local oversight of the district health service and provide linkages with community. The function of the District Health Council is to advise the District Health Management Team as well as be a watchdog for the public in the district. In addition, its role is to empower and supervise the management of health services and support public health care programs, and serve as a forum for feedback to the community.

*Hospital management boards*

The Hospital Management boards are important bodies the role of which is emphasized in the Health Policy Framework (HPF). These boards represent the interest of users and the community regarding hospital services to ensure standards are maintained and resources are efficiently used.

During the process of rebuilding the health system and implementation of HPF, there were some challenges and difficulties encountered by Ministry of Health, particularly with regard to the development of human resources. Therefore these bodies only began to function well in the middle of 2004, early 2005. Some of these bodies have continued unchanged since that time. Some have been modified and others have changed their name or added additional roles.

Based on the Decree Law No. 7/2007, the Ministry of Health redesigned its organizational structure (see Appendix 2). Therefore, in the period of 2008-2011 the structure expanded to five directorates. The National Directorate of Hospital Service which is a new directorate, manages three departments. The role of this directorate is to develop study designs, as well as to coordinate and regulate the activities of hospital services delivery and referrals. The Health Services Delivery with the new name of National Directorate of Community Health Services Delivery handles nine departments. It develops study designs, coordinates and regulates the activities for
health promotion and education, diseases prevention, Primary Health Care delivery and pharmaceuticals. The National Directorate of Administration, Logistics and Procurement take charge of four departments. The responsibility of this directorate is to support administration services, logistical and procurement management for the service and institution of the Ministry of Health. The National Directorate of Human Resources which is a new directorate controls three departments. The main role of this directorate is technical coordination and regulation of human resources development, record health professionals and management of health staff. Planning and Finance which is also a new directorate, handles three departments. It provides planning, budgetary, and financial management for the service and the bodies of the Ministry of Health.

DEVELOPMENT AND IMPLEMENTATION OF HEALTH POLICY FRAMEWORK 2002

The East Timor Health Policy Framework 2002 was formulated by a team, known as Health Policy Working Group (HPWG), which was established within the Ministry of Health. This group was active even before the Ministry of Health was established but the intensive work began after the establishment of the Ministry of Health. A leader in the HPWG stated:

… The work only intensified after the establishment of the Ministry of Health under the Second Transitional Government. By then we already had clear leadership from the Ministry of Health. … Under the Division of Health Service several experts from outside were brought in order to assist Timor-Leste to develop its health system including health policy. (A senior manager in HPWG)

The Health Policy Working Group members were all health professionals. Most were senior staff at the Ministry of Health including the Minister, Vice Minister, Director General, National Directors and Heads of Departments. Some health professionals were also drawn from health professional associations, for example: East Timor Medical Association; East Timor Nurses Association; East Timor Midwives Associations; East Timor Analysts Association; and others. The process was directly overseen by the Minister for Health, Vice Minister for Health
and the international advisors. Participants noted that there were three highly influential partners in the process of developing the East Timor Health Policy Framework 2002.

Those with particularly strong influence included the development partners, international advisers, and the Ministry of Health. The others contributed to the process but not much. To my knowledge, the other contributors only contributed during the stakeholder consultation. The first draft of the ETHPF was developed by Ministry of Health staff and international advisers. We valued contributions from stakeholders. (A senior manager in HPWG)

The development partner in this case was the World Bank, because the Health Sector Rehabilitation and Development Program (HSRDP) clearly mentioned the restoration of Basic Health Services and the establishment of an appropriate health system for Timor-Leste. The development of the East Timor Health Policy Framework 2002 was a response to the objective of establishing an appropriate health system for the country. It became a goal for the World Bank to establish the health system and devise an appropriate health policy to guide the health system development in Timor-Leste. The advisors who were contracted by the HSRDP to work for the Ministry of Health at that time were also key drivers for this process. An important partner was the religious institutions, dominated by the Catholic Church. These institutions were strong advocates for health policies and strategies in line with Timorese identity. The third partner was the Ministry of Health staff. Though some lacked comprehensive knowledge of health policy, the Timorese Ministry of Health staff worked tirelessly under the guidance of advisers to jointly develop this East Timor Health Policy Framework. A member of Health Policy Working Group as well as one of the former Head of Department explained:

I would say that I was not involved 100% in the process of development of East Timor Health Policy Framework 2002. The reasons were as follows. Firstly, the process was lead and influenced by the donors and international advisors. Secondly, I had a lack of knowledge, qualification, and experience on the subject. And thirdly was the language barrier. I could not involve myself well in the discussion because of the language problem. Our colleagues who speak little bit of English could participate in the discussion but the others depended on the interpreter. I did not know whether what I said
was interpreted correctly or not. The important issue from my perspective was ensuring that the health policies and programs conform to and reflect, Timorese local culture and tradition. … Some of the influential people in this process were the international advisors. They came with various objectives and interests. For example some of them were motivated by a desire to complete their study, gain experience in post-conflict countries, and earn a high salary, rather than a genuine concern for Timor’s best interests. (A former head of Department at Ministry of Health)

The barriers to participation in the processes of establishing East Timor’s Health Policy Framework included the lack of knowledge and experience in policymaking or policy formulation on the part of many of the Timorese participants, and the use of English as the language of consultation. Participants noted that after the formulation of the Framework there was a lack of technical guidance as to how to implement the East Timor Health Policy Framework 2002. Also the attention of the Ministry of Health at that time was primarily directed toward responding to health needs on the ground and ensuring that health service delivery reached the people. Therefore, the Ministry of Health gave little attention to the implementation of the East Timor Health Policy Framework 2002. That is, the Ministry of Health gave much attention to the development of the East Timor Health Policy Framework 2002 and other micro policies but lacked the time and energy to then systematically implement these policies.

Participants have said that at the time the East Timor Health Policy Framework 2002 was being drafted there was tension between international and local staff due to the huge disparities in salary. International staff salaries were very high while salaries of Timorese health workers, including Ministry of Health staff, were very low. There were also significant differences in salary level between local staff working with NGOs and local staff of the Government (Ministry of Health). Those working with the Ministry of Health had a much lower salary. Therefore, it is a credit to Timorese Ministry of Health staff who, with this low rate of salary, still chose to work with the Ministry of Health and contributed countless unpaid hours to the development of this East Timor Health Policy Framework 2002 (ETHPF-2002). Without this genuine willingness and sacrifice from Timorese Ministry of Health staff, perhaps the East Timor Health Policy Framework 2002 may have not been
produced and the content of the ETPF-2002 may have represented more views from the international advisers than the Timorese. A participant, as well as the leader in this group said:

We were able to do this with only one conviction in our mind that was, to contribute something to our beloved liberated Timor-Leste, although it was small. We were able to do it because we thought that we needed something or a policy to guide our health system development. We managed to do it because despite our limitations, we managed to work together with our international counterparts to produce something valuable for the country. (A senior manager in HPWG)

Cultural and traditional sensitivity and local history are the important aspects to be considered in the development of East Timor Health Policy Framework 2002 because it is a symbol and expression of Timorese identity.

The meetings of the Health Policy Working Group were held twice weekly. There were many topics presented and discussed. The advisers guided the discussions and took notes and presented the outcomes of the meetings at subsequent meetings. Participants identified that there were two consultative meetings with wider stakeholders. One was around February 2002 and the other one was in May 2002. The result of this process was the production of the East Timor Health Policy Framework 2002.

The draft of this document was then brought to the Council of Ministers and was finally approved in June 2002. The East Timor Health Policy Framework 2002 served as a foundation for all health policies produced after the ETPF-2002. For example, the East Timor Health Policy Framework 2002 informed the policy development for the National Health Promotion Strategy, National Tuberculosis Strategy, and National Malaria Strategy among others.

Challenges emerged after the approval of the Framework, as there was no guidance or action plan provided about its implementation. However, the East Timor Health Policy Framework 2002 was helpful in the development of health policies in specific areas such as HIV/AIDS and Malaria. The challenges in implementation lay with the fact that the East Timor Health Policy Framework provided general
guidance for the health sector development in Timor-Leste, while implementation in specific areas required policies developed specifically for those areas.

A participant in this study commented that to overcome these barriers in the future, policy makers need to take a holistic approach when dealing with policies (A senior manager in HPWG). When they want to develop a policy they need to pay attention to the whole cycle of the policy process: agenda setting, policy formulation, policy adoption, policy implementation and policy evaluation (Althaus, Bridgman & Davis, 2007; Soenarko, 2003; World Health Organization, 2003). Policy makers need to make sure that they follow this cycle. They cannot develop an appropriate policy without having a clear agenda in mind. They cannot just adopt a policy without implementing it. People cannot just implement a policy without evaluating it and so on. Policy makers need to make sure that all steps in the policy cycle are followed through.

Participants also experienced a disappointment in the form of an unfulfilled promise. One international advisor promised that upon completion of the work he would take them for a study tour in Malaysia. However due to lack of support and funding from the World Bank this did not happen.

GOVERNANCE ELEMENTS IN THE HEALTH POLICY FRAMEWORK 2002

The East Timor Health Policy Framework 2002 comprises a political commitment, macro policy\textsuperscript{21} and micro policy\textsuperscript{22}, the policy setting based on existing problems, and a priority determination. It addresses important elements of governance and policy.

\textsuperscript{21} Macro policy is a foundation or basis for development of the health system and micro policies.

\textsuperscript{22} Micro policy is more specific and detailed including operational policies.
Power and its decentralization

The process of formulating the Health Policy Framework 2002 showed that power-sharing and decentralization were valued. The document’s vision of the health sector, guiding principles, mission and goals of the Ministry of Health were defined and decided in consultation with stakeholders including religious leaders and donors. It is important to ensure that all subsequent decisions are consistent with these values.

The Health Policy Framework 2002 is strategic and directed toward the long term (See, for example, page 3 and page 12.) It is formulated in accordance with the objectives defined in the East Timor National Development Plan 2002. The East Timor Health Policy Framework 2002 is the “blueprint to guide health development” (East Timor Health Policy Framework, 2002, p.3). It is also provides the first comprehensive vision of the strategic policy direction of the Ministry of Health with the macro policy issues grouped into six areas.

The Framework includes a situation and problem analysis, which was used as the basis for the formulation of health policies in Timor-Leste. The policy gives due attention to the cultural, religious and other traditions of East Timor, as well as to local history and local problems. (See, for example pages 9-12.) The Framework states:

The overall goal of the program is to rehabilitate and develop its health system to be responsive to the immediate basic health needs of the population within a well integrated and sustainable policy framework appropriate for an Independent East Timor. (East Timor Health Policy Framework, 2002, p. 18)

The decentralization policy aims to gradually disseminate the planning, management and service delivery. Decentralization will transfer authority and responsibility to lower levels within the government health system and to national and autonomous health bodies. The decentralization policy is one of the strongest policies, which has been adopted by the Government of Timor-Leste. Bottom-up planning and capacity building will be emphasized through a more structured participatory process.
Responsiveness

The East Timor Health Policy Framework 2002 responds to the conditions, problems and real needs of the people of Timor-Leste. This policy demonstrates the Timor-Leste government’s commitment to increase responsiveness towards the community’s needs in the form of policy decentralization and to provide a sustainable health system focusing on priority health needs, and strengthening ability to effectively deal with health problems.

The document also articulates the Timor-Leste government’s level of responsiveness towards the community’s needs and condition. The Ministry of Health is committed not only to ensure appropriate care according to health needs detected through its own information, but also to satisfy as much as possible the consumers’ demands through the creation of networks and relationships with other relevant ministries and development partners. For example, relationships are sought with Ministries providing infrastructure such as road, telecommunication, water supply and electricity. Valuing of the perspective of the user is paramount if responsiveness of health system is to be achieved. The statements in the Framework on responsiveness are very strong but need to be elaborated in the operational aspect of document. This aspect is currently lacking in the Framework document.

In the Human Resources Development policy and strategy there is a focus on the importance of responsiveness. For example, it is written, “All training programs will be based on identified needs of the health services and should be delivered in the most cost-effective way” (East Timor Health Policy Framework, 2002, p.28).

Equity

One of the project commitments in the Health Policy Framework 2002 is “Restore access to basic health services” (p.17). This demonstrates the Timor-Leste government’s commitment to increasing the community access to health services. The increase of access will increase equity in the health services for the community. Equity is related to equality. The strategy was to be implemented rapidly to ensure delivery of quality basic services to as much of the population as possible. The mission statement of the Ministry of Health is “to strive to ensure the availability,
accessibility and affordability of health services to all East Timorese people” (East Timor Health Policy Framework, 2002, p. 24). This implies taking into consideration the needs of people in diverse geographic locations. It is also acknowledged in the Framework that to promote equity within the health sector it is necessary to establish criteria for allocation of resources (see page 26).

Referring to the management decentralization policy the Minister for Health states in the foreword that “we intend to focus more attention on the basics through decentralized management of health services” (East Timor Health Policy Framework, 2002, p.3). This decentralization policy encourages local government health officers’ participation, accelerating the decision making, and giving equal opportunity to all levels of management.

The government of Timor-Leste promotes equitable distribution of health resources and health services infrastructure, as well as subsidies to the poor (pro-poor policy). This is stated in the foreword, where it is stated that the government’s main goal is to increase access to services by making health care available and affordable to the people of East Timor, particularly the vulnerable groups. In the Human Resource Policy and Strategies there is also an effort toward equity, which is states: “in optimizing on available human resources, a key element of Human Resources Development policy will be productivity improvement” (East Timor Health Policy Framework, 2002, p. 27). Furthermore, it is also noted that the ministry gives high priority to health expenditure in areas of greatest need (East Timor Health Policy Framework, 2002, p 30-31). These statements indicate a political will to increase coverage of priority health interventions and equity of access to health services.

The establishment and gradual expansion of mandatory health insurance and the development of social/community financing schemes show the Timor-Leste government’s high commitment to equity policy. This is demonstrated in the following statement:

The Ministry of Health will manage financial resources available to the health sector, in a way that will promote sustainability, efficiency and equity. The policy objectives of these strategies will be the promotion of financial sustainability, public health goals of equity, access, efficiency and quality. The Timor-Leste government also encourages employer-based and cooperative-based insurance schemes. Special attention was given to
equitable distribution of health resources, increasing access to rural communities, targeting the poor, and applying cost-effective interventions in resource allocation. (East Timor Health Policy Framework, 2002, p. 30)

The ETHPF-2002 also mentioned that to bring health services closer to the community, the Ministry of Health would deliver health services through a network of 85 Health Posts staffed with a team of one nurse and one midwife able to deliver a minimum package of care.

**Ethics**

The vision statement includes the slogan: “Healthy East Timorese people in healthy East Timor”. The vision also reflects a commitment “to poverty reduction where the level of production and income allows all Timorese individuals to enjoy a healthy life and to have the minimum means to cover basic needs” (East Timor Health Policy Framework, 2002, p. 23).

As for an ethical perspective, the Framework determines that actions should not interfere with the development of the future health system but should take into account the principles, which were developed by the East Timorese Health Professionals Working Group, including sensitivity to local history, culture, religion, tradition and human value of the East Timorese people. This statement is fundamental in making culture and religion central to health development in Timor-Leste. In addition, the policy of ‘community protection’ is the implementation of ethics in health development. To protect the poor from financial cost of health care and to ensure access by those unable to pay, the Ministry of Health has developed a system of fee exemptions and waivers for selected health services and for high-risk population groups.

**Effectiveness and Efficiency**

In order to reach a high effectiveness, the Ministry of Health made a decision to group the health services by type: promotional, preventative, curative, rehabilitative, and palliative. They also categorized them by level of care: primary, secondary, and tertiary. (See page 26.) This policy can contribute to effectiveness
and efficiency in health development in Timor-Leste. In addition, the Human Resources Development priority determines that; “All training programs will be based on identified needs of the health services and should be delivered in the most cost-effective way (East Timor Health Policy Framework, 2002, p.28). In the health financing policies and strategies, it is mentioned, “The Ministry of Health will seek to secure adequate funding for provision of basic package of services and, to allocate and manage financial resources available to the health sector, in a way that will promote sustainability, efficiency and equity” (East Timor Health Policy Framework, 2002, p.30).

The Framework contains the arrangement of health organization management system in all levels. Chapter 5.4 deliberately states the arrangement of management structure in national and district levels. The structural arrangement impacts on the organizational structure, council, Districts Health Management Team, and Hospital Management Boards. (See pages 44-46.) In the third element of the three main components of the project, it is stated, “in order to ensure a proper implementation of the program, a management unit was included within the interim Health Authority structure providing support and building capacity of the Timorese counterpart” (East Timor Health Policy Framework, 2002, p.18). The effectiveness of health development programs in Timor-Leste will also be achieved through management re-arrangement in the form of proper supervision, discipline enforcement according to the priorities, deployment of staff, and an appropriate national incentives system.

The special priority given to preventive and promotive programs makes a valuable contribution to increasing effectiveness and efficiency levels. This can be found in the statement, which mentions that the Ministry of Health will give higher priority to preventative and promotional interventions than to curative. (See pages 30-31.)

In Human Resource Development policy and strategies there is also an effort towards improving effectiveness and efficiency. The Ministry of Health targets “areas of greatest need and impact on health status improvement” (East Timor Health Policy Framework, 2002, p.31). It will increase coverage of priority health interventions. Health system decentralization is being promoted by Ministry of Health on the basis of its potential benefits, as well as the presumed resulting greater effectiveness and efficiency in service delivery.
Cooperation

Cooperation with stakeholders and partners in the development of the Health Policy Framework 2002 is a reflection and manifestation of the understanding that it is important to develop strong cooperation and partnership with health stakeholders in Timor-Leste. The first project component identifies cooperation with NGOs; “the Interim Health Authority created, together with the health service providers, the ground for what lately were the District Health Plan (DHP) whose implementation was ensured through signature of Memorandum of Understanding (MoU) with all the NGOs” (East Timor Health Policy Framework, 2002, p. 17).

The health development policy in Timor-Leste also arranges the stratification of service level, starting from the lowest level up to the highest level. The Ministry of Health will build sub-district networks. This constitutes the entry point to the system for most of the community. Health services provided at the sub-district level includes a basic package of preventive, promotional and curative interventions. The Ministry of Health will implement community based rehabilitative programs through an integrated approach. The entire network within each level will be linked through a referral system based on two pillars: radio-communication systems and ambulance services. (See pages 16-20 and 44-46.)

Transparency and Accountability

In the Health Policy Framework 2002 it can be inferred that there is commitment to transparency, including financial transparency. This can be seen in a statement of the Operational Goal:

The Ministry of Health aims to provide quality of health care to East Timorese by establishing and developing a cost-effective and need-based health system which will specially address the health issues and problem of women, children and other vulnerable groups, particularly the poor, in a participatory way. (p. 24)

The establishment of District Health Councils and the involvement of NGOs in the health development in Timor-Leste constitute a manifestation of the
transparency policy in health development. As for financial accountability, the Health Policy Framework 2002 document has no specific statement. It is necessary to specifically state it in the next Health Policy Framework document. A clear statement of target outcomes in some of the priority programs in the East Timor Health Policy Framework 2002 reveals a commitment to the transparency principle. A significant weakness with regard to transparency is the lack of clear information about the amount, source, and allocation of the budget in the Framework. The unavailability of Key Performance Indicators (KPI) for each policy and program is another significant weakness.

There is a commitment to accountability for the health activities and expenses in this document and to the provision of information about the Ministry of Health vision and strategic perspective. According to the operational goal of the Framework “the Ministry of Health aims to provide quality health care to East Timorese by establishing and developing a cost-effective and needs-based health system which will specially address the health issues and problems of women, children and other vulnerable groups” (East Timor Health Policy Framework, 2002, p.24). The establishment of criteria for allocation of resources is a policy that promotes accountability.

All of these, including the arrangement of management structure and the decentralization policy, constitute manifestations of public accountability as well. The publication of the Framework shows the Timor-Leste government’s commitment to demonstrating this accountability principle.

**Participation**

The second component of the Health Policy and Health System Development prioritizes and focuses on basic health services. These include access, financing, target, private sector, and community participation, and others (p.19). In the mission statement, it is implied that there is an effort to: (1) guarantee the availability; (2) regulate the health sectors; and (3) encourage the community and stakeholders’ participation on health development in Timor-Leste (p.24). As for the decentralization policy, the Health Policy Framework 2002 identifies that it will guarantee: (1) to bring health services and their management closer to communities;
(2) greater ability to meet local needs; (3) greater possibility for community participation and involvement in health issues; and (4) greater accountability (p 39).

In addition;

Developing community level involvement in health program management is part of the decentralization strategy. These will centre on establishing inter-sector collaboration and working through local communities to search for new ways to plan and implement health programs. The provision of health care services will involve the other sectors and the community. (East Timor Health Policy Framework, 2002, p. 41)

It is clear that participation of all different partners or stakeholders including community in the health system is written into the Health Policy Framework 2002 through the decentralization policy. Another important aspect is the promotion of a pluralistic health system, meaning that the Ministry of Health promotes a health system drawing on a mixture of public and private provision and financing of health services. Although the government continues to be the dominant provider and financier of public health service in Timor-Leste, some health services in Timor-Leste will gradually shift to the private sector. The Ministry of Health will create an enabling environment for private sector participation in health care services as well. The balance of control and incentives mechanisms will also be implemented. The set of core health services will be financed and delivered by the government while the health care services outside these core services will be privately provided and financed.

In the Framework it is identified that future needs which cannot be met by Ministry of Health will be contracted to the private providers such as cleaning service, catering for hospitals and ambulance services. These approaches will be implemented to achieve the objectives of the Ministry of Health which are to increase: coverage; effectiveness and efficiency; quality; and equity through regulating participation of the private health sector. (See page 49.) The Ministry of Health has an initiative to implement the role of contracts or service agreements in health care services. This policy of Public-Private Mix encourages the community and private sector’s participation in health system development in Timor-Leste. (See pages 49 to 51.)
The concepts and ideas of governance foundational to the Health Policy Framework 2002 document are those that seek to encourage and guide the health actors, implementers and Ministry of Health partners in the central and local administration to develop and implement health policies and systems in ways that meet public need. These principles of governance are mandatory for a nation with commitment to the elimination of corruption, collusion and nepotism and the promotion of good governance in health system in Timor-Leste.

CONCLUSION

The East Timor Health Policy Framework 2002 was developed by the Ministry of Health Timorese team, called ‘Health Policy Working Group’ with assistance from the international advisors which were contracted by the Health Sector Rehabilitation and Development Program (World Bank). In June 2002 the Framework was approved by the Council of Ministers and became policy. The Health Policy Framework 2002 serves as the blueprint to guide the health system development in Timor-Leste.

The context of the Health Policy Framework 2002 highlights the essential role of factors that affect health. The vision, mission, goals, values and guiding principles, as well as the management and structure of the health service system of the Ministry of Health are presented in the Health Policy Framework.

Chapters Six and Seven will explore the extent to which the ideas and principles in the Health Policy Framework 2002 are applied by health service providers and administrators in the field.
CHAPTER 6: CASE STUDY: GOVERNANCE, HEALTH POLICY AND SYSTEMS IN DISTRICT A

INTRODUCTION

The study was conducted in District A (de-identified to protect interviewees). District A is a district in Timor-Leste with good health system performance and an acceptable standard of health outcomes as determined with reference especially to maternal health, immunization among children under one year, immunization for pregnant women, and average nutrition rating among children under five years of age.

Good governance is one factor that determines the quality of a health system, its health outcomes, and the achievement of the Millennium Development Goal (MDG) objectives. A careful analysis of governance of the health system in this district found some weaknesses which need improvement, but some strengths which can serve as an example for health system governance in other parts of Timor-Leste. Governance system provides an overarching framework for the administration and management practices that help to ensure the delivery of quality health care to the community. The governance of the health system in this district was correlated with people's lived experience of governance (good and poor) and current good practice as defined in the literature. These will be explored in this chapter.

DISTRICT A IN PERSPECTIVE

Geography and demography

District A, is located under 100 km from Dili, and spread over an area of 1,788 km2. Administratively, the district is divided into six sub-districts. Ten minutes out of the capital of Timor-Leste the road starts to climb, winding its way up the hills and mountains, exposing the traveller to beautiful views across land and sea.
Some of Timor’s most diverse and interesting flora and fauna is found in this district. The traveller will also encounter fishermen on the bay in canoes and swimmers having fun in the sea. About five kilometres before reaching the capital of this district, the landscape turns to rice paddies surrounded by community members’ homes.

The climate in this district is tropical, with a wet season and dry season. The temperature in the dry season range from 18-32° Celsius. General infrastructure such as roads, communication systems and clean water supplies are in poor condition. The road conditions between this district and Dili (capital of Timor-Leste) are good. However, from the capital of District A to the three sub-districts, located on the coast, the roads are in poor condition. These factors hamper socio-economic systems and affect the social determinants of health of the community, particularly in the three sub-districts. These conditions affect people’s access to health facilities and services and make it difficult for staff to reach the community in those sub-districts and villages. Consequently, people in those areas suffer health inequality.

In this district, six different languages are spoken, varying from sub-region to sub-region but most people speak Tetum, which is an official language in Timor-Leste. Most of the population (97%) identifies as Catholic. The total population of this district was approximately 43,200 comprised of 21,400 females and 21,800 males (Timor-Leste National Statistics Directorate, 2010). The majority of the population 79.1 % (34,200) live in rural areas with the remainder (9,000) in urban areas. The district has the lowest population density of Timor-Leste with an average 24.3 persons per hectare (Timor-Leste National Statistics Directorate, 2010). Life expectancy at birth was 60.3 years (Timor-Leste National Statistics Directorate, 2004) and the poverty headcount ratio, 73.7% (World Bank Group, 2010). Annual growth rate was 2.65%. The proportions of female and male household population with no education are 34.2% and 28.6% respectively. The main sources of income are fishing and cash crops such as coffee, coconut, fruit, vegetables and grains such as corn and rice.
Health indicators

The fourth objective of Timor-Leste Millennium Development Goal is to reduce the under-5 mortality rate. The goal for Timor-Leste as a whole is to achieve less than 56 deaths for every 1,000 live births. The under-5 mortality rate in this district is currently 69 deaths per 1,000 live births (Democratic Republic of Timor-Leste, 2009-2010). Among 200 children age 12-23 months, 53.6% have completed basic vaccinations but 28.2% have had no vaccinations (Democratic Republic of Timor-Leste, 2009-2010).

The aim of the fifth goal of MDG is to improve maternal health. The current estimated ratio of maternal mortality rate for Timor-Leste is 557 per 100,000 live births. In this district 93.9% of pregnant women received antenatal care from a skilled provider such as a doctor, nurse, midwife, or assistant nurse. The rate at which mothers received Tetanus Toxoid injections immunization to protect the unborn child against neonatal tetanus was the highest in the country at 94.8%. Delivery of babies in a health facility was 25.4%, with 74.6% delivered in a home. 36.9% of births are attended by a skilled birth attendant and 23.7% traditional birth attendant respectively (Democratic Republic of Timor-Leste, 2009-2010). The plan is for births attended by skilled health workforce to increase from 19% to 60%.

The aim of the sixth MDG is to combat HIV/AIDS, Malaria and other diseases. The number of confirmed cases of HIV/AIDS was low in Timor-Leste compared to other border country areas, though there has been an increase of reported HIV/AIDS cases from seven in 2002 to 151 in 2009 nationwide. However only 52.1% of women and 98.9% of men aged 15-49 years in this district have heard of HIV/AIDS. Malaria was and continues to be a leading public health problem in Timor-Leste. Relative to other districts this district has a high number of cases. In January-March 2009, over two thousand cases were reported (Ministry of Health Timor-Leste, 2009). This was likely due to the environment and the demands of rice productions and poor infrastructure, which provide ideal conditions for mosquitoes to breed. Other communicable diseases are also reported at high rate. For example 22 new cases of Tuberculosis were reported in January-March 2009 (Ministry of Health Timor-Leste, 2009).
Governance of the health system

All District Health Services (DHS) are served by a team called the District Health Management Team (DHMT). This has specific roles such as to develop plans, supervise, coordinate, monitor, report and evaluate all health activities or health policy implementation at the district level. The District Health Management Team was responsible for administration, financial and logistical functions to support health system functioning at the local level. The District Health Management Team in this district consists of: the head of the district service, Level 6; the Deputy Head of District Health Services, Level 5; and six District Public Health Officers (DPHO), Level 4. The DPHOs were specialized in the fields of: Maternal and Child Health; Health Promotion and Nutrition; Communicable Disease Control; Non-Communicable Disease including Pharmacy and Laboratory; Environmental Health; and Health Management Information System. The DPHOs function was to manage a group of integrated health services. These services officially report to the District Health Management Team manager but in practice DPHOs also function as vertical program managers. The District Health Management Team was also supported by an administrative section comprised of General Administration, Personnel Management, Finance, Ambulance, and Logistics.

To improve health services delivery and achieve Timor-Leste’s fourth, fifth, and sixth MDG objectives, Ministry of Health Timor-Leste developed the basic services package (BSP) for primary health care and hospitals. Similar to other District Health Services, the district health plans implemented by the Community Health Centres and Health Posts are based on the Basic Service Package and principles of Primary Health Care. The Basic Service Package was comprised of Maternal Health, Child Health, Communicable Diseases, Non Communicable Diseases, Health Promotion and Environmental Health. Each of these six priority areas were supported with a policy and specific strategies to address key priorities within each element. For example, Maternal Health has policies approved related to Nutrition, Family Planning and Reproductive Health. Child Health has policies for Immunization and Integrated Management of Childhood Illness (IMCI). Communicable Diseases has approved policies pertaining to managing and responding to Tuberculosis (TB), Malaria and HIV/AIDS Non-Communicable
diseases have policies pertaining to Oral Health and Mental Health. Health Promotion has policies relating to Environmental Health, School Health and SISCa.

These policies and strategies were developed by the central government Ministry of Health. However, there was no evidence of any strategies, policies, procedures or guidelines developed at the district or local levels. Primary Health Care focuses on providing accessible, affordable, appropriate health care at community level with participation and support of the community. Community participation in health programs implementation in this district included the engagement of Family Health Promoters (community health volunteers) in villages and community leaders, as well as the mobilisation of the community for SISCa activities and to take part in health events and Pastoral das Crianças organized by the Catholic Parish.

One Sub-District Health Centre was connected to at least four Health Posts and Mobile Clinics. The Health Post was the entry point into the public health system and key to achieving Millennium Development Goals. The Health Posts provided the BSP and health promotion and implemented the principles of Primary Health Care. The Health Posts also provided links to higher level referrals and emergency services through the radio communication system, as well as to the Family Health promoter program through community committees. Mobile clinic services were provided by Health Posts. Staff were rostered to work the mobile clinics and budgets provided for service provision to communities that are over two hours walk from the health facility (remote areas) or regular community gathering such as the local village market (Ministry of Health Timor-Leste, 2007a). The following section summarizes the role and function of these services based on BSP provided by the central level Ministry of Health.

Health Posts (HP) are situated in sucos (villages) within the sub-district and serve 1,000-5,000 people (200-1,000 households). The function of HPs was to provide simple preventative and curative services including ante-natal and post-natal care; immunization and community education; normal deliveries at the facility; support of the FHP (Family Health Promoter) to encourage community participation and education; Integrated Management Child Illness (IMCI); basic curative care for
communicable diseases including STDs; TB DOTS\textsuperscript{23} follow up; mental health patient follow up; and Mobile Clinics. A minimum staffing and infrastructure was provided including two staff (one community nurse Level 4 and one community midwife Level 4); an outpatient department open eight hours a day, (with 24 hour emergency call); a maternity delivery unit (with 24 hour call); maternity waiting home (with community support) where appropriate; a functional 2-way radio or mobile phone for emergencies communications; a motorcycle for mobile clinics; a refrigerator for immunization; and solar power for light, refrigerator and radio, where there was no electricity.

Sub-District Health Centres (SDHC) were located at the sub-district level. They provide care for 5,000-15,000 people. The role of the SDHC was to provide HP services plus a higher level of service than the Health Post. The services included technical and managerial support to Family Health Promoters; a full package of child care based on IMCI and regular immunization; facility based deliveries and management of emergencies; emergency care for newborns smaller than 2 kg; BEOC\textsuperscript{24} in a phased approach; maternity waiting houses where there was good community participation; regular outreach at health posts to provide clinical and preventive services; dental services; pharmaceutical services; basic laboratory services for ante natal care, malaria and tuberculosis; and a few short term (24 hour) observation beds to treat complicated cases. The minimum staffing and infrastructure provided included 12 staff, including a doctor, technical, and managerial staff. The manager had responsibility for coordinating all services at health posts in the sub-district to ensure the basic package of services was available to all citizens. The manager also oversaw; two or three 4WDs; five motorbikes; BEOC facilities; short

\textsuperscript{23} DOTS (Direct Observed Treatment Short-Course) is a tuberculosis control strategy that combines five strategies: (1) government commitment including both political will at all levels, and establishing a centralized and priorities system of TB monitoring, recording and training; (2) case detection by sputum smear microscopy; (3) standardized treatment regimen directly observed by a health worker for at least first two months; (4) an effective drug supply and (5) a standardized recording and reporting system (monitoring and evaluation) that allows assessment of treatment results (WHO, 2011).

\textsuperscript{24} BEOC (Basic Emergency Obstetric Care) refers to life saving services for maternal complication being provided by a health facility or professional which must include the following six signal functions: administration of parenteral antibiotics; administration of parenteral oxytocic drugs; administration of parenteral anticonvulsants for pre-eclampsia and eclampsia; manual removal of placenta; and assisted vaginal delivery (WHO, 2011).
term observation beds; and basic laboratory facilities including antenatal care disease detection, dental equipment and pharmacy.

The District Health Centres (DHC) were situated in districts that do not have hospitals and provided outreach and referral services to all facilities and mobile services to remote areas. The function of the DHC was to provide a higher level of service than the health post. Thus the DHC provided responses to complicated curative cases requiring referral or in-patient treatment; BEOC in all districts by 2007; newborn resuscitation using oxygen; treatment for the mentally ill and the disabled; eye care, disability services (with NGOs); outreach services to Health Centres and Health Posts; pharmacy services to all health facilities within the district; vehicle based mobile services to remote and rural areas; and the Voluntary Counselling Test (VCT). The minimum staffing and infrastructure requirements include 17 personnel including a manager and two doctors; radio communications with direct access to ambulance services with one ambulance per district; in-patient beds for longer stays, a laboratory services including TB microscopy and HIV testing; a unit for VCT and Prevention of Mother to Child Transmission (PMTCT) for HIV positive mothers; and four 4WDs and 5-10 motorbikes.

To ensure the health services delivery in this district, the Ministry of Health and its development partners provided six community health centres, 18 health posts and 76 posts of SISCa25. Logistical support and transportation were also provided by central government, through provision of eight operational cars, three ambulances, 26 motorcycles, nine bicycles, four horses, nine two-way radios, nine generators, 18 solar panels, one photocopier and 16 computers. During the period of fieldwork most of these items were found to be in poor condition and in need of repair or maintenance.

The total staff including administrative and other support staff was 142 people. This included eight doctors, 46 nurses, 30 midwives, 19 other health professionals, and 39 administrative and support staff. The 103 health professionals

25 SISCa (Servico Integrado da Saude Communitaria): Integrated Community Health Service (MoH, 2008).
serve a population of 43,246. This means that there was one health professional per 419 persons.

In this district, all pregnant and postnatal mothers and children, were provided with a unique health record, which documented the date when they should revisit the health facilities. To ensure pregnant women and children maintained good health, health staff in cooperation and coordination with community leaders including hamlet chiefs and Family Health Promoters, made afternoon visits to patients’ homes after attending to other patients at the health facilities in the morning. In cooperation and coordination with UN Agencies and International NGOs, 270 members of Promotor Saude Familia nian (Family Health Promoter) provided health services in this district.

The District Health Service of District A had a pilot program called ‘Local Development’ hosted by the district authorities. Teams from various departments visited and had monthly meetings with the villagers to obtain information, share information, and discuss any problems including health problems, which occurred among members of the community. They sought solutions together, identifying ways to solve problems directly with all departments and communities themselves in their village. Local authorities also respected community members and paid due attention to concerns they raised. If they could not resolve concerns immediately they took them to higher-level authorities in the central government in Dili. This program aimed to increase human capital, empowerment and capability of local communities to solve their own problems.

**PERCEPTIONS OF GOVERNANCE**

In health systems, the importance of good governance was usually appreciated in theory by stakeholders, but often remained poorly implemented. Therefore, the application of the elements of governance was explored in this study. The elements of good governance that guided and informed the health systems in this district included organisational structure, power, responsiveness, effectiveness and efficiency, equity, ethics, accountability, transparency, cooperation, and participation.
This analysis of governance of the district health systems examined the systems in terms of the structures and processes that have been established, and the extent to which the structures and processes have enabled the delivery of health services and the achievement of health outcomes in practice. Further the legitimacy, as well as capacity for communication, consultation, and coordination, as expanded upon in Chapter Two: the Analytical Framework.

**Responsiveness, structure, effectiveness and efficiency**

According to the participants, responsiveness referred to the provision of better infrastructure and support to the health workforce by the Ministry of Health, other relevant ministries and their development partners. Examples of infrastructure in need of attention included roads, electricity, clean water supplies, and communication facilities. Support of the health workforce constituted ensuring their access to adequate medicine, vaccines, and equipment. Support also included provision of relevant documents, guidelines, and other logistical support in health facilities.

This District Health Service (DHS) has not fully participated in the process of developing health policies, strategies, procedures and guidelines. The local government\(^{26}\), health authority, staff and community leaders in this district recognized that these health policies and procedures are linked to the objectives, social and cultural norms of the district. The interaction between government and community should be driven by the local social, economic and cultural norms (Panayiotopoulos, 2002) and political pressures. These policies were disseminated by Ministry of Health to District Health Service and its partners.

A majority of participants said that the lack of responsiveness by the Ministry of Health and its development partners put the implementation of health programs in jeopardy. When the respondents were asked to elaborate on the need for improved infrastructure they reported:

\(^{26}\) Local government including all departments (relevant ministries) within the district.
Three remote sub-districts are difficult to access due to the poor quality roads. This prevents us from transporting expectant mothers to deliver their babies in the health centres. ... The level of maternity services recorded in these health centres is low. (Senior health staff 1)

One of the senior staff added:

I think we are facing the same problems as the community. They keep raising the issue of electricity and water at every meeting. Yesterday we had a meeting on the environmental health program as we have requested to find a way to solve the water issue, so that people can have access to clean water. Currently diarrhoea is widespread in our sub-district as people take water from the river for drinking… You tell people that they should wash their hands before they eat, etc, but there is no water. That is a problem. (Workforce 1)

The staff commented on the lack of constant and reliable electricity. The Community Health Centre only received six hours of electricity per day. They had a generator for back up power supply but it constantly broke down. They had to use rechargeable lanterns or candles even when they are helping mothers deliver their babies in Health Posts or Community Health Centres. Participants also explained that they had provided this information several times in national meetings. They were promised by Ministry of Health that some companies would address this issue. Some of health posts (communication) radios were broken, some did not function well and needed to be replaced. Some operational cars, motorcycles and radio communications required mechanical repairs and maintenance in Dili, but they continually received no response from Ministry of Health in Dili. One of the senior midwives observed:

On our radio, we can only receive calls, but we cannot make any calls. We use our personal mobile phone for emergency cases. We have informed them (people from Dili) several times, but receive no response. In emergency situations we have to climb high up on a hill to get a telephone signal to make a call and we use our own credit for the calls. (Workforce 2)

A majority of respondents noted that provision of pharmaceuticals, logistical support, health equipment and transportation was insufficient to ensure the delivery
of health services to the community in this district. When participants were asked to elaborate they reported:

Among six community health centres in this district, there is no radiology machine. We need a radiology machine in this Community Health Centre. A radiologist was employed three years ago in this Community Health Centre, but as there is no radiology machine, he does other jobs. Some patients complain if they have to go to Dili (the national hospital) simply to get an X-ray. They have no family over there to cover their stay in Dili. (Workforce 8)

Staff also complained about the lack of medicines available in this district. Medicines, received from SAMES - the national central pharmacy - for mothers and children’s health are very limited. Medicines provided to midwives as documented in essential drug list should be in regular supply to reduce the mother and child mortality rate. In some cases, there was simply no medicine at all. Participants from six Community Health Centres, stated that only one sub-district in this district has an oxygen tank. They have reported this for two years to Ministry of Health with no reply. In rural communities expectant mothers went to traditional midwives first and only come to the health facilities when their health condition was poor. It was usually too late to go to Community Health Centre and Health Post with delays leading to the patient’s death. Therefore, oxygen tanks, medicines, electricity and clean water were critical for midwives to help mothers and babies in Community Health Centres and Health Posts. A senior District Health Service staff reported:

Ministry of Health and SAMES need to improve their medicine procurement, distribution (oxytoxin, mertergin, and medicine for children) and oxygen distribution systems for mother and child health (MCH) program. Sometimes, they send us medicines that have almost expired. They should provide medicines in a timely manner. Also, they should send us the amounts requested, not decreased amounts. For example in July 2009 we were out of stock for polio immunization, therefore some children missed out. (Senior health staff 1)

The researcher observed during the fieldwork for this research that in some Community Health Centres, rubbish had piled up in the courtyard of Community Health Centres, and cleaners used gloves borrowed from laboratories or Mother and Child Health unit to collect the rubbish. Cleaners did not have any equipment to
collect the rubbish in the health centres and they used their bare hands. The Water and Sanitation Department in this district did not provide a rubbish truck. They used the District Health Service Landrover to transport the rubbish, and then they had to clean the car before returning it to District Health Service.

A senior staff member observed: “The District Community Health Centre should be a role model for the community. However as you see (she pointed to rubbish piled up) we have no rubbish bin, masks or vehicles to transport the rubbish” (Support staff 1). One of the participants from the laboratory department observed: “… We have to share masks and gloves with cleaners and doctors. I have only one pair of gloves for everyday use” (Workforce 5). This situation was conducive to the spread of disease and poor public health in this district.

Reflecting sentiments expressed in relation to other District Health Services, the lack of human resources to staff this District Health Service was a concern of many. However, the district was in a relatively strong position in terms of human resources, with enough professional staff to fill all positions in CHCs, and HPs. The health staff had good relationships with each other which allowed them to overcome barriers in the field.

**Ethics**

Throughout the period of this research, community leaders, community health volunteers and patients lamented the poor attitude and behaviour of some staff working in health facilities and District Health Services. People acknowledged that some staff demonstrated good attitudes and behaviour when serving as health professionals. However, some District Health Services staff were rude, dishonest and lack transparency in the work place. One example pertained to the process of recruitment for a new health facility and DHS staff. One participant said: “In a recent case, the recruitment for new staff was not transparent. They employed people from their family and people close to them. They did not act ethically. They favoured some people and reject others” (Community leader 1). An example of rudeness of health staff was also provided by community leader 1 who reported; “some staff in health facilities shout at patients if patients arrive late to the health facilities” (Community leader 1).
In their own defence one staff member stated: “We have heavy workloads attending to out-patients for the SISCa program and other programs, and it can affect our attitude and behaviour in the delivery of health services to the community” (Workforce 9). Another staff member acknowledged: “We occasionally get upset and say mean things to the patients … but we continue to provide services to them” (Workforce 3).

**Power**

The vast majority of informants reported that there were certain individuals and institutions, which held the power in health policy, planning, budget and activities. Participants who served in local government, as health authorities or staff in this district articulated that there were certain persons and institutions who had a disproportionate influence on issues pertaining to health in the district. These included persons who occupy high-level positions in Ministry of Health like the minister, vice minister and senior staff; representatives of the dominant party; donors such as the World Bank; UN agencies; International NGOs and the Catholic Church.

A senior staff member reported: “The Catholic Church has a strong influence on health policy because the majority of the population (97%) belong to the Catholic Church. An example was the development or implementation of policy and strategy for family planning.” (A senior health decision maker).

Another respondent noted:

The senior staff in the Ministry of Health, NGOs and appointed staff from the dominant political party always make decisions without consultation with us in the field. They change their decisions many times. This is the effect and attitude of people who have never held power and then suddenly gain power (said in ridicule). Many times they misuse it. People who have power in Ministry of Health should consider the opinions of the staff in the field before making decisions, because we are the people who live in the communities. Their mistakes affect health care services to community. (Workforce 4)

A decision maker of local government articulated: “When talking about family planning, we try to coordinate with and involve the Church, council of villages, some traditional power structures in villages, and the elders (who believe in and still
practice the traditional way of giving birth)” (A senior decision maker of local government).

One of the other participants explained:

In some villages in this district the head of the village is a descendant of the *liurai*. Everyone knows that most kings’ descendants try to be good leaders… They are respected by the local community and local government. Therefore government representatives always approach them first in order to influence the community. … In the Portuguese era I know that this tradition was applied. During Indonesian occupation the customs and tradition continued to be upheld, and continue up until the present. This is because the customs and traditions bring the community together. In my village mostly we resolve problems through customary or traditional mechanisms or *adat* (traditional law) because the formal justice process takes too long… The traditional law is respected by community and more strongly if it is led by the traditional power structure such as a *liurai* (king) or *datos* (tribal elders) or *katuas lia nain*. (Community leader 1)

Participants noted that in their experience, the traditional structure in some parts of the district was still strongly influential in community and state activities. For example, traditional leaders were the point of contact with the communities for leaders of political parties.

The participants were asked whether partners and stakeholders meet with heads of Community Health Centres or with staff at the Health Posts to discuss health issues. One of senior staff replied: “I think yes, especially the administrator of the district, some people from parliament, community leaders and more often donors” (A senior health decision maker).

A majority of participants identified a need for greater decentralization of power. The current level of decentralization of power from the Ministry of Health to the local health authorities in this district (DHS, CHCs and HPs) was insufficient and hindered decision-making at the local level. Participants who served as local government and health authorities at the district level were asked about their roles and responsibilities in the implementation of health programs at the district and sub-district levels, one of them replied:
My responsibility is the overall coordination of all departments and services. With regard to health I do my best to ensure that the community obtains a high standard of health care. To attain this we need to work together to raise community awareness about the importance of visiting the health centres to prevent disease. (A senior decision maker of local government)

The administrator of the district sometimes made unplanned visits to the communities without informing the administrator of the sub-districts, community leaders and community. This was in order to get an idea of what was going on. Wherever he went he always pretended to have a headache or feel unwell so he could go to the health centre in that village. This gave him information on the condition of the health centre: were medicines always available? If not, why? This was an effective technique to obtain accurate information on how the health service works, and then he would report this information to the Ministry of Health through his ministry (Ministry of State).

One of the participants said:

My job as the director of community health centre is to implement instructions or programs from both Ministry of Health and District Health Service, and coordinate with local government to implement the programs. I cannot make a decision without consultation with Ministry of Health through the District Health Service. (Workforce 1)

They also were asked to identify the current level of decentralization. They had limited power given by Ministry of Health. Research participants reported that the national level agents (Ministry of Health) determined the budget and procured the materials. The District Health Service or District Health Management Team (DHS or DHMT) only received medicines rather than the funds to buy medicines or other supplies. Ministry of Health delegated the authority to District Health Service in cases of emergency or when the medicine costs are less than US$1,000. In decision-making the local administration DHS cooperated and consulted with the partners to decide actions. They consulted each other as a team to reach a decision to achieve results and benefits to the community. One of the senior health staff stressed:
Most things are dealt with at the national level such as capital development, minor-capital, fuel, and vehicle maintenance… Only the senior staff in the Ministry of Health have power and the right to make decisions, even though sometimes the decisions are not in line with district needs. (A senior health decision maker)

One example provided was the SISCa program. Staff at the national level instructed District Health Service to only open six SISCa posts as they have only six villages. Due to the size of the District there was a need for at least 17 posts to service all communities. One participant said that this has been highlighted to the Ministry of Health several times but they have had no response. Ministry of Health held the power to decide because they managed the money. As a consequence, District Health Service authorities had to split the money allocated for six posts among 17 posts.

One of the participants explained:

I have authority to use the money from the pasta mutín for minor expenses up to US$100 or US$200 per month including vehicle maintenance, or to cover daily expenses of the community health centre. … Any expense above US$1000 for example to repair a car should get the authorization of District Health Service or Ministry of Health. The head of the Community Health Centre coordinates with District Health Service and then District Health Service report and organize with Ministry of Health in Dili to get money for the car repair. (Workforce 3)

27 Capital Development is the full amount a Body may spend on Capital Development projects. The funds are meant to support infrastructure such as road, bridges, logistic facilities including storage infrastructure, health facilities, water treatment and sanitation facilities and other infrastructure promoting strategic development (RDTL State Budget, 2011).

28 Minor Capital is the full amount a Body may spend on the acquisition of Minor Capital goods, such as ambulances, transportation for monitoring school education and health facilities in rural areas and movable stalls (RDTL State Budget, 2011).

29 White pouch discretionary funds allocated to district.
When the participants were asked if they were given the authority and flexibility to manage the money of the *pasta mutin*, they replied:

Yes, to manage the US$1,200 per month…but what kind of flexibility do we really have with such a small amount of money to cover all health activities within a district? They delegate the responsibilities on the one hand but they keep the authority or power in the other hand. Therefore, how we can attend to these responsibilities? We can make a health-related decision in an emergency only and we have limited power to do more than that…. (A senior health decision maker)

When the participants were asked how they overcome barriers related to implementing health services and find solutions to problems, one of them replied:

We tell them (community and community leaders) that we do not have the power to solve these difficulties. We can only bring the problems to the attention of the sub-district administrator to inform people at the district or national to resolve them. We just take notes and bring up the issues in the monthly meeting with DHS, so the issues can be conveyed to the relevant ministries. (Workforce 1)

Participants were also asked why the Ministry of Health controlled all procurement, in light of the fact that the guidelines stipulated that districts should be able to procure their own supplies. One of them replied:

The reason was limited human resource to manage and lead the procurement at the district level. The money we receive does not match our plans. They do not care about the list of items in our budget to be purchased… For example we are supposed to buy our own stationery based on our office needs but they do it for us. This kind of management is not in line with the spirit of decentralization. (A senior health decision maker)

**Cooperation and participation**

Participants described cooperation as coordination, communication, collaborative relationships, working together, support and participation. The District Health Service always invited and involved the administrator of the district and sub-
districts, all departments under administrator’s authority, and heads of health centres, health staff, community leaders and stakeholders to participate in the process of dissemination of health policies. As the geographical area was large, some people faced transportation difficulties and lacked funding to attend the event. These were their challenges. To inform the community about these policies the local government through this District Health Management Team and its partners made the effort to go to sub-districts, villages and hamlets to communicate and disseminate these policies several times before implementing.

To facilitate the implementation of health policies and programs in this district the District Health Service had a strong network. They had good cooperation, coordination with development partners, international and national NGOs, community leaders, the Catholic Church, and traditional structures in some villages through which they gained support from all communities within the district. Participants said that District Health Service and its development partners did their best to implement health interventions so that the community could enjoy good health conditions. They worked as a team. They constantly coordinated with local authorities and other departments in this district. They have as their motto: “Public interests above private interests”. This means that they have to put the people’s interests first, especially in primary health care services.

This District Health Service also collaborated well with relevant parties and departments to conduct monitoring and evaluation of the programs directly in the field. Meetings were held in the office of district administrator or the administrator of the community development program. The District Health Service also had a team consisting of representatives of all development partners and coordinators of health programs. The role of this team was to monitor, monthly or fortnightly, the implementation of health programs and policies in the field. If they found any barriers to the process of implementation they resolved them immediately, or reported to the administrator’s office or Ministry of Health to find the solution. The administrators of sub-districts always visited Health Posts once a month. The sub-district administrators accompanied health staff and communities when the latter conduct health events. The administrator of the district also visited health facilities while monitoring and supervising government programs and activities in villages.
Another important partner of District A District Health Service was the Parish Catholic Church, which had an organization called *Pastoral das Crianças* (PDC). This organization aimed to foster the holistic development of children and mothers health and wellbeing by promoting the development of their families and communities, without distinction of race, profession, nationality, gender, political, and religious affiliations. The objective of *Pastoral das Crianças* was to reduce the infant and maternal mortality rate. This program was run through volunteer leaders under the aegis of the Catholic Church. It promoted community action for health to prevent diseases and promoted nutrition, education and responsible citizenship. The program leaders came from the villages and had to attend three phases of training conducted by nuns and priests in cooperation with District Health Service, Community Health Centres, and Health Posts. These leaders and representatives were responsible for guiding and advising 10 to 15 children in their neighbourhoods on disease prevention, nutrition, education and citizenship. The goal was to empower individuals and support them to take responsibility for their personal and social development.

This District Health Service also had good internal coordination and harmonious relationships among the staff. Thus if the midwife of one health centre was going to Dili for a meeting or for other reasons, a midwife or nurse from another health post filled in. They coordinated and supported each other so that the patients, in particular the pregnant women and children, could have access to health care services every day. Staff in Health Posts were supported by their officials (the heads of the health centre), who visit them two to three times a week to follow-up health activities conducted in the health posts.

According to participants’ information and the researcher observations during the fieldwork, health programs and activities were well implemented including monitoring and evaluation because of the good collaboration at a high level. For example between the local authorities and the health workforce there was good collaboration and they also gained good participation from the community. They worked together with community leaders or council of villages and raised awareness in the community about key health issues such as the importance of maternal and neonatal care through accessing health centres and SISCa posts, located in the centre of the village. A senior decision maker in this district articulated:
Each department has their monitoring and evaluation team to follow-up activities conducted in this district. I also do monitoring and evaluation regularly every two weeks in the villages. I go and discuss the program implementation with the community or community leaders and ascertain the benefit for them. In urgent matters we communicate through telephone calls, crosschecking information when we hear of problems occurring in the communities. We strive to find solutions immediately. Our relationship is very good. We are like a family. (A senior decision maker of local government)

The District Health Service including health facilities in the district had good cooperation with the Catholic Church, Pastoral das Crianças (PDC) organization and PSF (community health volunteer). An advisor of Pastoral das Crianças (PDC) reported:

We recognize that we cannot work alone thus we have to cooperate and communicate to health professionals to assist our community to get health treatment if needed. All the findings we put in a report with recommendations forwarded to the health facilities. If PDC finds a sick patient, suffering from, for example, diarrhoea, we do not provide any medical treatment but give some advice and refer them to the health facilities. (Participant 3)

The Pastoral das Crianças have a community centre called Centro Celebração da Vida or CCV (Centre for the Celebration of Life), which was located in the Parish Church in their area. They always implemented health activities jointly (have one timetable) with health staff and family health promoters in the CCV. Most Pastoral das Crianças were also Family Health Promoters therefore it was easier for them to develop good communication, collaborative relationships and coordination when implementing health activities. For example, health staff provided vaccination, vitamins and treatment, while Pastoral das Crianças and family health promoters weighed the children and mothers, and conducted health promotion. If they found children with malnutrition Pastoral das Crianças taught the mothers how to make nutritious food. These were all examples of excellent cooperation, and coordination among all parties involved in health program implementation in the field to achieve health indicators, MDG objectives and health system performance.
The District Health Service was also found to provide great relationships with community leaders and traditional structures in villages and hamlets. They involved these partners in their meetings before the implementation of health programs. Hence, health programs were doing well despite some challenges as the various participants try to support each other. In health campaigns, district and sub-district administrators came and joined with them, so that all communities took part in health events. In one example, a campaign promoting vitamin A was conducted in a sub-district. The community, community leaders, administrator of sub-district and his local officials participated with the speaker, the administrator of the district. They reached 98% of the population with their campaign. This was typical of the processes that occurred in this district’s Community Health Centres with sub-district administrators and local leaders as well as in Health Posts with villages and hamlets. They involved youth and local authorities, which promoted ownership of programs. Another example of the positive relationships was found in the way Promotor Saude Familia nian and Pastoral das Crianças reported patients to staff in Health Posts or brought them to Health Posts for treatment.

Researcher observation during the fieldwork found there was good coordination between health staff, Pastoral das Crianças, Promotor Saude Familia nian, and community in the process of health service delivery. For example they had one timetable. Each party had their own clear job description. They shared equipment and worked together to achieve the objective of community wellbeing. A Family Health Promoter observed:

We are supported by staff, Pastoral das Crianças and community, when we run SISCa programs in our village. Everything goes well from preparation to implementation of the program. If we find any difficulties in the field the health professionals are willing to help us, show and teach us what we do not know. There is only one measurement for the arm. There are no scales. We use the equipment belonging to Pastoral das Crianças. We help staff to cook porridge for the children using Pastoral das Crianças kitchen equipment or equipment borrowed from the community. The Community Health Centre does not provide equipment for SISCa activities in the field. The chief of village or hamlet always helps us to find the necessary equipment to deliver
this service to the community. We have good coordination and relationships.

(Community volunteer 2)

A senior health staff observed:

People in this sub-district give great support to health programs. This support is manifest in provision of transportation and participation in our programs. We have regular meetings involving all parties (NGOs, PDC, PSF, community leaders and workforce) to discuss and evaluate what has been done, what will be done next, and who does what. Each party knows what they should do, so it’s easier for me to coordinate the activities. The meeting is chaired by myself (as head of Community Health Centre) and conducted here (in the Community Health Centre). We also have a good relationship with the Church. If we find a communicable disease is likely to spread, we inform the priest who announces it through mass on Sunday. I have also been asked by the priest to talk about health issues during mass. (Workforce 1)

There was a regular meeting every three months between Promotor Saude Familia nian (PSF) and community leaders to discuss health activities in their villages or hamlets. Each hamlet had two or three Promotor Saude Familia nian who had data on pregnant women and children. During the fieldwork, staff conducted refresher training for PSFs on how to identify signs of pregnancy, delivery, and how to assist midwives. A staff member articulated:

… I think the local authorities and community leaders all support us. Heads of villages, the administrator of the district and sub-districts, the police commander all take part in most of our activities. They attend meetings and help to find solutions to problems that emerge in doing our programs. There is no impediment so far. (Workforce 1)

**Transparency and accountability**

Participants provided various definitions of transparency as it pertains to the health sector in this district. These definitions included: openness of health administration; accountability or full communication and explanation of the health plan and budget results to the public; involvement of local community leaders in the development of the health plan and budget; and full accessibility by the public
through various media of all information about the health system and its procedures. Transparency was also considered to have implications for the way in which new staff are recruited.

A majority of participants said that transparency of human resources management in the health sector was lacking in this district. Participants were asked whether or not the Ministry of Health consulted them when they changed or moved staff to another position or district, Community Health Centre or Health Post. Responses included:

I do not know anything… They just asked for staff names. Every health centre sent two names, and before that, an audit team from Dili came to get information about health workers and talk to the people. Perhaps, the change was due to performance evaluation? I do not know. They did not explain why and how the staff was being transferred to another position. (A senior health decision maker)

Another participant said:

…If there is any job opportunity in the District Health Service or health facilities or health NGOs we should be prioritized. But what happens is they recruit other people instead of us…we think that is not fair. … Although the Community Health Centre advertises the vacancy (said with emotion) it is simply a formality. We know they have already chosen someone. The qualifications of the people they recruit are the same as ours, or even lower … the recruitment process is not transparent. (Community volunteer 1)

The participants were asked if they felt followers of any particular political parties or relatives were favoured by the District Health Service and health care providers in the district. One of them replied:

I think it occurs. In one recent case, the recruitment for a new health worker was not transparent. They employed someone from their family, people to whom they are close. The district is small so that we know who was recruited for what position. There was no public announcement of the vacancy … this is what we observe here and transparency in health sector really needs to be improved in this district. (Community leader 1)
Some participants stated that there was lack of transparency and accountability of the health plan and budget by health decision makers in this district. When asked how much remuneration they received for attending a workshop or training they replied:

We get some money when we attend training, US$1.00 – US$2.50 per day. But I have a feeling that they cheat us. The payment is not transparent. We sign a blank form. They do not put the amount of money that we are supposed to receive on the form. This is the attitude of people from both Community Health Centres including District Health Service and national (MoH-TL). It is the same when we do health campaign programs. They sometimes give us US$2 or US$3 per day without any other incentives and no transport provided. Everyone knows that we should mobilize the community three days before the campaign. We ask them for clarification why the training and campaign fee were different. They responded that it is in accordance with the budget, but they never show us the budget and plan to which they refer. Also when problems or questions arise, District Health Service (DHS) directs our queries to the chief of the village but the chief of the village says we should ask DHS for help because we are supporting their health programs. It is so confusing we are like Ping-Pong balls. This is corruption, and power abuse they do not accountable to us. They should be aware that they are playing with the money of the community. (Community volunteer 1)

Some participants articulated they cooperated with the health sector to disseminate health information to the community. They only had one issue with the health office (District Health Service and Community Health Centre). It was about money. They knew that the Ministry of Health has allocated money to the SISCa program. They needed the Ministry of Health to pay attention and recognize their work. They also asked the Ministry of Health to allocate funds for SISCa every month on a regular basis. Lately, funding for SISCa had been delayed for up to three months, but the activities still had to go ahead. They had talked to the director of CHC about this issue and also regarding the fact that they had not receive funding for SISCa from October to December 2008. A participant asked the manager of the Community Health Centre “Where did the money go?” No explanation… The
government’s campaign of anti corruption does not work here. We are willing to help our community to get a healthy life but funding is a big problem.” (Community volunteer 6)

The participants also reported the lack of transparency in the provision of health information by health decision makers to the public. For example, when participants were asked if any information about government-funded provision of health services both within Timor-Leste and overseas treatment was provided to the public, they replied they heard this information discussed when they had a meeting in the sub-district administrator’s office, but they had not received any formal notification or letter on the criteria and procedures from either Ministry of Health or District Health Service to verify this information. They did not want to give unclear or inaccurate information to the community. Moreover they stressed that if the government provided funding for treatment overseas, they should announce it through the media or local government to the public and provide information about how one can access this service. One of the participants observed:

There are no documents posted here about the procedures and regulations… In the sub-district administration office, there is a social facilitator who oversees subsidy for mothers and patients, including subsidies for those patients who seek treatment overseas. We receive this information from there (pointing to the sub district administrator’s office) verbally not written. How can I be sure this information is true? (Community leader 1)

When participants were asked if the information on health from Ministry of Health and District Health service was sufficient for their community, or whether it needs to be improved, the same person replied, “It is not sufficient nor transparent” (Community leader 1).

**Equity**

Distinct from other districts, this district has only public health facilities to provide primary health care to the community. Staff did not discriminate among patients and they treated people equally regardless of gender, religion, socio-economic status, and political party affiliation. To ensure equality of health care service to the community, since early this year (2009) they avoided providing
treatment at patients’ houses, as “the community here understand that they should go to the health facilities for treatment” (Workforce 1). Regarding the relationship between gender and health, women with children made most use of the health facilities because generally men are farmers and they worked in the fields. A workforce member stated:

We do not discriminate here. We create a good atmosphere so that the patients tell us freely about their sickness. All patients are welcome to our Community Health centre because we are public servants that provide services for whomever has need. But our challenges are sometimes we run out of medications and reagents. So that, people who have money and relatives in Dili they will go directly to Dili to do further examination. But for poor people they just accept what we provide for them… We tell them that both men and women should accompany their children to the Health Posts. This reduces the tendency to blame each other when a fatality occurs. Most importantly, when we are talking about family planning, we insist on the presence of the couple. (Workforce 1)

A community leader from a sub-district in this district observed:

My observation is that the health service in this sub-district is very good. Every one receives equal treatment, no discrimination. Health care providers respond to all need regardless of whether the patient is man or woman, rich or poor, and regardless of religion, ethnicity, and political party affiliation. There has been good coordination between health staff, community leaders and community, traditional structure, Church, pastoral das crianças and promotor saude família nian … the health program has been very successful. The mortality rate, particularly for children under five years has been reduced significantly…This year the child mortality rate is zero. There is no unfair discrimination in accessing the health service. However women and children are prioritized because they are more vulnerable to illness. (Community leader 2)

The workforce followed the procedures for primary health care services as documented in BSP. If a patient in a Health Post needed an advanced examination or treatment, the staff referred the patient to the Community Health Centre, which should have appropriate equipment to conduct further examination and treatment.
However, based on the researcher observation during the period of fieldwork some health facilities had poor equipment, pharmaceuticals, logistical support, transportation, road conditions, water supply, and electricity supply, all of which are required and essential in Basic Service Package developed by Ministry of Health Timor-Leste. They tried as much as possible to overcome these barriers for the continuation of health services delivery to community.

**DISCUSSION**

There were both strengths and weaknesses in the governance of the health system in this district.

**Responsiveness, structure, effectiveness and efficiency**

A weakness in health policy implementation in the district was responsiveness of the central administration Ministry of Health and its development partners. This has affected the structure, effectiveness and efficiency of health service delivery to communities, most particularly Health Posts in remote areas.

*Development of health policies, strategies and procedures*

Although the District Health Service of this district has not fully participated in the development of health policies, the local government, health authority, health staff and community leaders in this district recognized that these policies and procedures were linked to the objectives and social-cultural norms of the district. However, Hill (1997) highlights public policies impact on economies and societies so that any satisfactory implementation of any public policy must involve interdisciplinary experts. Government institutions exist at national, regional and local levels. An underlying aim is to ensure that policies are developed and implemented in line with governance definitions and concepts as addressed in Chapter Two and in the most appropriate jurisdictions including the direct involvement of particular communities and the public as a whole. Moreover, a public policy should be driven by the local social, economic, and cultural norms (Democratic Republic of Timor-
Policies were disseminated by central government to local government District Health Service and its partners. This is significant that communication is an essential aspect which bridges and links decision makers in government and people in developing and implementing policy to achieve desired outcomes and objectives (Althaus, Bridgman & Davis, 2007).

A strength of the District Health Service constituted the efforts taken to ensure the application of all parts of these health policies (Basic Service Package, SISCa, and other strategies), by going to sub-districts and villages to communicate and disseminate any new health policy and program. To ensure the health policy improved community health, the policy needed to be effectively and successfully introduced, communicated, and distributed to the target recipients (Althaus, Bridgman & Davis, 2007; Birkland, 2005; Dye, 1972; Rhodes, 2000). A requirement for the effectiveness of policy implementation is that those who are responsible for carrying out a policy must be familiar with what they are supposed to do and the means by which they are to do it. Included in the policy implementation are laws, regulations, funding agreements and information strategies.

The District Health Service was limited in its freedom to develop internal guidelines and procedures to assist staff and partners achieve Timor-Leste health MDGs as policies were written by the Ministry of Health. But they cooperated to create a health network with partners to assist the partners understand and implement health policies and programs. These activities constituted aspects of good governance (Pierre & Peters, 2000; Althaus, Bridgman & Davis, 2007; Birkland, 2005). This in turn contributed to the achievement of Timor-Leste’s health MDGs objectives and improved the overall performance of the health system. As stated by Pearson (2007), governance in health systems is to assist countries to achieve the health MDGs objectives.

Social determinants of health

Education, housing, transport, food security and potable water are classified as social determinants of health (Marmot, 2005, 2010; Marmot et al., 2008). Whilst not accountable to the Ministry of Health, these factors impact on the health and
wellbeing of the total community and are the responsibility of the Timor-Leste government. Therefore, the national and local governments and its development partners should understand and be responsive to the investments that support overall governance, good performance of health system and essential to achieve MDGs objectives. Investments and decisions made outside the health sector (directly and indirectly) influence the patterns and magnitude of health inequities (World Health Organization Regional Office for Europe, 2010).

Participants’ experience and concerns centred on the relationship between Ministry of Health and partners’ lack of responsiveness in attending to logistical support, health equipment, infrastructure and the lack of achievement of health indicators and targets as planned. These conditions were significant challenges for community wellbeing and human poverty reduction and impacted everyday life. For example there was difficulty accessing rural and remote areas, and socio-economic growth was impeded when food and environmental insecurity was high (Jahan & McCleery, 2005).

The road conditions in the sub-districts were generally poor. The implications included limited public transportation and high cost of transport. These in turn made it difficult for patients and community members to reach the health facilities thus limited their access to quality health care. Although in theory even the poor and the remote are entitled to free health care services, they are often prevented from access by the overwhelming cost of transportation, as well as the additional costs of travel such as food and accommodation. These factors influenced the use of health services and impacted on health equity and health system performance. There is also a connection between infrastructure matters and governance (Jahan & McCleery, 2005) in health systems; for example, monitoring and evaluation of the impact and sustainability of infrastructure for health services.

Poor communication systems in this district affected the delivery of basic health care services. Good communication services allowed health professionals to discuss and access information over the phone or Internet to guide the treatment of a patient. For example in Ghana and Rwanda, health providers explored the use of mobile phones to discuss complex cases with their supervisor or call an ambulance (Ban, 2010). This saved time and resources and promoted effective and efficient delivery of health services to the community, especially in remote areas.
Another issue was unreliable provision of electricity. An important purpose of electricity in health facilities was to refrigerate medicines and vaccines and assist mothers delivery babies in the night. Electricity also contributed to health by reducing household injuries and accidents (Jahan & McCleery, 2005). For example, most communities in this district still used traditional lamps or burn wood to back up the power supply and for cooking. Wood smoke contributed to air pollution, which can lead to respiratory diseases and serious health problems (United States Environmental Protection Agency, 2005) with children under five years of age, pregnant women and the elderly particularly vulnerable.

Most health facilities had no clean water, which threatened their hygiene and sanitation. This contributed to conditions favourable for the outbreak of communicable diseases such as diarrhoea. A study in South Asia and West Africa found that having potable water helped reduce the under-five mortality rate caused by diarrhoea by 21 percent for both regions (Jalan & Ravallion, 2003).

Geographical conditions significantly hindered access to health care services with access measured in both distance and time to any given health facility. A study conducted in Timor-Leste showed that long distances to health facilities discouraged community members (patients and relatives), particularly in the case of non-urgent conditions (for example, antenatal care and immunization for pregnant women) but also in the case of critical illness (Zwi et al., 2009). This study found that the long journey, up and down hills, to the Health Post negatively impacted on the patient’s condition and that during the wet season even short distances became impassable (Zwi et al., 2009). Due to geographical difficulty, patients normally arrived at health facilities in poor stage. Experts asserted that the distance to a health facility was the main predictor for maternal mortality rate in rural Guinea Bissau (Hoj et al., 2002).

Based on researcher observation during the period of fieldwork these social determinants of health standards were not met and most equipment was found to be in poor condition. Some operational cars and motorcycles were broken down and parked in front of the office of District Health Service (DHS), Community Health Centres (CHC) and Health Posts (HP). Some radio communications and generators were broken and waiting for repair by a technician. If no technician was available, equipment was taken to Dili for repair. The implications of these conditions were that staff cannot work effectively and efficiently, which limits their ability to reduce
the morbidity and mortality rates and to achieve health MDG objectives. Effectiveness and efficiency are the core governance issues in public services. In this regards it is significant that effectiveness and efficiency are related to the quality of public goods and services (Agborsangaya-Fiteu, 2009; World Bank, 2004).

The Health Posts are key to achieving the MDG objectives, the Basic Service Package was provided and the principles of Primary Health Care (PHC) were implemented. However, the poor infrastructure, logistical support and supplies provided by central government\textsuperscript{30} (Ministry of Health and relevant ministries) and its development partners did not adequately support health performance and humanitarian services.

In order to address the complex drivers that shape health and the determinants of health inequities, strengthen governance of health equity and attainment of policy and governance goals, a multi sectorial (cross-governmental) approach is required, as the Ministry of Health cannot address all the contributors to health on its own. These requirements need a policy that incorporated the views and aspiration of other ministries – education, housing, transport, food security, infrastructure – and the local community and included appropriate indicators for monitoring and evaluation to address the quality of the governance in the health system. This was recognized in the Adelaide Statement on Health in All Policies, 2010, and in the Final Report of the WHO Global Commission on Social Determinants of Health 2008 (World Health Organization Regional Office for Europe, 2010).

\textit{Monitoring and Evaluation}

Local government and officials (district administrators, sub-district administrators, community leaders, village leaders, and managers of DHSs), actively engaged in monitoring and evaluation of health program implementation in health facilities and community. Policy evaluation assists government and health care providers to set priorities and contribute to improving aspects of governance such as responsiveness and accountability to parliament and the public (Birkland, 2005; Edwards, 1984). The development of systems, policies, plans and procedures was

\textsuperscript{30} Central government including all ministries at the national level
meaningless if the outcomes and impacts of this activity did not match the objectives. Suitable indicators must be identified and the results of the monitoring and evaluation activity must inform future policy development (Althaus, Bridgman & Davis, 2007; Birkland, 2005; Dye, 1972; Rhodes, 2000). In this district, the reduction of infant and maternal mortality and overall better health outcomes was achieved in part through monitoring and evaluation activities. Through monitoring and evaluation the factors contributing to maternal and infant health were identified and addressed.

It was also the responsibility of the Ministry of Health to monitor the use of resources to ensure these are used in the right activities that will have the right impact on health services provision. The evaluation should be able to identify what works well or does not work in the health care delivery system.

Health staff in this district conducted afternoon home visits to pregnant and post partum women and children under five. Similar to the Bangladesh monitoring and evaluation of health programs, community and health workers undertook home visits for pregnant women twice before birth and three times after delivery to monitor maternal well being and provide neonatal care (Doskoch, 2009). Baqui, Arifeen, Williams, Ahmed, Mannan, Rahman, Begum, Seraji, Winch, and Santosham (2009) found that the infant mortality rate in Bangladesh was lower for those visited by a health staff than for those who never received a home visit (21 deaths compared to 65 deaths per 1,000 live births). In Peru and Nicaragua a new method of monitoring and evaluation through online data collection has led to rapid improvement in health outcomes (Ban, 2010). District A and other districts in Timor-Leste could adopt these methods to improve the health care system.

**Shortage of health staff**

On the ground, Ministry of Health Timor-Leste faced a shortage of health professionals including doctors, nurses, midwives and health technicians (Ministry of Health Timor-Leste, 2007b) within public and private health facilities. The lack of human resources was lamented by District Health Services throughout the country. The ratio of medical staff to community members in the district was 1: 400. This increased the likelihood of staff working overtime. This district had limited staff and
health professionals to occupy all positions from District Health Service to the Health Posts. Although in this district almost all Health Posts had a nurse or midwife as a manager, the structure outlined in the Basic Service Package (BSP) was not fully implemented due to lack of human resources including qualification and quantity of health professionals. Despite the limited human resources communication, internal relationships and coordination ran well within this district. This unity of vision and action contributed to high levels of support of each other in the field. For example, health staff created an internal mechanism to back each other up on the job when needed. This internal mechanism had been implemented by the staff in health facilities within the district. This contributed to good health outcomes compared to other District Health Services In this regard it is relevant that in reconstructing administration after post conflict, civil servants and professionals should relate to each other and their capacities for positive engagement (United Nations Economic and Social Affairs, 2010).

Ethics

Ethics should help health professionals define right actions from wrong and understand the long term impact of corruption. Thus, ethics and values are interrelated and are normative in nature (Denhardt & Denhardt, 2003; United Nations Economic and Social Council, 2006). The impact of limited human resources and staff working overtime in this district saw a decline in staff performance and attitude. According to Farazmand (1997), administrative ethics and professionalism are crucial. Codes of professional conduct in public services have contributed to the rise of modern administration. There was a code of ethics within the health professional associations in the district (Kenny, KE, 2006; Westerholm, Nilstun & Ovretveit, 2004), but it was not practiced well, and refresher training on this would be of benefit. By clarifying what is right and wrong, staff can make choices for moral action and to uphold moral standards (Denhardt & Denhardt, 2003). All ethical behaviour is concerned with how an individual feels and behaves in a given situation or under a particular set of circumstances.

A health care seeking behaviour study conducted in Timor-Leste by Zwi et al (2009) showed that if a patient was received and treated with respect, empathy and
care in health facilities they return, but if they were directly or indirectly criticized, or treated harshly, they do not return. Therefore, poor attitudes and performance on the part of health care providers or poor professional ethics in the workplace also discouraged people from accessing health care services and impacted negatively on legitimacy and health care system performance in this district.

**Equity**

Based on information from health staff and development partners, staff did not discriminate when delivering health services to communities in the district, which was in line with the aim to ensure that everyone has the same access to health care services. Equal access to health care services does not ensure health equity, because equity refers to all having access, in reality, to the same quality of health care services. Based on findings from the fieldwork it was evident that health inequity occurred in this district. For example, all Community Health Centres in this district have no X-Ray machine, while there was a high prevalence of Tuberculosis (more than 22% new cases reported every three months until March 2009).

Quality health care services were not always available to communities in remote areas because of poor responsiveness by local and central government, poor health professional ethics, and poor decentralization of power from Ministry of Health to local administration (DHSs, CHCs, and HPs). This situation was not in line with the commitment to health equity for all Timorese citizens articulated in the Constitution of the Democratic Republic of East Timor. Regardless of Timor-Leste’s strong policies (Democratic Republic of Timor-Leste, 2002a) and plans to provide equitable health care services for Timorese people, there were weaknesses and social challenges that need to be improved to ensure equity in health care for people in general and specifically for poor and vulnerable people in remote areas. The latter constitute 79.1% of the population of this District Health Service. This is significant that in under developed countries there are significant problems in terms of access to public services (Schaffer & Wen-hsien, 1975) and fragile states are not capable of offering basic services (Blunt, 2009; International Dialogue on Peacebuilding and Statebuilding, 2012).
Accountability and transparency

Other important aspects of governance in health policy implementation were transparency and accountability. Participants understood the meaning and definition of transparency and accountability in the health sector to include openness of health administration, human resources management and leadership, as well as accessibility of health information and procedures by the community. As stated by the World Bank (1996) transparency refers to the availability of information to the public and clarity of government rules, regulations and decisions.

Participants stated that transparency and accountability in the health sector was lacking in District A. They made concrete and useful suggestions for enhancing the transparency of health service delivery. Analysis of these findings revealed that transparency and accountability in the health sector in this district involved three things: human resources management; communication of health plans, budgets and reports of results of health policy implementation; and provision of health information to the public.

Human resources management included open explanations to public by decision makers at all levels of the reasons behind the appointment, transfer or firing of staff. With full information staff were more likely to welcome a new colleague to their team. The process of recruitment should avoid nepotism. Because people in this district knew each other and were aware of each others’ education and experience, the process of recruitment and the issue of nepotism was a very sensitive issue causing pressure, distrust, and diminished morale. Nepotism must be eliminated and recruitment processes of health care providers made fair, impartial and honest to achieve credible employment and defend against such abuse in the health system.

The literature made clear that nepotism and favouritism often led to the employment of inefficient and unqualified candidates, which led to weaker performance (Ponzo & Scoppa, 2010), and ultimately government funds wasted. However, a study conducted by Hyden, Court and Mease (2003) in 16 developing countries including Indonesia, reported that only a few countries have a merit-based system for recruitment and most recruitment was done subjectively without regard to qualifications. Similarly, in Russia, it was common for people without experience
and skill to be selected to occupy high-level positions (Hyden, Court & Mease, 2003).

Part of transparency and accountability was the communication of health plans, budgets and reports on health policy implementation. People in this district wanted to know the plans and budgets for their region; the ways in which resources were allocated; and how government and partners developed, managed and implemented programs. These questions are relevant to strengthening governance in health systems in the era of democracy (World Bank, 2004). These features played a fundamental role in influencing how a health system was governed and performed.

Community leaders’ (village leaders) involvement in the health programs and budget development was an essential part of the governance in health systems, as they facilitated, coordinated and encouraged their community to take an active part in the development of health systems in their area. This was also identified as important by the Constitution of the Democratic of Republic of East Timor (2002), East Timor National Development Plan (2002). It ensures transparency and accountability, and avoids misuse of state resources through reducing poor administration in the process and progress of health program implementation. The researcher believed the success of a health program occurred when the local community had ownership and active participation, and the result was an outcome that satisfied everyone. Community participation in the health system was essential if programs aimed at promoting health, wellbeing, quality of life and environmental protection were to be embraced and sustained (Marmot, 2005; Taylor, Wilkinson & Cheers, 2006).

Another aspect of transparency and accountability was the provision of health information to the public. Citizens have the right to access all information that affects their life (United Nations, 1948). The access to health information by the community aims to protect them from danger or threats to their health and to guarantee equal health care service for everyone. The community has the right to access health information through mass media and other channels of information in a transparent manner. The World Bank (2010) affirmed the use of mass media to ensure good governance processes in health system. Pande emphasized the role of the mass media to expose corruption in government’s plans and programs in the field (Pande, 2007). The researcher believes that the health sector’s lack of transparency and accountability mechanisms affected the quality of health service delivery to the
community, and increased corruption, nepotism, political intervention, conflict of interest, and health expenses. This lack of transparency and accountability supported ongoing power abuse by health decision makers from both central and local administration and its partners. This is applicable to governance power, relationships, transparency and accountability, where an institution is accountable to those who be affected by its decisions or actions (Birkland, 2005; Blakemore, 1998; Pierre & Peters, 2000; World Health Organization Regional Office for the Eastern Mediterranean, 2007).

**Power and its decentralization**

There are certain individuals and institutions, which influenced issues and activities pertaining to health in the district. These included: local government officials, donors, NGOs and dominant political parties. Public policy and decision making process are influenced by official and unofficial actors (Birkland, 2005). The Catholic Church also had a strong influence on certain aspects of health policy implementation because more then 97% of the population of this district identify as Catholic and Catholicism was an important aspect of East Timorese national and cultural identity. The doctrines of the church informed decisions pertaining to such issues as family planning and HIV/AIDS. The Catholic Church was a defender of Timor-Leste cultures and norms (Salla, 1995). Panayiotopoulos (2002) argues that the interaction between government and community should be driven by local social and economic, cultural and norms.

Moreover, traditional power structures were still considered by the community, the Catholic Church and local government as part of the government system. Both the Catholic Church and traditional power structures have existed for hundreds of years and continued to play an important role in present day Timor-Leste. This is relevant to the New Deal for engagement in fragile states that international partners should give importance to the local context in the rebuilding processes (International Dialogue on Peacebuilding and Statebuilding, 2012). However, not all government partners particularly in this district and Timor-Leste generally met this requirement.
Participants expressed concern that a lack of decentralization of power to the local health authorities had a significant impact on the quality of health services. In governance and public administration, decentralization is commonly regarded as a process through which powers, functions, responsibilities and resources are transferred from central to local governments and/or to other decentralized entities (United Nations Economic and Social Council, 2006). They found they could not fully take responsibility for community wellbeing within their jurisdiction, though decentralization was stressed as an aim in the Constitution of the Democratic Republic of East Timor (2002) and East Timor National Development Plan (2002). According to the latter, decentralization was to provide more efficient delivery of services and decision making, with priority given to communities who understand their local need and circumstances. To ensure decentralization based on East Timor’s national development plan, the ministries need to give priority to capacity building through formal education and training for the administration and management of local government. However the Ministry of Health has yet to entrust some sensitive activities such as developing health policy and managing the financial system to District Health Service. The UN Economic and Social Council (2006) has reported developing countries have made efforts to decentralize their political and administrative systems successfully because each country responds in its own way to unprecedented changes and challenges in its administrative and political performance.

All of these concepts and ideas of governance relate to the use of power in this district. Power is an essential element to critique in any assessment of good health system governance. Historically, Timor-Leste was governed by several colonizers: the Portuguese, the Indonesians and UNTAET. The nature of power in developing countries was influenced by international factors such as the activity of colonial powers (Turner & Hulme, 1997). Therefore current health governance was affected by the character of those past colonizers. One consequence of this was the culture of granting authority to certain people despite the fact that there are those who have more experience and formal skills.
Cooperation and Participation

An excellent example of good governance in the health system, which were provided by this District Health Service (DHS) was the cooperation through strong networks within the health system (Pierre & Peters, 2000). Cooperation, coordination, collaborative internal and external relationships, communication and participation were the concepts that informed engagement between District Health Service and its development partners, community and council of villages including family health promoters. This cooperation aimed to promote good governance of health systems, responsive to public experience and opinion. Some scholars define cooperation as a team of people who have the same idea for doing something together to achieve an objective (Myers, 2003; Rogers, 1995). According to Pierre and Peters, (2000) a network consists of a wide ranging interconnection of individuals, agencies or systems working for a common outcome. Through the use of networks, District Health Service of this district achieved good health outcomes.

Similar to other districts, the District Health Service had the authority to develop its annual health plan and budget, and then submit it to the Ministry of Health. District Health Service A did not involve community leaders in the planning process. However, community leaders were actively involved in the process of dissemination of these health policies and programs before implementation. Participation in the latter processes contributed to the community leaders’ sense of ownership and their subsequent willingness to participate in the processes of the health system in their village. Community participation in development and implementation of health programs was fundamental to ensure the improvement of local health systems and objectives (Democratic Republic of Timor-Leste, 2002a, 2002b; Ministry of Health Timor-Leste, 2002a; Narayan, R, 2008). According to Pierre and Peters (2000), governance as community is a key pillar of good governance. Hence, successful governance of the health system also depended on the involvement and support of local community.

Another important and interesting aspect was participation of all, especially the council of villages and the community itself, in the process of developing and implementing health policies and programs implementation to accomplish government objectives in this district. All parties who participated in the health
system required opportunity for input. At the same time it was important to recognize that community participation and health development was expensive and required plenty of time (Preston, R et al., 2010). The most important and key players of the principles of the comprehensive Primary Health Care were families and communities. Therefore, health care (rehabilitative, curative, preventive and promotion) provided by health facilities but uninformed by community experience and opinion, had limited impact on health outcomes, objectives and well-being.

The researcher found that the Timorese community and community leaders welcomed the opportunity support any government activity in their villages. In order for this support to be attained and sustained, however, it was essential that the government and its partners respected them and considered their social, cultural and traditional values. This mutual support and respect ensured that communities and their leaders did not feel alienated from health system processes.

CONCLUSION

In summary, a District Health Management Team (DHMT) was established in this district based on Decree Law 5/2003 to guarantee district health system functioning. The specific roles of the DHMT was similar to other District Health Services; to plan, supervise, coordinate, monitor, report and evaluate all health policies and program implementation at the district level.

There were weaknesses and strengthens of governance in District A in terms of health service delivery. These findings were based on information provided by staff of local government offices, District Health Service, Community Health Centres, Health Posts, NGOs, private organizations, as well as community leaders and community health volunteers. Data also came from researcher observation during the period of fieldwork and secondary data analysis. It was clear that participants understood the concept and meaning of health system governance to include organisational structure, power, responsiveness, effectiveness and efficiency, transparency and accountability, cooperation and participation, equity and ethics in providing health services to the community.

Responsiveness of the Ministry of Health and its partners in this district was
deficient. Participants identified that responsiveness would be manifest through better understanding and management of the social determinants of health including infrastructure and other logistical support. The implications of these conditions were that staff cannot work effectively and efficiently to achieve good health performance and MDG objectives. In this regards it is significant that effectiveness and efficiency are related to the quality of public goods and services (Agborsangaya-Fiteu, 2009; World Bank, 2004).

There was a limited number of people involved in health decision-making. Decentralization of power from the central administration Ministry of Health to local administration District Health Service in this district was generally poor. Improved decentralisation of power would allow the District Health Service the full authority, responsibility and flexibility to make decisions and manage expenditure in line with district objectives and community needs. Participants wanted full decentralization of health decision-making, as a matter of urgency, in order to have the power and responsibility to improve the quality of health services and community wellbeing in this district.

Transparency and accountability in the health sector in this district was generally lacking. Local administration demonstrated some excellent health system governance in the form of cooperation through strong networks, monitoring and evaluation of health programs, management and leadership, and community participation. Attention was required to these issues in order to facilitate provision of quality health services to communities and to achieve better health outcomes, MDG objectives and governance in health system in this district.
CHAPTER 7: CASE STUDY: GOVERNANCE, HEALTH POLICY AND SYSTEMS IN DISTRICT B

INTRODUCTION

The study was undertaken in District B. It was de-identified to protect interviewees. This district is a region in Timor-Leste with poor health system performance and lower than expected health outcomes as determined by Ministry of Health, especially in maternal health, immunization of children under one year of age, immunization for pregnant women, and nutrition ratings among children under five years.

A proposition of this thesis is that good governance will contribute to achieving the goals of the health system such as the health Millennium Development Goals (MDGs) and overall good health of the population. It would do this by establishing systems and by ensuring the functionality and integrity of those systems. In turn these systems (for example of communication) will lead to an increase in cooperation, responsiveness and mutual accountability, equity, and transparency, as well as a reduction in corruption. The existing governance in this district was not meeting the expectations of the local people of the district. The reasons for, and implications of this will be explored in this chapter. The context of the district is first described, against which to view the responses of interviewees and other findings.

DISTRICT B IN PERSPECTIVE

Geography and demography

District B is one of thirteen districts in Timor-Leste and spread over an area of 746 sq km. Administratively the district is divided into five sub-districts within which there are 52 villages. This district is a mountainous region and the climate is temperate. There are two seasons: wet (October to May) and dry. During the rainy
season the temperature is around 15-17 degrees Celsius. The capital of this district is reasonably close to Dili, the capital of Timor-Leste. People can catch local transportation called *mikrolet* (mini bus), *angguna* (open backed truck) to access sub-regions and villages within the district. Just beyond Dili the road starts to climb, revealing wonderful views across the sea and islands. With the higher altitudes the temperature starts to drop. By the roadside there are women and men - young and old - walking, pushing carts, carrying bundles, hoes and baskets to the fields, carting clean water or selling fruits and vegetables. Public servants ride motorcycles and cars to and from Dili for work. In the mountains there are elementary schools and health facilities. Many of these schools and facilities lack clean water, reliable electricity and proper communication systems.

As a result of torrential rains during the wet season, the road was in poor condition. It was damaged, covered with red mud and stones and some bridges were broken. The condition of the road and bridges made it difficult for the movement of public and private transportation between the district and the capital of Timor-Leste, and within the district. Consequently, health staff could not reach the remote areas such as sub-district health posts and community members struggle to access health facilities.

Most of the population was bilingual, speaking one of two local languages as well as Tetum the official language. The majority of the population (95%) was Catholic. The total population was 114,635 with 57,069 female and 57,566 male (Timor-Leste National Statistics Directorate 2010). Most of the population 92.9% (106,502) lived in the rural area with only 8,243 in the urban areas. This was a densely populated district. The population density was 149.3 people per hectare (Timor-Leste National Statistics Directorate, 2010). Life expectancy at birth was 56.6 years (Timor-Leste National Statistics Directorate, 2004). This district had a poverty headcount ratio of 54.6% (World Bank Group, 2010). The annual growth rate was 1.73%. On average 51.9% of women and 42.9% of men in this district had no formal education (Democratic Republic of Timor-Leste, 2009-2010) with most of the population’s income coming from the production of cash crops.

People looked forward to the weekly market day. On Thursdays, the market activities started by 7am in the centre of the district. While vendors sold and bartered their goods, they also socialized with friends and relatives from near and distant sub-
districts and villages, as well as from Dili. Some returned to their homes as soon as their goods were sold. However, some shared their food and spend time together talking and laughing before leaving the market place. Normally, vendors from distant villages travelled home together because they used the same public transportation. By midday on Thursdays there may be intoxicated men of various ages around the marketplace, but the police patrolled the area to maintain order.

**Health indicators**

The fourth Timor-Leste Millennium Development Goal (MDG) was to reduce by two-thirds the under-5 mortality rate by 2015 (Democratic Republic of Timor-Leste, 2009). This means that the under-5 mortality rate for Timor-Leste should be less than 56 deaths for every 1,000 live births. This district currently had the highest under-5 mortality rate: 102 deaths per 1,000 live births, nearly double the MDG (Democratic Republic of Timor-Leste, 2009-2010). Among children age 12-23 months, only 44.6% had completed basic vaccinations with 35.4% having no vaccinations.

The fifth MDG goal was to improve maternal health such that the maternal mortality rate between 1990-2015 will be reduced by three-quarters (Democratic Republic of Timor-Leste, 2009). Thus the maternal mortality rate should be reduced by 30%\(^{31}\) as the current estimated rate for Timor-Leste was 557 per 100,000 live births. In this district the rate at which pregnant women received ante natal care (ANC) from a skilled provider (such as doctor, nurse, midwife, or assistant nurse) was the lowest in the country, only 70.5%. The number of mothers who received Tetanus Toxoid injections immunization to protect their child against neonatal tetanus was also the lowest in the country, only 65.5%. The rate of delivery in health facilities was only 3.2% while a vast majority 96.8% give birth at home (Democratic

\(^{31}\) No nationwide survey based data can be provided because no data collection had been completed to reflect the current situation of the country in relation to maternal deaths (TL, 2005). This was a conservative estimate since it uses the lowest maternal mortality rate ratio 380/100,000 live births (UNICEF, 2009)
Republic of Timor-Leste, 2009-2010). The proportion of births attended by skilled health workforce should increase from 19% to 60%.

The sixth MDG was to combat HIV/AIDS, Malaria and other diseases. The number of confirmed case of HIV/AIDS was low in Timor-Leste, though there had been an increase of reported HIV/AIDS cases from 7 in 2002 to 151 in 2009 nationwide. Nevertheless, only a small percentage of women and men age 15-49 in this district had heard of HIV/AIDS: 13.8% and 20.8% respectively. Malaria was a leading public health problem in Timor-Leste, but in this district, only 840 cases were reported in January-March 2009 (Ministry of Health Timor-Leste, 2009), which was low relative to other districts. However other communicable diseases such as Tuberculosis were high with 65% of new cases reported between January-March 2009 (Ministry of Health Timor-Leste, 2009).

To achieve Timor-Leste’s fourth, fifth, and sixth MDG objectives, Ministry of Health Timor-Leste had developed a Basic Service Package (BSP) for primary health care and hospitals to improve health service delivery. A national Strategic Plan for STD/HIV/AIDS, Malaria, Tuberculosis and other diseases had also been developed.

**Governance of the health system**

It was specified by law Decree 5/2003 that under the Ministry of Health’s direction the District Health Management Team (DHMT) was to implement health policies and strategies. The DHMT followed annual action plans and contributed to the appropriate local service delivery and effective use of resources. The role of the DHMT was to plan, supervise, coordinate, monitor, report, and evaluate all health activities at the district level (Ministry of Health Timor-Leste, 2007a). The team was to carry out administrative, financial and logistical functions that fell under their jurisdiction to support health system functioning at the district level.

The District Health Management Team was made up of: the head of District Health Service (DHS) Level 6; the deputy head of district health services Level 5; and two District Public Health Officers (DPhO) (Ministry of Health Timor-Leste 2007a). However in this district there were also nine (9) DPHOs (Maternal and Child Health, Health Promotion, Communicable Disease Control, Non-Communicable...
Disease, Environmental Health, Nutrition, Pharmacy, Laboratory and Health Management Information System). The District Health Management Team was also supported by an administration made up of general administration; finance; ambulance; and logistics sections. The District Public Health Officers were in charge of a group of integrated health services responsible to the DHMT manager but in reality DPHOs also functioned as vertical program managers.

Implementation of the district health plans were carried out by the Community Health Centres and Health Posts based on the BSP and the principles of Primary Health Care. Primary Health Care focused on providing accessible, affordable, appropriate health care at community level, with participation and support of the community (Ministry of Health Timor-Leste, 2007a). One aspect of community participation in health system in Timor-Leste was Promotor Saude Familia nian (PSF) or Family Health Promoter (FHP). The Family Health Promoters were volunteers that provided no clinical services but were central in health promotion and behaviour change communication programs at the community level. They also promoted the use of health facilities and referred patients to staff and facilities for treatment. Another important task of Family Health Promoter was in coordination with the community leaders (chiefs of villages and hamlets) to prepare and provide the SISCa monthly programs in the field.

Based on the Basic Service Package, one Sub-District Health Centre (SDHC) had four Health Posts (HP) and Mobile Clinics. The Sub-District Health Centres of this district contain two to four Health Posts and Mobile Clinics and the responsibility of the SDHC was to provide HP services plus a higher level of service than the Health Post. The services provided by Sub-District Health Centre of this district including: technical and managerial support to FHPs; a full package of child care based on IMCI and regular immunization; emergency care for newborns weighing less than 2 kg; BEOC in a phased approached (but in this district not all SDHCs conducted this program). Moreover, basic laboratory services for antenatal care, malaria and tuberculosis; a few short term (24 hour) observation beds to treat complicated cases; dental services; pharmaceutical services were also provided to ensure the BPS were available to communities. Mobile Clinics provided by staff from Health Posts (HP) were for communities that were over two hours walk from the health facilities.
A Health Post in this district served more than 5,000 people. The function of HP was to provide simple preventative and curative services. For example ante natal and post-natal care, normal deliveries, immunization and community education. The Family Health Promoter program, also supported by the Health Posts encouraged community participation and education in health system. Other important tasks of Health Posts in this district were TB DOTs follow up and mental health patient follow up. As mentioned in the BSP, the minimum staff required by a Health Post (HP) was at least two staff, one nurse and one midwife. But in this district a HP was staffed by one health professional. A minimum infrastructure also required by an HP included an outpatient department working eight hours a day, (with 24 hour emergency call); a maternity delivery unit (with 24 hour call); a functional two-way radio or mobile phone for emergencies communications; a motorcycle for mobile clinics; a refrigerator for immunization; solar power for light, refrigerator and radio where there was no electricity (Ministry of Health Timor-Leste, 2007a).

To ensure health service delivery, the central Ministry of Health provided six public Community Health Centres including a Community Health Centre with 20 beds in the capital of the district. It also provided 23 Health Posts, and 52 SISCa (Serviço Integrado da Saúde Comunitaria) posts spread throughout the district. There were some private clinics such as the Coperativa Café Timor (CCT) and Catholic clinics in sub-districts. Logistical support and transportation were also provided by central government, through the provision of five operational cars, two ambulances, 35 motorcycles, four bicycles, nine radios, 16 generators, 17 solar panels, 17 computers and one photocopier. When the research was undertaken, motorcycles in good condition were kept at the District Health Service office and in Community Health Centres and Health Posts. Most other vehicles and equipment such as radios and an ambulance were found to be in a poor condition. Based on the BSP these provisions were inadequate to support health service delivery in this district.

According to information from participants and the researcher’s observation during the fieldwork at the level of the District Health Service office or District Health Management Team, there were sufficient employees to fill all positions. Each staff member was expected to play only one or two roles. However, at the level of the Community Health Centres and Health Posts, health professionals were expected
to occupy many and diverse roles due to a lack of staff. For the same reason, many staff occupied positions for which they lack qualifications and experience. In one Community Health Centre in this district an assistant nurse was assisted by a security guard and a cleaner to distribute medication to patients.

Based on human resources data from this District Health Service, the total number of workforce including administrative and support staff was 132: eight Cuban doctors, 35 nurses, 21 midwives; and 14 other health professionals. The 78 health professionals (excluding administrative and other support staff) served a population of 114,635. This means that there was one health professional per 1,470 persons. In some village Health Posts within the district, a nurse or even an assistant nurse may be required to take responsibility to manage a Health Post by themselves. The Ministry of Health in collaboration with UN agencies and international NGOs provided 256 Promotor Saude Familia nian or Family Health Promoter for this district.

The Statute of the Civil Service exists for the entire health workforce in all health facilities and includes a Code of Ethics for the health professional associations. These policies focus on both individual rights and obligations of civil servants and health professionals, and the regulatory framework within which they work including disciplinary mechanisms. The level of salary for all civil servants was the same nationwide for anyone on a given level. From 2001 to 2008 monthly rates of pay for health professionals ranged from US$123 for level 3 staff (at which many nurses and midwives were employed) to US$361 for level 7 (the permanent secretary or director general rate of pay at the national headquarters).

Documents guiding health care provision in this district were provided primarily through official written documents such as the Basic Service Package, Health Promotion Strategy, Save Motherhood, PSF and SISCa guidelines and procedures which had been developed by the central government, the Ministry of Health Timor-Leste.

The District Health Service in this region had the authority to develop its own annual health plan and budget, and then submit it to the Ministry of Health. However, the District Health Service did not involve community leaders, Family Health Promoters, NGOs nor the private health sector in this the planning or budgeting processes.
The approved total budget from Ministry of Health did not reflect the budget proposal submitted by DHS. Everything was included in the budget plan, but the funds were administered by the Ministry of Health. Every three months District Health Service received funds for operational services from the national office Ministry of Health, and then were immediately allocated to Community Health Centres according to their budget plan.

Monitoring and evaluation was decentralized to support the implementation of Basic Service Package by the District Health Management Team and health facilities. However, the Ministry of Health and District Health Service did not regularly put this activity in practice. An important role of District Health Management Team was to conduct regular meetings to follow up the results of monitoring and evaluation. A core function of District Public Health Officers was data quality control, analysis and dissemination. Community Health Centres should collect data and compile them into a monthly report. The report should be complete, correct, and consistent with the data analyzed locally to produce performance indicators for the facility.

PERCEPTIONS OF GOVERNANCE

The concept and elements of good governance as a key determinant of health were considered in this study. In essence, elements of good governance that guided and informed the health system study in this district were: organisational structure, power, responsiveness, effectiveness and efficiency, equity, ethics, accountability, transparency, cooperation, and participation. These matters were central to governance and underpin policy systems in terms of their existence, operation and legitimacy.

Responsiveness, structure, effectiveness and efficiency

Most participants expressed that the current levels of responsiveness of decision makers at national level were insufficient. For example, when participants were asked to what extent the infrastructure, technology, human resources,
pharmaceuticals, logistics, road conditions, transportation, communication, clean water and electricity met the needs of the communities, one of them responded:

We have difficulties with human resources. There are not enough health staff in the field, especially in the remote areas. Government needs to establish more health posts in the remote areas during the rainy season. We also need refrigerators at Health Posts because we need to keep the medications in the refrigerator, like those used for the vaccination program… In addition in the remote areas electricity is not available. Clean water is not sufficient in all areas. In some remote areas, due to climate change or the season, water becomes scarce at the Health Post. We need a program providing clean water as well because in the Health Post clean water is not available. There was pipe installed but it has no water (said with a sarcastic smile). (A senior decision maker of local government)

A majority of participants considered that responsiveness from decision makers constitutes the provision of strategies, procedures, guidelines, and formal letters to ensure the implementation of health programs in the field. But not all desired procedures and guidelines were provided. The District Health Service in this district had little or no input into some health policies, strategies, guidelines or procedures because the development of these documents was centralized in Ministry of Health in Dili. These policies were poorly communicated to staff and community leaders in this district by central government Ministry of Health. As an example, participants noted that the District Health Service was yet to receive a policy or set of procedures from the national government pertaining to protection of patients and their families receiving medical treatment overseas. A senior staff of local government lamented:

We have never received official letters outlining procedures. I just tell patients whatever I have heard myself. It is hard for us to give proper information to the community. We do not want to end up with everyone going for treatment overseas (he laughing). How will we get the money to pay for it? (laughing continuously)…We need a written guarantee or at least a formal letter from the Ministry of Health (MoH) and Ministry of Social Solidarity (MSS) so that we can instruct the community to prepare their application documents for a passport, just in case anyone has to go to
overseas to continue their treatment. (Senior decision maker of local government)

Another concern of participants was an unduly complicated bureaucracy. When participants were asked how the patients and families access information and endorsement from the Ministry of Health and Ministry of Social Solidarity to have treatment overseas one of the senior health workforce said:

We referred a breast cancer patient to the National Hospital (Hospital Nacional Guido Valadares - HNGV). The patient was accompanied by her husband. They come from a poor family. While she was in the national hospital, her husband was required by the Ministry of Health and Ministry of Social Solidarity to find money and documents to attain a passport for both his wife and himself, so that they could go to an overseas hospital to continue her treatment. The husband returned to the village to get money and documents. But the bureaucratic process was so complicated that it took around a month to process these documents. Meanwhile his wife passed away. This is a common occurrence due to the time-consuming and lengthy bureaucratic processes. The Ministry of Health and Ministry of Social Solidarity could take action to facilitate urgent access by poor members of the communities to passports and so on. (Workforce 1)

Some participants wanted the local District Health Service administration and its development partners to go out into the field to conduct monitoring and supervision of health program implementation. Participants said that when the staff, Promotor Saude Familia nian32 (PSF) and community leaders conduct SISCa programs in the villages, the sub-district and district administrators did not attend or monitor these activities.

For many participants responsiveness also constitutes government’s responsibility to reward and promote health care providers and increase their salary, based on their level of education and experience. Most health care providers had been working for more than ten years and were doing multi-functional jobs, however

32 Promotor Saude Familia nian (PSF): Family Health Promoter or community health volunteer.
they never received promotions, and they were “stuck” with Level Three salary. A key argument was that the government and the Ministry of Health did not take responsibility to improve health professionals’ current and future social conditions.

Participants also noted that this district was large and mountainous. The population was spread throughout the region, rather than concentrated in central locations. There were health facilities in place. However, they had limited staff to occupy the positions outlined in the Basic Service Package. Some staff were forced to cancel their annual leave because there were not enough health personnel to replace them. One staff member serves a population of 1,470 which meant that staff in health facilities including Health Posts in this district had a heavy workload. The staffing pattern was based on the assumption that each health worker could see 15 – 25 patients a day and each midwife undertake three deliveries a week (Ministry of Health Timor-Leste, 2007a). If this basic target was met, it was possible to achieve health coverage, and targets, indicators and health outcomes will be satisfactory.

**Ethics**

The impact of limited human resources, particularly health professionals, was over burdened staff. Staff also suffered from very low salaries and the absence of rewards and incentives, from District Health Service and Ministry of Health. These had negative psychological effects, which limited staff performance and attitudes in providing their services and assistance to the community.

One example comes from a Community Health Centre in this district. A few months ago a group of people reported on the unsatisfactory treatment that their relative received from health staff. The manager recognized that some of his staff were not treating patients with due respect. As the head of the health centre he kept reminding his staff in every meeting, to perform their job well. The Ministry of Health and District Health Service made mention of ethics in serving the patients. However, they did not address these ethical issues directly through concrete action. Instead they focussed on the program activities.

The respondents reported that the Ministry of Health and District Health Services did not give due consideration to the ways in which they encouraged staff to improve their performance and attitudes in the delivery of service to communities in
remote areas. Many years ago there was a workshop on ethical issues conducted at the national level through the Institute of Health Science. One staff member from this district was invited to participate but similar workshops had not been made available for other staff at the district and sub-district levels.

**Power**

Participants said that those with the power to influence health policy and issues within the district included local government authorities, district health authorities, the Catholic Church, NGOs, and leaders of dominant political parties. A majority of participants in this study stated that in their experience the Catholic Church had a strong influence on aspects of health policy such as family planning and HIV/AIDS. More than 95% population of this district identify as Catholic. Traditional leaders, the *liurai* in some villages also held power in the community. When the participants were asked why representatives of traditional structures continued to hold the power in society, a senior decision maker of the local government replied:

Some still conserve the traditional structure and the people still trust traditional leaders, *liurai* (kings). The son of *liurai* must be in the front line … For instance the junior chief of village always invites the *katuas or dato* (elders or tribal leaders) and sons of the *liurai* to consult or make decisions because those traditional leaders’ descendants still have some powers in the community. As a local government authority we create and maintain good relationships with them and use this opportunity to approach our community. (A senior decision maker of local government)

In this district some project contractors who had money also held power to influence health issues. For example a senior staff member said:

This water pipe installation project (he pointed to a water pipe in front of Community Health Centre) was constructed by a local company. The work was of poor quality. After no more than three months the pipes were broken again. But our government at the national and local level still trusts and uses this company to construct other health projects in this district. Perhaps, the man who manages this company has a relative who manages the tenders for
the project in Dili…I have no idea. These situations always arise here (this district) with companies and projects. (Workforce 5)

Participants complained that the decentralization of power from central government Ministry of Health to District Health Service was lacking. When participants were asked about their role and responsibility in the health programs implementation, responses are:

The power should be in the hand of the districts right? But I would say that the current practice is centralizing in Ministry of Health. We are only authorized to manage staff, programs and develop health plans and the budget, but the budget is determined over there (pointing to Dili) … For example, stationery is prepared by them. We only receive the papers etc. … The reason was a national tender is required… We are doing nothing… The budget is not according to our plan… The budget for the program implementation was kept in Dili … every three months we went to Dili to collect the money and distributed directly to the Community Health Centres for program implementation. (Health decision maker 1)

Another participant added:

… If we are strictly following the budget plans decided by the central administration Ministry of Health then we will have troubles with the communities and we will never respond to the demands in the field… however, we had to manage it in a different and an effective way to address the real needs in the field. People in the central office, they do not know exactly what is happening in the rural areas but they hold the power to decide, rather than us here… (Workforce 1)

The implications were that the District Health Service (DHS) officials did not make even urgent decisions relating to health issues. The District Health Service consulted with Dili (MoH) but decisions were made by them and District Health Service simply followed the advice of Ministry of Health.
Cooperation

Health services in this district were delivered by various organizations including Ministry of Health, national and international NGOs, representatives of the private sectors and community health volunteers. Thus it was clear that the Ministry of Health represented by this District Health Management Team had a commitment to share responsibility with the private sector for community health and wellbeing. This was a recognized global goal of the health care system.

Participants defined cooperation as collaborative relationships through coordination, communication, respect and consideration. According to respondents cooperation was not in place and was not practiced to the degree that many people would like. An overwhelming majority of participants identified that their experience was one from which cooperation was largely absent. For example, when public health providers were asked if the director of District Health Service ever came to visit and discuss health issues with them, one of them replied: “It never, never happens” (Workforce 8). Another participant added:

We would like to ask the government or Ministry of Health to support us. National and local authorities should see the importance of our work in health to assist the community. Somehow, these authorities have more interest in other things and in NGOs that have money. (Community volunteer 2)

For many participants cooperation was manifested in the opportunity to participate in meetings, debates and discussion, to develop and identify plans, budgets, and solutions to problems. When the Xefe Sukus (village leaders) were asked whether they were approached by District Health Service to participate in the development of health plans and budget for programs that directly affect their villages, one replied:

No, we are never involved in such activities. It is only limited to health staff…. They are the Ministry’s programs. We are not involved in any discussion on budget or plans for the next year. It is the same with other ministries: we the heads of villages are not considered and involved in any budget planning discussions. (Community leader 2)
A vast majority of people found there had been a lack of cooperation. They believed that poor cooperation and relationships in their district had contributed to problems in the delivery of health services. The local government authorities (district and sub district administrators and the head of District Health Service) were involved in health activities when they were invited by workforce or community leaders or they showed up when there was a visit of high level authorities from the central government in Dili, such as the ministers or other VIPs.

Health staff did not get enough support and cooperation from the local government authorities in the provision of health services. As an example, the second round of the tetanus campaign program in 2007-2008 almost failed because there was no interest or participation of the local government during the campaign.

People considered relationships to be an important aspect of cooperation in the context of achieving health objectives. It was recognized that there was a lack of cooperative relationships among the local authorities and health providers. One of the senior health staff said:

… Some of our local authorities and health providers do not have good relationships with each other. For example, we invite them all for a campaign preparation meeting, but if one comes the other one does not come. It affects our programs in the field. How can people co-coordinate a program if they have poor relationships with each other? (Health decision maker 1)

Associated with this, communication was considered central to cooperation and for some participants improved cooperation would entail increased commitment from local government to attend meetings to which they were invited. Some defined cooperation as valuing and using free health services provided by community health volunteers at the grass roots as well as the provision of encouragement, assistance and professional development to these staff (that is, teaching basic skills required for their work). For example, when the Family Health Promoters asked if the director of Community Health Centre ever comes to visit and discuss health issues with them they replied: “It never happens ... unfortunately we have never met the Community Health Centre director” (Community volunteer 3).

Participants identified that cooperation would be characterized by reliability, consideration, respect and trustworthiness, as well as by the provision and sharing of
material resources. Although, according to these understandings of cooperation, many in this district felt that cooperation levels were low, some reported that the relationship between local health authorities including health workers and their partners was characterized by a high level of cooperation. For example, a local health authority observed:

We have good cooperation with the Catholic Church…we have been very successful when implementing programs with the Church. For example the campaign on TT (Tetanus Toxoid) in 2007 and 2008 was a bit complicated but the program was successful because we got support from the Church and the priests. We were in touch with them to make announcements during the mass. (Health decision maker 1)

Some respondents wanted more participation from those higher up the hierarchy in the form of direct engagement with health related activities and events. At the same time, others sought opportunities for those lower in the hierarchy to participate in the health plans and budget discussions, which affected their villages.

**Accountability and transparency**

A majority of participants said that accountability and transparency in the health sector were generally lacking from the national level to this district. For example, neither the minor-capital nor capital-development budget was received by the District Health Service. Both the minor-capital and capital-development budgets were managed at the national level Ministry of Health. The Ministry of Health did not explain the way the financial processes were conducted. They simply said a national tender was required. The District Health Service only received materials and equipment in-kind. For example, the District Health Service received fuel but not cash to buy fuel. Similarly with computer equipment, and medicines. The District Health Service received what Ministry of Health allocated, whether it was enough or not. The District Health Service was not involved in the procurement process. A senior health staff member commented:

The approved budget is not allocated according to our budget plan. We do not know how the national budget is allocated because we only receive in-kind materials. We develop the plan and the budget here but the budget is changed
and decided by them Ministry of Health and they do all the procurement at the national level. I asked Mr. Y (national staff member) why the budget allocation does not reflect our proposal. In fact the proposed budget and the approved budget are complete opposites. He did not give a clear reply. …

The procurement process was done at the national level (MoH). We only receive the medicines… and US$11,000.00… Each health post receives US$100/ month. … We have two Health Posts and nine posts of SISCa… I think the allocated budget is not enough to manage all the programs for one year. (Senior health staff 2)

There was also a lack of accountability and transparency from District Health Services to the Community Health Centres and Health Posts within the district. Some participants reported that in their experience as health program implementers in rural areas (Community Health Centre and Health Post), the current level of accountability was low in the health sector within the district. When asked if any explanation was offered by District Health Service during the budget allocation and why it differs from the original proposal, one participant said:

The District Health Service asked us to submit our budget and plans but the allocated budget does not correlate with our plans. …There is no transparency in the budget allocation from district to sub-district. Last year in 2008, we did not receive the allocated budget for the three months of October, November and December and we also received no clear explanation from DHS. (Workforce 2)

There was a lack of accountability and transparency from government and its partners to communities in this district. They identified the need for accountants and auditors at Ministry of Health and District Health Service to produce quality reports for the community or public. For example, when the community leaders were asked if they and their communities received information on the budget allocation for health centres, or reports on activities, or information on how the health budget had been spent in their village, or whether this information was announced publicly to the community, they replied:

Zero, no explanation. We just accept what they offer. Decision makers in District Health Service (DHS) and Community Health Centre say that all the decisions are made in Dili… so we have no idea about the amount of budget
allocated and used by Ministry of Health and District Health Service for our sub-district, or even my own village… I think the information on health programs sent out to the public is not sufficient. They never announce or report to the community about what they do for us… We are living in the era of democracy. We want open governance. We need to have enough information on how the budget has been utilized and spent. We need health staff at DHS with strong skills in accounting and auditing. (Community leader 2)

Participants said that the District Health Service never explained or reported to the community about how the health plan and budget was allocated and used to implement health activities. District Health Service only gave the information about prevention of diseases. Participants also lamented that the health information system was not well developed and not transparent even for staff. The district had a community radio, which covered most of the remote areas within the district, but they did not use it properly to share the health information with the community. For example, staff were never informed by Ministry of Health and District Health Service about opportunities to access health assistance in overseas hospitals. They were not even given information about the process of sharing information with patients. Staff and patients get information informally through relatives of the patients.

**Equity**

There were public and private clinics throughout the district that facilitated access to basic health care. However not all geographically remote areas in this district had Health Posts or even Mobile Clinics. Some joined with neighbouring hamlets or villages to meet health care service providers when the providers visited the general area. Other factors that hampered people in remote areas to access health care services were poor infrastructure and a lack of resources provided by government and its development partners. Another hindrance was people’s limited knowledge and awareness of health-related matters. Consequently, inequity of health care services existed in this district.
If a patient in a Health Post needed an advanced examination, health staff referred the patient to the Community Health Centre, which should had the complete equipment to conduct further examination. However, based on the researcher’s observation during the fieldwork, some health facilities services were hindered by poor equipment, lack of pharmaceuticals, lack of logistical support, lack of transportation, poor road conditions, limited water supply and limited electricity supply all of which were required in Basic Service Package developed by Ministry of Health. One of the participants who was a senior midwife in a Sub-District Health Centre stated:

We provide equal treatment to everyone. For example, the assistance to a woman from remote areas giving birth is the same as that to a woman living in the town … We bring mothers from remote areas to the health centre, doing observation and helping them until delivery, and the babies have to get immunization before they leave the health centre. But there were various challenges. For example, the relatives call us only at the point when the patient’s condition is severe. Other challenges include the road conditions, which are sometimes so poor that it is difficult to access by ambulance or motorbike. In some parts there are no roads at all, only a mountain path… (Workforce 1)

Another participant added

... Regardless of status - rich or poor - everybody has the same right to receive the same treatment at the health centre or at the health post. But the fact is that the poor people prefer to use the remote health facilities which have limited equipment in poor conditions, lack medication, water and electricity rather than come to the community health centre in sub-district. In contrast the wealthy families prefer to go to Dili and visit private clinics and doctors that provide advanced and modern equipment for examination rather than come to health facilities here. (Workforce 5)

These perceptions and experiences indicate there was theoretical equality for community to access to health care services but health inequity was none the less experienced in this district.
Participation

People in this district, as with the population in other districts, held ideas about community participation in health that was very different from the reality. Public or community participation in the health system in this district was generally poor. Only some members or groups of the community contributed to health policy development and the implementation processes. Some participants in this study (health care staff) informed the researcher that there was limited participation of the local community in health policy implementation in the field. It was affected by the quality and level of education and health illiteracy. A senior health staff observed:

Community participation is minimal in health policy implementation. This indicates that the health awareness of the public is low. Their level of education is low. Most of them did not finish primary school. Some of them never set foot inside a school. (Senior health staff 1)

On the other hand, a participant who was a community leader noted:

They never invited us to participate in the development of any health plan and budget... The heads of villages were not involved in such activities. How can a head of village influence the planning of health activities implemented in our villages? They just involve us in program implementation, like SISCa or other health events, which needs community mobilization. (Community leader 1)

The low level of community participation in this district reflected also a limited appreciation by health staff and managers of the meaning of cooperation, coordination, relationship building, and informed contribution from all levels. There was a lack of awareness about the benefit of engaging sincerely and fully with the community to help resolve issues of health care planning, delivery, monitoring and evaluation, especially at the local level.
DISCUSSION

A number of weaknesses and very few strengths were identified in the governance of the health system in District B.

Responsiveness, structure, effectiveness and efficiency

Health policies, strategies and procedures development

Development of health policies, strategies and procedures were centralized in the Ministry of Health Timor-Leste in Dili. The local health authority and health staff in this district simply followed these policies and procedures, which were developed at the national level Ministry of Health, despite the fact that they were unsuitable and did not reflect the situation on the ground in their district. Public policy should respond to and reflect relevant needs, principles and values of society (Democratic Republic of Timor-Leste, 2002b; Ministry of Health Timor-Leste, 2002a; Panayiotopoulos, 2002). The local health authority had limited knowledge on how to develop internal guidelines and procedures to assist staff and partners to achieve Timor-Leste health indicators and MDGs as policies were written by the Ministry of Health. It is significant that for post conflict countries is a need to address poor and corrupt governance and implement and institutionalizes new leadership models (UN Department of Economic and Social Affairs, 2010). Difficulties arise due to limited capacity and qualifications of people who occupy key position in government. When a government has legitimacy but does not have sufficient capacity to formulate and implement policies effectively, its legitimacy decreases (Carroll & Carroll, 1999). Therefore, internal procedures and guidelines based on district capacity and objectives should be developed and provided by District Health Service to facilitate staff and partners understanding and implementation of health policies. Local officials in post conflict countries have to demonstrate their capability to provide leadership and administer programs to rebuild society independently of international assistance and support with a clear focus on reducing capacity deficits and overcoming the lack of trust by citizens (Brinkerhoff, 2010). These internal procedures include the roles and responsibilities of District Health Service in
managing health policy implementation in their jurisdiction that respect cultural values (Democratic Republic of Timor-Leste, 2002b; Ministry of Health Timor-Leste 2002a; Panayiotopoulos, 2002), and cost effectiveness which constitute accountable systems of government.

The national health policies and strategies which were provided by Ministry of Health and its development partners as mentioned previously, were poorly disseminated by Ministry of Health and District Health Service to some staff and partners in this district. Policy dissemination is required before implementing to establish interaction between central and local administration and management in the field. If a policy implemented without dissemination the objectives will often not be met. The researcher believes that this contributed to the under achievement of Timor-Leste’s health indicators, MDGs objectives and overall performance of the health system in this district. Dissemination was an important activity to guarantee that the community receives, values and contributes to these health policies. Therefore health policy dissemination is an important part of the process of health system governance. Pearson (2007) argued, the objective of health system governance is to assist countries’ achievement of the MDGs. Siddiqi, et al (2008) commented that the goal of health system governance is to achieve better health outcomes and performance of health systems. Thus, the researcher considers health system governance to be not the end goal of health activity but a means to the achievement of better health indicators, outcomes and MDG objectives. These objectives must also be identified and their achievement planned in a transparent and accountable manner.

Social determinants of health

Infrastructure (road, water, communication systems, and electricity) are included in the definition of social determinants of health and logistical support through provision of generators, solar panels, radio communication, motorcycles, ambulances, operational cars and computers were the responsibility of the government. However, much of these were in poor condition or no longer functional. The infrastructure in this district was generally poor. Poor road conditions and bridges made it difficult for health staff to reach the remote areas and for the community to access health facilities. Some people and health facilities did not had access to clean water, reliable electricity and a telecommunication system.
Consequently, communities lived in conditions which exacerbated illness. Staff were unable to work effectively and efficiently and thus fail to meet the expectations of the community. This environment was not conducive to improved wellbeing and health. Populations were hampered by the socio-economic systems within the district where people could not improve their life without money. These poor conditions were related to the lack of responsiveness of the central and local government and its development partners. It is relevant that in post conflict and fragile states, governments can increase the barriers to provide basic needs for communities (Brinkerhoff, 2010; Agborsangaya-Fiteu, 2009; Blunt, 2009; Meagher, 2007; Organisation for Economic Co-operation and Development, 2007). Hogwood and Gunn (1984) articulated a precondition for perfect implementation of public policy, as the combination of adequate resources is actually available both generally and for each phase in the implementation process. Both central and local government had a responsibility to address these conditions (Democratic Republic of Timor-Leste, 2002b; Ministry of Health Timor-Leste, 2002a) as they affected the social determinants of health (Freire, 2011; Marmot, 2005), and governance in health system which impact people’s ability to achieve better health outcomes.

The need for physical resources such as vehicles and infrastructure could have been met more adequately because they have direct and indirect impact on policy implementation (Edwards, 1984; Hogwood & Gunn, 1984). In this case a good cooperative network with relevant ministries and development partners including community was needed (Calderini, Garrone & Sobrero, 2003; Myers, 2003; Pierre & Peters, 2000). Poor communication systems were a nationwide concern that also affected this district. Telecommunications were an important aspect of a functional health system as they facilitate networking, collaborative relationships and more importantly it contributes to a reduction in mortality rates. Currently more than 100 countries in the world are using mobile phones to achieve better health outcomes and performance (Schweitzer & Synowiec, 2010). For example in India health staff send text messages to share health information and prevent ill health and in Rwanda community health workers use SMS (Short Message Service) to inform health centres about emergency obstetric and infant cases, and enabling them to call an ambulance (Ban, 2010).
Monitoring and evaluation

Another important aspect of responsiveness of the District Health Service and Ministry of Health was monitoring and evaluation. The lack of monitoring and supervision of health programs implementation in the field by District Health Service authorities also contributed to the poor performance of health systems in this district. Local government officials including District Health Management Team (DHMT) should monitor health professionals when in the field or at the Community Health Centre (CHC) to obtain information on the progress of health program activities and to garner information about staff concerns. A regular schedule for monitoring and evaluation was needed. Monitoring and the periodic follow-up of activities were continuous processes that provide ongoing and regular descriptive information on progress. Evaluation takes place periodically and provides overall information on achievements or failures of health policy and program implementation in the field. Legitimacy of governance is affected by the content, processes, outputs and outcomes of policy (Baldwin & Sunkin, 1995; Birkland, 2005; Soenarko, 2003; Walt & Gilson, 1994). Effective governance is part of local government’s administrative role and responsibility (Democratic Republic of Timor-Leste, 2002b; Ministry of Health Timor-Leste, 2008a) to ensure good administration of the health system. Effective governance also provides guidance for policy implementers and to ensure the legitimacy of policy and Ministry of Health with its systems that trusted by public and satisfied everyone. As stressed by Debiel and Terlinden, (2005) public distrust in government will undermine the legitimacy of the government.

Policy evaluation is a part of a system to assist government and policy implementers to improve governance (Birkland, 2005; Edwards, 1984). The monitoring and evaluation system for Basic Service Package was based on a set of indicators and evaluation criteria that should provide timely feedback on progress towards the agreed results (Ministry of Health Timor-Leste, 2007a). These criteria and procedures were supported by improving DHMT’s skills in monitoring and evaluation. But this District Health Service needed more guidance, support and resources to put this into practice. The core functions of the monitoring and evaluation system were data collection, analysis and application. Poor monitoring
and evaluation by this District Health Service and local government had contributed to the negative health outcomes in this district.

*Shortage of health staff*

There were severe shortages of qualified staff in this district, which results in a ratio of health staff to community members of 1:1500. Shortages of health professionals were a common issue in Ministry of Health and all District Health Services. The reality was that on occasions an assistant nurse was the only health professional connected with a Health Post. In post conflict states for example in Rwanda, the new political and the administrative leaders were returning exiles with little or no experience in running the public service (United Nations Economic and Social Affairs, 2010). While there was a willingness among staff to do whatever was required to meet the health needs of the community, this increased the likelihood of dangerous mistakes being made, with serious implications for patients’ health. Sometimes a nurse acted as a doctor because the job description was not clear. This was made worse by the Ministry of Health failing to provide adequate orientation, training or clear job description for new recruits. This also created tension among staff because people argued about who was doing what. In this case local and central administration and its development partners should make every effort to reduce tension and destructive competition among staff to make sure that each action is responsive to community’s needs and wellbeing. Inadequately trained health care providers should not be permitted to work in remote Health Posts in order to ensure that staff can provide quality, effective, equitable and efficient health service delivery to all community members and to avoid malpractice. With adequate numbers of prepared staff in place there was potential to create a functional governance and health system in this district.

Governance as hierarchy was a mechanism for facilitating communication between organizational and functional structures within systems. It means that the hierarchy and structure of this District Health Service should be strong and staff should have appropriate qualifications and experience. Appropriate governance will facilitate the achievement of the health MDG objectives identified in the Basic Service Package (BSP) and improve the health system performance in this district. The East Timor’s National Development Plan (2002) and Workforce Development
Plan, Ministry of Health Timor-Leste (2007) were increasing the number of health professionals through both national and international colleges and universities aimed at improving governance in health system within the country.

The health facilities such as Referral Hospitals in the districts, Community Health Centres, Health Posts and Mobile Clinics made up the health structure providing delivery of health care services to community. In this district many communities were situated long distances from the health facilities. Some community groups moved back to ancestral land after independence and were now located in the mountainous areas vast distances from health facilities. Consequently, heavy rains, poor communication, lack of transport and other problems made it difficult to reach health services when needed. Health staff were also hampered in their efforts to reach remote communities.

**Ethics**

The shortage of health staff and the lack of evaluation, reward and promotion by District Health Service and Ministry of Health of health care providers had affected the performance and attitude of staff health service delivery to communities. A Code of Ethics existed with the professional associations (Kenny, KE, 2006; Westerholm, Nilstun & Ovretveit, 2004), but was not well understood and practiced. If a Timorese patient was directly or indirect criticized or was treated unkindly they did not return to health facility (Zwi et al., 2009). Therefore, negative attitudes and ethics of health staff also contributed to poor performance and health inequity in this district. The researcher agrees that political leaders and civil servants have their own set of beliefs, attitudes and behaviours that may be difficult to transform for positive engagement (United Nations Economic and Social Affairs, 2010). Capacity building, leadership and professional ethics training should be considered in relation to local context (culture, tradition, belief and value). But, health staff argued that the Ministry of Health and District Health Service did not take seriously their responsibility to improve health professionals’ work conditions. Low salaries for the majority of Ministry of Health staff, and a lack of incentives for health staff to work in remote areas were some of the critical factors that limited effective delivery of health services in the district. They required the attention of the Ministry of Health.
Another concern of participants in this district was an unduly complicated bureaucracy, which was found to hamper staff and communities’ access to local and central government offices with implications for staff conduct and ethics. Some scholars argued that bureaucracy was an instrument to guide policy implementation (Hyden, Court & Mease, 2003) and bureaucracy performance was an important part of performance development (Kaufmann, Kraay & Zoido-Lobaton, 1999). But complicated bureaucracy in a government system can lead to poor performance of the system and hamper the processing of community requests. The researcher believes that complicated and inefficient bureaucracies also open “windows of opportunity” for bureaucrats to engage in corruption, collusion, nepotism and the abuse of power. This had occurred in this district with an example given by a senior health workforce (p. 168-169).

Hirschmann (1999) has stressed if related to macroeconomic policies, bureaucracy is not the key to improve development, but is an impediment of development. Moreover, Narayan, Chambers, Shah, & Petesch, (2000) through their Voices of the Poor study identified that the poor often experience bureaucrats as unpleasant, unfair and corrupt. In the 1960s and 1970s Hirschmann (1999) reported bureaucracy in third world was associated with increasing feelings of frustration, inefficiency and corruption (Hirschmann, 1999). This is significant that participants in this district lamented similar complaints. Reform of bureaucracy including attitudes, performance criteria, and career incentives systems in public office in Timor-Leste is long overdue.

**Cooperation, participation and equity**

The community leaders and Promotor Saude Familia nian or Family Health Promoters expressed concern about their powerlessness to take part in the health system in their villages. One impact of this lack of collaboration was an increased likelihood of an overlap in parts of the budget and plans for health activities within this district. Governance as community is a key pillar of good governance (Pierre & Peters, 2000). Therefore, District Health Service needs to give more attention to the power of community members and structures to develop a successful health system.
The involvement of the community in the health system was generally poor in this district. Community leaders (village leaders) observed that health authorities never invited them to be involved in health plan and budget discussions for their villages and sub-districts. The village leaders were key people in their village, and their involvement in health plans, budgets, strategy development and implementation were essential. Community participation in development in their area was also promised in the Constitution of the Democratic Republic of East Timor (2002).

An important consideration was that there will be no permanent improvement of the public health system without active and full local community participation in the development and implementation of local health programs (Narayan, R, 2008). Moreover, “people have the right and duty to participate individually and collectively in the planning and implementation of their health care” (World Health Organization, 1978; World Bank, 1996; Constitution of the Democratic Republic of East Timor, 2002). Their involvement contributed to transparency and a sense of ownership that would assist District Health Service in implementing, monitoring and controlling health activities in their area. Another benefit was the facilitation of community engagement and mobilization to participate in health policy systems implemented in their region. Local government, particularly District Health Management Team, Community Health Centres and Health Posts should acknowledge community leaders as controllers, regulators and facilitators of health systems in their region. The Alma-Ata declaration (1978) calls for maximum community and individual self-reliance and participation in the planning, organization, operation and control of Primary Health Care, as did the Constitution of the Democratic Republic of East Timor (2002).

The communities needed empowerment and awareness rising on health issues and activities so that they can learn to recognize the importance of good health for themselves and their family and so that they will be willing to participate in health policy processes within the sub-district and district. Despite low levels of literacy, which characterized much of the community, an appropriate mechanism should be identified by local and central government Ministry of Health and its partners to ensure community and community leaders in this district were able to participate in health activities in their village, sub-district and district.
An effective approach is community empowerment on health issues incorporated through community development (Arole, Fuller & Deutschmann, 2004; Freire, 2011; Toomey, 2011; World Health Organization, 1986), where the community was provided sufficient knowledge and skills for prevention and promotion of health. To ensure the success of the community empowerment approach to addressing health issues, both top-down and bottom-up methods must be combined (Arole, Fuller & Deutschmann, 2004; Braunack-Mayer & Louise, 2008).

Governance as market was stressed through local administration District Health Service which had a collaborative relationship with relevant ministries or departments, NGOs, project contractors and companies with the intention of providing goods and services to meet communities’ health related demands (Ministry of Health Timor-Leste, 2002a). However, some goods and services provided were not of good quality. This poses a challenge for staff who were then unable to work effectively and efficiently. As a result the operations of the health policy system did not meet the expectations of health governance of policy systems in this district. The consequences were that the communities within this district suffered inequity in access to good quality health care services. Ultimately, this led to increased morbidity and mortality rates associated with communicable diseases and difficulty in decreasing the maternal and child mortality rates. These health inequities were unwanted, unnecessary, and preventable.

Cooperation, which referred to collaborative relationships, coordination, communication, respect and consideration between health workforce and local government officials was not in place and was not practiced to the degree many people would like. For example, the local government officials were only involved in health activities when they were invited or present when there was a visit from high level authorities from Dili. Health staff also agree that they did not get enough support and coordination from the local government authorities. The researcher found that these aspects served as barriers for the health workforce to trust local officials, in the delivery of health services to communities in remote areas, make it hard for District Health Service of this district to achieve desired health objectives, indicators and outcomes, and demonstrated poor performance of the health system. Furthermore, local government authorities as community leaders can use their ability to influence and engage other stakeholders (Gaventa, 1982; Lukes,1974; Thynne &
Goldring, 1987) to support health professionals to take part in improving community health and well-being. Local government (district and sub-district administrators) had an important role to play in collaboration with other partners in improving health of the community in their area of jurisdiction (National Public Health Partnership, 2002).

However, an aspect of governance in health policy implementation, which was successful in this district, was the involvement of international and national NGOs, the Catholic Church, and the private sector, in the development of the health system. To ensure the functioning and delivery of health services and the achievement of the TL-MDG objectives, the Ministry of Health through local administration District Health Service and in cooperation with the aforementioned agencies, provided a number of health facilities spread throughout the district. Networking is an essential part of governance in health systems (Pierre & Peters, 2000; Torfing, 2005). In response to District Health Service interest and community demand, a network was established to collaborate and build relationships among all stakeholders with an interest in health sector development in this district. This network was to mobilize all resources such as local community leaders, public and private health organizations, and to take part in implementation of health policy including improvement of health services delivery and creating stronger health systems (World Health Organization, 1978; World Health Organization Regional Office for the Eastern Mediterranean, 2007).

**Power and its decentralization**

A review of the notions of governance in this district, identified power as a key issue. It was identified that those who influenced health policies and issues in this district included local government authorities, the Catholic Church, NGOs, project contractors who had the funds, and leaders of the dominant political parties. The traditional power structures drew on customs and traditions in Timor-Leste, and the Catholic Church played an important role in some health policy development and implementation. These aspects had affected the quality of health services and community wellbeing, both negatively and positively.
The Constitution of the Democratic Republic of East Timor (2002), states that, “the state shall promote the cooperation with different religious denominations that contribute to the well-being of people of East Timor”. Whether it was accepted or not, the Catholic Church had a strong influence on health policy, particularly in such areas as family planning and HIV/AIDS management. The Catholic Church encouraged and protected universal human values. Traditional power structures such as the liurai (king) and dato or katuas (tribal leaders in village) also held power in some villages within the district. The interaction between government and community should be driven by the local social and economic, cultural, tradition and norms (Ministry of Health Timor-Leste, 2002a; Panayiotopoulos, 2002), and political pressures.

Participants lamented they could not fully take responsibility and power for health program implementation in the field. However, decentralization refers to the transfer of decision-making power and administration from central government to local government (Bossert, 1998) and aims to offer more efficient delivery of services and decision-making with priority given to communities who understand their local needs and circumstances (Democratic Republic of Timor-Leste, 2002a; Ministry of Health Timor-Leste, 2002a). The researcher found that the local government officials including District Health Service in this district lacked focus and commitment to their work, and were incapable of implementing health programs. The decentralization of power also necessitated the capacity, capability and leadership of the District Health Service (managers and staff) to put plans into action. Beethham (1991) stressed that power depends on certain precondition: personal capacities such as health, strength, knowledge and skill; the possession of material resources; and space in the sense of freedom from control. These precondition are interrelated, with legitimacy based on rules, shared belief and consent.

**Accountability and Transparency**

There was also a lack of accountability and transparency from Ministry of Health and District Health Service and its partners to communities in this district. The community leaders in this district showed interest to know the plans and budgets for their district, particularly for their villages and how the local administration
District Health Service (DHS) used the state budget for health program implementation. Moreover, a need was identified for accountants and auditors at central Ministry of Health and local District Health Service levels to produce quality reports for the community or public (World Bank, 2006). The District Health Service and its partners need to explain and justify openly through regular meetings and/or the media what they have done, or failed to do, and how they have disbursed funds. These points are to ensure the effective, accountable, transparency, responsiveness (World Bank, 1996) and sustained use of health resources allocated by state to this district. Mass media can contribute to the improvement of governance (Hollihan, 2010; Norris, 2010), to communicate and present health plans and implementation process, as well as to receive feedback from the public to evaluate health programs and facilitate revision of programs. Alternatively, media can be manipulated, in newspaper, radio or television stations to prejudice and influence decision making processes. In many developing countries, the mass media was not yet seen as a core government strategy, because some government officials consider it as purely political (Hollihan, 2010; Norris, 2010).

National and local health authorities must take a leadership role to advance credible governance to ensure the health system is trusted by the health workforce, partners and community. This includes dissemination of health information, based on local needs with equity and without discrimination, throughout the public and private health service providers, and health service users. However, health information in this district was not well developed or transparent even for staff. For example, staff had not been provided with information by Ministry of Health and District Health Service about health assistance from overseas hospitals, or about what information should be given to patients in this regard. There was unequal access to health information and health care for some communities in remote areas of the district which was contrary to the Timor-Leste constitution and universal declaration of human rights (Democratic Republic of Timor-Leste, 2002a; Morsink, 1999; United Nations, 1948; World Health Organization Regional Office for the Eastern Mediterranean, 2007). Also the accounting and auditing systems needed to be lead and managed with honesty, accountability and transparency. This was crucial for enhancing governance in health systems in this district.
The weaknesses of governance and the low achievement of health indicators in this District Health Service has made it difficult for this district to compete with other District Health Services within the Timor-Leste and achieve better health outcomes as desired by central administration Ministry of Health. Careful consideration should be given by Ministry of Health and its development partners to the issues of context, condition, capacity of human resources including capability and leadership of managers (District Health Service and health facilities) infrastructure, culture and social complexity of the district before developing health policies and defining health indicators, which had been adopted through Timor-Leste Health Policy Framework 2002. Reviewing these variables and key factors will strengthen governance in health systems in this district.

CONCLUSION

The district health system was structured by Ministry of Health according to the design laid out in official documents (Ministry of Health Timor-Leste, 2007a). A District Health Management Team (DHMT) through District Health Service (DHS) was established in this district based on Decree Law 5/2003 to guarantee district health system functioning. The specific roles of the DHMT were to plan, supervise, coordinate, monitor, report and evaluate all health policies and program implementation at the district level. People of this district had their perception of how the DHMT in District Health Service was operating the health system in their district. Governance as a process of a public or private system was also explored in this research.

The research findings identified that the health system governance in this district was generally poor. These findings were revealed in communication with staff of local government offices, District Health Service, Community Health Centres, Health Posts, relevant ministries, UN agencies, NGOs, private clinics, community leaders and community health volunteers, as well as through researcher observations during the period of fieldwork and secondary statistical analysis. It was clear that participants understood the concept and meaning of governance in health system, which included organisational structure, power, responsiveness,
effectiveness and efficiency, equity, ethics, accountability, transparency, cooperation, and participation.

They also appreciated the value of governance in the health system, lamented the lack of it and wanted to practice it to achieve the MDGs objectives and overall performance of health system in this district. However, the mechanisms of good governance were not in place and were not practiced to the degree that many people would like. It was identified that governance in the health system could be improved through the enhanced responsibilities and reputation of the local and central administration and among various parties such as central government (Ministry of Health and relevant ministries), local government (local officials, District Health Service and workforces), religious leaders, community leaders, community health volunteers and community, development partners (UN agencies, national and international NGOs), donors, stakeholders, and the private sector in this district.
CHAPTER 8: COMPARISON DISCUSSION OF GOVERNANCE OF HEALTH SYSTEMS IN DISTRICTS A AND B

INTRODUCTION

The governance of the health system in District A and District B has been discussed in chapter six and seven respectively. This chapter compares and contrasts governance between the health systems in the two districts and how the central administration (the Ministry of Health and its partners) support each district to make it function. Both districts have similarities and differences in history and experience of governance as well as geography, demography, and socio-economic backgrounds. These have resulted in significant variation in performance and achievement of health indicators and objectives. The similarities and differences in the theory and practice of governance in health of Districts A and B are identified and discussed in this chapter.

SOCIO-ECONOMIC CIRCUMSTANCES

The two districts differ in terms of geographical location, demographics, socio-economic and human capital. Other significant differences are health staffing, infrastructure, and logistical support. They also have differences in achievement of health indicators, particularly in the achievement of MDG objectives. The following tables illustrate these aspects.
The table shows that District B has significant differences when compared to District A in terms of: population density, life expectancy, poverty health count and formal education. High population density often contributes to the more rapid spread of communicable diseases due to increased contact among individuals. Poverty and the lack of formal education impact negatively on health status. People living in rural areas have limited
access to primary health care services because of lack of infrastructure development, cost pressures associated with distance and isolation, and the inequitable distribution of the health workforce. These factors affected health outcomes negatively in District B.
Table 5: Comparison of health staffing, infrastructure and logistical support in District A and B

<table>
<thead>
<tr>
<th>Health staffing:</th>
<th>District A</th>
<th>District B</th>
<th>Standard of Basic Service Package (BSP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctor</td>
<td>8 (1: 5,400)</td>
<td>8 (1: 14,329)</td>
<td>2/DHC, 1/SDHC</td>
</tr>
<tr>
<td>Nurse</td>
<td>46 (1: 939)</td>
<td>35 (1: 3,275)</td>
<td>5/DHC, 5/SDHC, 1/HP</td>
</tr>
<tr>
<td>Midwife</td>
<td>30 (1: 1440)</td>
<td>21 (1: 6,887)</td>
<td>4/DHC, 2/SDHC, 1/HP</td>
</tr>
<tr>
<td>Other health professionals</td>
<td>19 (1: 2,213)</td>
<td>14 (1: 8,188)</td>
<td>6/DHC, 4/SDHC</td>
</tr>
<tr>
<td>Other support staff</td>
<td>39 (1: 1,107)</td>
<td>54 (1: 2,678)</td>
<td>3/DHC, 2/SDHC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infrastructure:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health Centres (DHC)</td>
<td>1</td>
<td>1</td>
<td>1/District, 1/Sub-district</td>
</tr>
<tr>
<td>Sub-District Health Centre (SDHC)</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>= 6 (1: 7,200)</td>
<td>= 6 (1: 19,105)</td>
<td></td>
</tr>
<tr>
<td>Health Posts (HP)</td>
<td>18 (1: 2400)</td>
<td>23 (1: 6,288)</td>
<td>4/SDHC</td>
</tr>
<tr>
<td>SISCa Posts</td>
<td>76 (1: 568)</td>
<td>52 (1: 2,204)</td>
<td>1/Village</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transportation:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational cars</td>
<td>8</td>
<td>5</td>
<td>1/SDHC</td>
</tr>
<tr>
<td>Ambulances</td>
<td>3</td>
<td>2</td>
<td>1/DHC</td>
</tr>
<tr>
<td>Motorcycles</td>
<td>26</td>
<td>35</td>
<td>5-10/SDHC</td>
</tr>
<tr>
<td>Bicycles</td>
<td>9</td>
<td>4</td>
<td>- (If needed)</td>
</tr>
<tr>
<td>Horses</td>
<td>4</td>
<td>-</td>
<td>- (If needed)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support equipment:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio communication</td>
<td>9</td>
<td>9</td>
<td>1/DHC, 1/SDHC</td>
</tr>
<tr>
<td>Generators</td>
<td>9</td>
<td>16</td>
<td>1/DHC, 1/SDHC</td>
</tr>
<tr>
<td>Solar panels</td>
<td>18</td>
<td>17</td>
<td>1/HP</td>
</tr>
<tr>
<td>Computers</td>
<td>16</td>
<td>17</td>
<td>1/DHC, 1/SDHC</td>
</tr>
<tr>
<td>Photocopiers</td>
<td>1</td>
<td>1</td>
<td>1/ DHS (District Health Services)</td>
</tr>
</tbody>
</table>

This table shows that District B, despite being larger and spread over a greater space with a rural population, has fewer resources in terms of ratio of health professionals to population, and transportation. This impacts on health service to communities and achievement of health outcomes in negative ways. The reasons for these differences were firstly, as a post conflict state and new nation, the Timor-Leste
government could not provide accommodation and other logistical support or incentives for a health workforce employed from beyond the districts (Blunt, 2009; International Dialogue on Peacebuilding and Statebuilding, 2012; Meagher, 2007a; Organisation for Economic Co-operation and Development, 2007; United Nations Economic and Social Affairs, 2010). Therefore the Ministry of Health and the District Health Service employed local health professionals to occupy the health services in the districts and sub-districts. District B had fewer local health professionals compared to other districts. Most Timorese health professionals live in Dili, the capital of Timor-Leste, and they prefer to work for NGOs that provide incentives, rather than the public health sector. Secondly, the Ministry of Health distributes transportation and other logistical support for the District Health Services based on the district health plan. This means that access to these resources depends on the capacity of the District Health Management Team to request them. This is lacking in District B. Therefore, District Health Service B needs to be prepared to assume responsibilities like management and leadership that the Ministry of Health and its international partners have delivered. A critical governance issue for post-conflict state recovery is the creation of a professional public administration and civil service, including the establishment of mechanisms for oversight, accountability, and financial controls (United Nations Development Programme, 2008).
Table 6: Comparison of health indicators in District A and B

<table>
<thead>
<tr>
<th>Health MDGs</th>
<th>National target reduced (between 1990 and 2015)</th>
<th>District A</th>
<th>District B</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDG 4, under-5 mortality rate</td>
<td>Target less then 56 deaths for every 1,000 live births.</td>
<td>69 deaths per 1,000 live births.</td>
<td>102 deaths per 1,000 live births.</td>
</tr>
<tr>
<td>MDG 5, improve maternal health</td>
<td>Estimated ratio for maternal mortality rate is 557 per 100,000 live births. Proportion of birth attended by skilled health workforce should increase from 19% to 60%.</td>
<td>Pregnant women receive antenatal care from skilled provider: 93.9%.</td>
<td>Pregnant women receive antenatal care from skilled provider: 70.3%.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mother who received TT (Tetanus Toxoid injection: 94.8%.</td>
<td>Mother who received TT (Tetanus Toxoid injection: 65.5%.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The rate of delivery in health facilities: 25.4% and at home 74.6%.</td>
<td>The rate of delivery in health facilities: 3.2% and at home 96.8%.</td>
</tr>
<tr>
<td>MDG 6, Combat HIV/AIDS, Malaria and other diseases</td>
<td>Targeting the halt and reversal of the spread of HIV/AIDS by 2015.</td>
<td>Women and men age 15-49 have heard of HIV/AIDS: 52.1% and 98.9% respectively. Malaria: 2,106 cases reported between January and March 2009. Tuberculosis: 22% new cases reported between January and March 2009.</td>
<td>Women and men age 15-49 have heard of HIV/AIDS: 13.8% and 20.8% respectively. Malaria: 840 cases reported between January and March 2009. Tuberculosis: 65% new cases reported between January and March 2009.</td>
</tr>
</tbody>
</table>
This table illustrates that District B has a higher under-5 years mortality rate, less women receiving antenatal care from skilled providers, fewer women giving birth in health facilities, fewer people who have heard of HIV/AIDS and a higher number of cases of Tuberculosis disease. Thus, the achievement of health indicators, outcomes and MDG objectives in District B was affected by those factors outlined in Tables 5 and 6. Poverty, density of population, large rural dwelling populations, lack of formal education (particularly for women), shortage of health professionals and logistical support, are significant issues for the District Health Management Team of District B that hampered them in achieving better health outcomes.

Analysis of data presented in Tables 5, 6 and 7 shows significant differences in demographics, health resources and the achievement of health indicators, MDG objectives and performance of health systems between District A and District B. The latter are affected by demographic and geographic conditions, socio-economic background of the respective populations and basic human capital including health workforce and infrastructure inequalities. They are also affected by governance of their respective health systems.

The demographic and geographic factors, such as total population, population density, percentage of population living in rural areas, socio-economic background and human capital are crucial factors that impact on the outcomes of the health systems. As (Hyden, Court & Mease, 2003) have affirmed, geography, demography and social stratification have impacted on equal access to public services which is an important indicator for legitimacy of the civil services and development outcomes. The total population of District B is much higher than District A and the total area of B is smaller than A, therefore B is a densely populated district in comparison to A district. But in District B 93% of the population resides in rural areas. A consequence of higher population density in District B is increased risk of transmission of communicable diseases. This impact is confirmed by data in Table 7, and constitutes a heavy burden on the health system. Population density is a critical factor in the transmission of diseases spread by the respiratory route and through person-to-person contact (Pan American Health Organization, 1982).

Human capital is an important factor contributing to healthy communities. Some scholars have argued that people with higher levels of education live longer and are more healthy compared to those with lower education (Cutler & Lleras-
Muney, 2006; Grossman & Kaestner, 1997; Mirowsky & Ross, 2003; Preston, SH & Taubman, 1994). It is significant therefore that more than half of women in District B have had no formal education as this impacts their knowledge and awareness of health-related matters including keeping their family healthy. As a result District B has a higher under-5 years mortality rate and less mothers who received Tetanus Toxoid injection. People who have higher levels of education and literacy, also have better prospects of employment and income (Cutler & Lleras-Muney, 2006; Grossman & Kaestner, 1997; Mirowsky & Ross, 2003; Preston, SH & Taubman, 1994). Therefore, education is a significant determinant of health (Marmot et al., 2008). An important way to achieve a better service delivery and governance in health system involves the enhancement of the organizational efficiency, human capital and social capability that includes educational levels of the health workforce and community. Therefore, the central and local administration (Ministry of Health and District Health Service B) and their partners should do well to focus on the capacity building of District B to get significant health outcomes as expected.

HEALTH GOVERNANCE

Good governance can assist and enhance the performance of leadership and management in the public system, which can contribute to the achievement of indicators and the MDG objectives. Health governance refers to developing and implementing health policies, strategies and rules to achieve better health outcomes and improve the performance of health systems (Siddiqi et al., 2009; Strach, Hall & Pirožek, 2004). There are also similarities and differences of governance in health systems between the both districts. The following table presents these aspects.
Table 7: Differences and similarities of governance in health system between District A and B

<table>
<thead>
<tr>
<th>No.</th>
<th>Criteria</th>
<th>District</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Outcomes and MDG</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>1</td>
<td>Responsiveness, structure, effective and efficiency</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>2</td>
<td>Infrastructure, logistical support and pharmaceuticals</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>3</td>
<td>Development of health policies, strategies guidelines and tools</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>4</td>
<td>Shortage of health workforce</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>5</td>
<td>Reward and promotion of health workforce</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>6</td>
<td>Ethics</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>7</td>
<td>Power</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>8</td>
<td>Gender and Patriarchy</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>9</td>
<td>Relevant ministries, donors and partners</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>10</td>
<td>Decentralization of power</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>11</td>
<td>Accountability and transparency</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>12</td>
<td>Equity</td>
<td>Poor</td>
<td>Poor</td>
</tr>
<tr>
<td>13</td>
<td>Dissemination of health policies, strategies guidelines and tools</td>
<td>Good</td>
<td>Poor</td>
</tr>
<tr>
<td>14</td>
<td>Competence of local leaders and managers</td>
<td>Good</td>
<td>Poor</td>
</tr>
<tr>
<td>15</td>
<td>Monitoring and evaluation</td>
<td>Good</td>
<td>Poor</td>
</tr>
<tr>
<td>16</td>
<td>Cooperation and participation</td>
<td>Good</td>
<td>Poor</td>
</tr>
<tr>
<td>17</td>
<td>Internal relationship</td>
<td>Good</td>
<td>Poor</td>
</tr>
</tbody>
</table>

District A and District B share some disadvantages. However, despite these similarities of disadvantages in governance, District A is different to District B in the achievement of health indicators, outcomes and MDG objectives identified by central administration. This may be due to the fact that District A performs well in terms of dissemination of health policies, human resources (leadership and management), monitoring and evaluation, cooperation and participation of local government and community. The following highlights the similarities and differences in governance.
Similarities: Responsiveness, structure, effectiveness and efficiency

The current levels of responsiveness of health decision makers, relevant ministries and development partners at the national level were insufficient. This lack of responsiveness affects the structure, efficacy, and efficiency of the health system in both districts.

Similarities: Social determinant of health and logistical support

It was reported by interviewees of both districts that the lack of infrastructure such as poor roads and bridges in rural and remote areas, unreliable electricity, the lack of clean water and the lack of a proper communication system (as social determinants of health), along with insufficient pharmaceuticals and other logistical support, hampered health service delivery. Scholars acknowledge that health systems can be hindered by a range of constraints including those related to staff, effective financing, health equipment and medicines, transport, communication and infrastructure (Alva et al., 2009). Participants from headquarters, relevant ministries and funding partners also confirmed these issues. The Timorese government through the Ministry of Infrastructure (supported by its development partners) continues to give high priority to improving roads to make access to social service delivery, including health services to remote communities more sustainable. Roads and water provision were the two highest priorities of the Timorese government in 2010 (Independent Review Team, 2010). It is the aim of pakote referendum (the referendum package)\(^\text{33}\) to resolve these concerns.

When Indonesia left Timor-Leste in 1999 much of the electric power system was deliberately and systematically destroyed, particularly at the district and sub-district levels. Since Timor-Leste gained its independence Electricidade de Timor-Leste/EDTL (Electricity of Timor-Leste) and its development partners have installed new generators in district and sub district capitals including in Districts A and B, but

\(^{33}\)Referendum package refers to the projects commissioned by the Ministry of Infrastructure to local companies to develop infrastructure including roads and installation of clean water systems in remote and rural areas.
the generators are no longer functioning because of lack of technicians and maintenance. The Timorese government has contracted a large company from China to build three electric power generating stations using heavy fuel oil and nationwide high voltage distribution system (La'o Hamutuk, 2011). This project will take three years to complete and the construction was started in 2010. The government is excited about the fact that all districts and sub districts including all households and offices within the country will have access to electricity soon after the project is finished.

Timor Telecom (TT) is the only company providing a telecommunication system in Timor-Leste and 86% of the population has access to the mobile network (Timor Telecom, 2011). Communities in remote areas of both districts have less access to the TT network due to limited access to electricity. However, all Community Health Centres (CHC) within the country have radio communication provided by the Ministry of Health to assist health professionals in delivery of health services to the community. To support the power system the Ministry of Health also provides solar panels to some health facilities with no access to other sources of electricity. If the health facilities are facing any problems about radio communication and solar panel systems, they are expected to keep in contact and coordinate with the logistics department in the Ministry of Health to solve the problem. Therefore, the health systems’ performance in both districts was affected to the same extent by poor infrastructures provided by central and local government.

*Similarities: Pharmaceuticals*

A majority of participants from headquarters acknowledged that provision of pharmaceuticals to health facilities was not meeting expectations in any districts including both Districts A and B. The supply of pharmaceuticals impact was similar in both districts. Experience shows that the provision of pharmaceuticals was not in line with Timor-Leste national policy. The policy aims for a continuous supply of safe, effective, and quality essential medicines and the promotion of rational and safe use of medicines both in the public and private sector throughout the country (Ministry of Health Timor-Leste, 2004). The availability of medicines in both A and B health facilities was not based on the essential medicine list. Patients are obliged to travel to Dili, the capital, to purchase medicines for their own treatment. This
contravenes the statement in the Constitution that health services are to be free to all citizens (2002). Similar findings have been reported in other developing countries (MeTA 2007).

Lack of pharmaceutical supplies was the most important problem in all health facilities including at the central pharmacy warehouse in Dili. This problem was caused by the inefficient procurement system of the Project Management Unit (PMU) of the Ministry of Health using World Bank procurement procedures. The PMU developed internal procurement tools to accelerate the distribution of pharmaceuticals within the country. However, experience shows that the World Bank established numbers of PMUs with its procedures in developing countries in order to avoid government weaknesses, but this has often created as many problems (Huff-Rousselle, 2009; Rondinelli, 2006; United Nations Department of Economic and Social Affairs & United Nations Development Programme, 2007). The procurement procedures system is complicated, confusing and non-transparent (Wiehan, 1997). These complicated processes lend themselves to abuse and manipulation resulting in inconsistencies in the quality and quantity and medicines. This paves the way for the misuse of state resources, the primary impact of which is borne by the communities deprived of medication.

*Similarities: Development of health policies, strategies and guidelines and tools*

Another concern from both District A and B relates to health policies, guidelines, procedures and instructions that ensure the implementation of health programs in the field. Health policy requires clear objectives, alternatives strategies, and careful consideration of the social determinants of health and local contexts (Birkland, 2005; World Health Organization, 1978; (Grindle, M. S., 2004; Siddiqi et al., 2009). Health policy is a package of promises and commitments to follow an outline of action designed to achieving defined health objectives (Shariati, Farzadi & Akhlaghi, 2005), where governments convert their political vision into programs and action to deliver service and outcomes (Nutley, 2000).

Governance as process is related to policies, strategies and procedures and is crucial for ensuring all the components of governance are working within a system and are guided and synchronized to achieve common purposes (Blakemore, 1998;
Both districts recognized that staff had little input into health policies, strategies and guidelines. The reasons for this lack of involvement include the distance from the districts to Dili, and the limited number of health staff to cover for absent colleagues. The Ministry of Health only invites one District Health Service from each region to represent other District Health Services within the region when developing a draft of a health policy or strategy. Other District Health Services and staff are invited to a consultation or workshop when the draft of health policy or strategy is already developed. This meeting is usually held for one day in Dili. This process does not allow for other districts and staff concerns to be incorporated into the policy or strategy. However, the health policy should respond to and reflect the needs, principles and values of the population. As people in their district will be affected by these health policies (Althaus, Bridgman & Davis, 2007) they have the right and should be afforded opportunity to identify problems and desired actions, and make suggestions and a contribution to the process of policy development. This issue is of major concern to headquarters in the Ministry of Health and its development partners. However, headquarters and its partners expressed doubt about the capacity, qualification and experience of managers at district and sub-district levels to identify, analyze and write policy. One of the senior staff in the Ministry of Health noted:

We need to pay attention to the capacity and qualification of the managers’… experience in identifying, analyzing and writing… Have we put the right man in the right place? Have they been prepared, trained? These are my concerns…Good policies, structures, guidelines are in place but these are not enough. We need capable human resources to implement these things well to achieve the objectives and obtain good results. (Headquarter 3)

Headquarters and its development partners recognized that an important aspect of responsiveness of the Ministry of Health is to provide health policies, tools, guidelines, procedures and formal directives to ensure the implementation of health policies and programs in the field. However, it is still to be implemented. The researcher found that some health policies and strategies have no tools and guidelines. For example, when the participants were asked if there are any guidelines
or procedures for supervision and inspection available, one participant occupying a key position in the Ministry of Health said, “We have no guidelines available. We just develop our schedule and implement it every year according to the annual action plan. We have thought about developing guidelines but our human resource capacity is very limited...” (Headquarter 2). This is significant that state fragility is directly related to capacity deficits of individuals, organizations and institutions (Brinkerhoff, 2010). Governments need to have the legitimacy and capability to develop and implement policies. Carroll and Carroll (1999) acknowledge that there is mutual relationship between policy capacity and legitimacy, particularly in developing countries.

The achievement of policy objectives requires rules and regulations as policy instruments (Bemelmans-Videc & Vedung, 1998; Salamon, 2002; Schneider & Ingram, 1997) established by government to regulate activities. Structurally, some procedures and guidelines have been developed by the Ministry of Health. Unfortunately, they have not been well implemented by departments, institutions and both District Health Services. Reasons for the poor implementation included the lack of capacity and leadership of managers. It was contrary to the precondition for perfect implementation raised by Hogwood & Gunn, (1984) and direct and indirect impacts on implementation (Edwards, 1984). Some tools are yet to be developed, including those for monitoring and evaluation. Policy instruments such as procedures and tools are to assist policy implementers in the filed to improve good governance issues such as responsibility and accountability (Birkland, 2005; Bemelmans-Videc & Vedung, 1998; Salamon, 2002; Schneider & Ingram, 1997). The Ministry of Health needs to identify and pursue pathways to capacity building and risk management in health policies and programs.

**Similarities: Shortage of health staff**

On the ground, the Ministry of Health encounters a shortage of health professionals within public and private health facilities. Data in Table 5 shows that workforce in Community Health Centres and Health Posts in both districts had a heavy workload, as indicated by the ratio of health care providers to patients. The data also indicate that District B is significantly under-resourced when compared with District A. The researcher found that, in collaboration with the central office of
the Ministry of Health, the District Health Management Team of District B has recruited more administrative and other support staff than health professionals. However, there were no data to indicate how their leadership has improved to better manage these shortages and ensure the provision of quality health care service to the community. The support administrative staff was relatively strong in terms of numbers and usually has enough staff to fill all positions at the level of the District Health Service, though not all positions in Health Posts headed by a health professional. Therefore, both districts also lamented the lack of health professionals in their area to deliver health services to community. There were several reasons for this shortfall. Under Indonesian rule many positions were occupied by Indonesian nationals. After the violence of 1999 referendum, Indonesia officially pulled out of East Timor, and thus many health professionals, senior administrative and other technical staff abandoned their positions. From August 2000 civil administration was managed by United Nations Transitional Authority (UNTAET). In rebuilding the health system in Timor-Leste at that time UNTAET recommended recruiting 1,500 staff but CNRT\textsuperscript{34} were concerned that they would not be able to support so many staff in the future. Thus CNRT only accepted 1,087 Timorese health staff (Smith, JH, 2001). This is significant in that, in a post conflict country, CNRT needs to identify and understand how conflict affects state institutions and their political, economic and social foundations in the future, and how conflict legacies affect post-conflict state building processes. This concern is relevant in post conflict and fragile states as the first step in strengthening governance and public administration institutions is to specify and analyze current capacities, challenges and opportunities of the state (International Dialogue on Peacebuilding and Statebuilding, 2012; United nations Development Programme, 2005; United Nations Economic and Social Affairs, 2010).

The focus of the Ministry of Health in Timor-Leste was on the provision of basic health services (Democratic Republic of Timor-Leste, 2002b). Each District Health Service had four staff and each Health Post, two health staff. The Ministry of Health then announced that they would conduct a redistribution and recruitment of

\textsuperscript{34} Conselho Nacional de Resistência Timorense - National Council of Timorese Resistance coalition formed in 1996, uniting UDT, Fretelin and others on Independence platform. Replaced CNRM in 1998... Dissolved July 2001
health staff, depending on the budget and based on the workforce development plan (Ministry of Health Timor-Leste, 2007b). It was intended that as a result of this initiative, by 2020, each Health Post would have two midwives Level Four and two Nurses Level Four to serve 1,000-5,000 people, or 200-1,000 households as identified in the Basic Service Package (Ministry of Health Timor-Leste, 2007a, 2007b). Currently, approximately 4,000 health staff are working in Timor-Leste, with a ratio of medic to citizen of 1: 250. District B is far from achieving its goal in this regard.

The Ministry of Health headquarters and its development partners had an adequate understanding of the significance of responsiveness in the health sector. However their theoretical understanding is not always practiced in the Ministry of Health. They realize that the Ministry of Health responsiveness to staff providing health service delivery was poor. They have a clear understanding of the meaning of responsiveness, which they defined to include: provision and development of health policies and technical tools to facilitate service delivery at the grass roots; provision of equity of service as per Timor-Leste’s constitution; development of relationships and partnerships with relevant ministries and development partners to support health professionals by ensuring they have adequate human resources, funds, medication, infrastructure and other logistical support; and the provision of monitoring and evaluation of health activities in the field.

Unfortunately, responsiveness, according to any of these definitions is not in evidence within the Ministry of Health. These findings had huge implications for the quality of health service delivery to communities in both districts. The lack of responsiveness contributes to increased morbidity and mortality rates of communicable and non-communicable diseases; decreased morale of health professionals delivering services and burn-out of health professionals; inequity in access to health services especially for those in remote areas; communication of concerns from local government to central government; and increase in number of patients referred to the national hospital. Headquarters should be responsible both for the fulfilment of predetermined health policy goals and for the responsiveness of health policies to the needs of those members of the community who most depend on public health services in remote areas.
**Similarities: Reward and promotion of health workforce**

Another manifestation of responsiveness in the health system constitutes government’s acknowledgment and reward of its staff. This can take the form of promotion and salary increases based on qualifications and experience. Financial rewards, other incentives (housing schemes, transport, family welfare benefits) and promotion of health staff were issues and concerns similarly reflected in both District A and B. Research in other parts of the world has found that health facilities can retain valuable staff and motivate health staff through direct financial rewards such as compensation and benefits (New England Baptist Hospital, 2009).

The Timor-Leste central government has a system called *Regime Carreira* (Career Regime), which seeks to motivate and retain staff through increased salaries; offers of rewards; consideration of experience, background, and education. Unfortunately, *Regime Carreira* is under the process of development in coordination with the Ministry of State and will need much time to be approved and implemented. This system development involves a range of stakeholders including other ministries and professionals. To reward civil servants, the East Timor Council of Ministers has approved the scheme of allocation of scholarships to civil servants (Democratic Republic of Timor-Leste, 2008a). Presently, some health staff including some in districts in this study, receive scholarships from the East Timorese government to attend formal and informal training and education within Timor-Leste and overseas. However, staff also demand good salaries based on the career regime system as planned and promised by government. Fieldwork revealed that the current salary of health professionals is considered very low. Under this condition some health professionals of the Ministry of Health and both District Health Services are forced to supplement their incomes with additional paid work. This increases the likelihood of high turnover and poor performance of staff and of staff engaging in unprofessional behaviour. It also leads to corruption and misuse of government resources as staff use work time, transport and equipment to do other work providing additional income.
Similarities: Ethics

Most participants reported that poor health professional ethics in the workplace was affected by a shortage of health professionals, very low salaries, the absence of rewards and incentives from the District Health Service and Ministry of Health, poor infrastructure and other logistical support in health facilities. These problems and their impacts were the same in both districts. When questioned about this, one of the health associations responded:

There were complaints that the health staff particularly the midwives have been very unsatisfactory in providing their service and assistance to the community. We have conducted a number of seminars that focus on professional ethics. However it has been not very effective in changing the attitudes of the staff. I think it might be caused by other factors, such as low salaries, which are insufficient to maintain a decent standard of living lead to them not performing their job at their best. (Stakeholder 8)

A senior medical doctor who occupied a new position in an institute under the Ministry of Health observed:

Well ... if we are talking about professional ethics, particularly in the health sector, I think the attitude toward the patients is poor and this attitude pervades not only one or two health facilities but all health facilities in our country. It is not just nurses or just health technicians or just the doctors. They are all the same. … My observation is that the health providers do not have enough patience. They feel they are an important person, whom the patient must listen to and obey. Even when they are just chatting to each other, no patient should interrupt them… (Headquarter 11)

The fieldwork revealed that many research participants felt that health professionals employed by the Ministry of Health were in an ethical crisis. The Ministry of Health frequently receives many complaints about the discourtesy and lack of professionalism of health professionals. This needs special attention. The underlying causes may include the fact that health care providers are working under pressure, with high workloads and low salaries. However, other factors that influence the treatment provided by health care providers include concern with patients’ social
status. For example, some staff give attention to influential or high status patients and prioritize them over other patients. One participant as a senior medical doctor noted:

… When I arrived I did not know the local people. Where they come from? What are their titles? From which party they are? I did not know these people. But from the attitude of the health staff I came to understand who these people are… Whether they are the owner of a big shop that I never knew before. When I saw the nurses or doctors or health professionals all are trying to assist, then I had a feeling that this must be an important person. I then asked who is this person? The answer was ... he/she is a leader, owner of that shop or the leader of this party. … These are attitudes that I have seen not only from doctors who have been working here for a long time, but also for new doctors who have just started working in this health facility including the international doctors. (Headquarter 11)

This behaviour and these attitudes impact on the equity in health care and lead to discrimination such that some people cannot access good quality health care provided by health professionals. In addition, the researcher found poor professional ethics not only in the remote health staff within both districts but also with top decision makers in the office of central administration of the Ministry of Health and District Health Services.

One significant concern of the Ministry of Health’s partners was that the top decision makers lack friendliness, consideration, and respect. They often avoid meeting stakeholders, counterparts and staff even when solving a problem or discussing urgent concerns. Stakeholders tried to make appointments with the top decision makers but they responded that their diary was full of meetings, even for months ahead. A stakeholder stressed, “…We have discussed issues with the middle level managers in the Ministry of Health but it needs leadership from top decision makers… They put themselves on a pedestal and therefore it is difficult to meet with them or have questions answered…” (Stakeholder 2). This response from Stakeholder 2, could suggest that the Ministry of Health decision makers did not know how to resolve problems and address the issues.

Poor professional ethics by health staff in both District Health Services and their superiors (top decision makers) in the workplace were an impediment to collaboration and trust from partners and communities in health development at
district and sub-district levels. Top decision makers are role models for staff and communities so they should behave competently and professionally to create a conducive atmosphere and culture in the workplace. The researcher found from this fieldwork three factors that have emerged that appear to influence professional ethics in workplace particularly in both District Health Services and other health institutions: (1) economic factors; (2) the capacity of the government to respond to health staff and community needs; (3) and the individual behaviour of the health professional. Economic factors refer to some health care workers’ choice of profession because it is easy for them to find employment and better their income. The World Health Organization has reported a cause of the shortage of doctors and nurses in the developing countries as these workers look for jobs in developed countries (O’Brien & Gostin, 2008), where they are able to earn a significantly higher salary. The WHO code of conduct should be addressed by the Ministry of Health’s staff. There is a need for a code of practice or procedure in Timor-Leste health facilities to guide and support health professionals in doing their jobs. There is a policy and procedure in the Timor-Leste Statute of the Civil Service but it was poorly implemented by top decision makers and health professionals.

Personal qualities required by health professionals include at least compassion, patience and empathy, responsibility and creativity. They should have good communication skills, excellent time management skills, interest and respect for people’s needs, maturity (Kenny, KE, 2006; Kenny, NP, 1996), problem solving skills, physical and psychological health. Moreover, a health professional must be able to work hard, and practice their profession with honesty, integrity and neutrality. These factors are essential to ensure health professionals’ ethics in the provision of health services in the health system. Because this system relies on teamwork among various health professionals, health care providers should be able work independently or in a team, create a cooperative relationship with communities or patients and their relatives as well as other health professionals and support staff in a health facility. People come to a health facility because they need professional attention, therefore a health professional should attend to this person with professional skills and knowledge. This is not easy for everyone to do. If a person wants to dedicate him or herself to serve other people, the researcher believes that the ethical problems can be resolved, but if a person becomes a health professional for
other reasons (status and money) it will be a challenge. But it is not possible to transform public administration without transforming the beliefs, attitudes and behaviours of political leaders and civil servants so that they perform effectively within a democratic setting (United Nations Economic and Social Affairs, 2010).

Another important concern of both districts was the unduly complicated bureaucracy in local and central government offices including the Ministry of Health and both District Health Services with implications for ethics and integrity. Bureaucracy constitutes the rules guiding how policies are implemented and is important for the development of work performance (Hyden, Court & Mease, 2003). In contrast, the weakness or inefficiency of a bureaucracy can lead to poor work performance. For example when a local government is affected by political pressure, the bureaucracy may disregard the need for professionalism (Blunt, 1983; Hyden, 1983).

The researcher found that the unduly complicated bureaucracy of both District Health Services and some public offices in central government in Timor-Leste had been influenced by the colonizing Indonesian bureaucracy. Blunt (2009) has highlighted that during twenty-five years of Indonesian occupation in Timor-Leste the Indonesians left ineradicable marks on bureaucracy practice. Within this system bureaucrats were working ineffectively and inefficiently though the public relies on their assistance in the processing of requests. An example from the District B, a patient’s relative waited such a long time for a bureaucrat to process his relative’s documents that the relative passed away. This example highlights that whilst the public is dependent on the bureaucracy, the public’s needs are frequently not met (Hyden, Court & Mease, 2003). It is reasonable to assume that the attitudes and behaviour of leaders in public office are a significant factor disturbing the quality and existence of governance and public administration institutions.

**Similarities: Power**

The next governance factor examined between the two districts pertains to the individuals and agencies who hold power to influence health policies and issues. In both districts this includes central and local government authorities, the Catholic Church, NGOs, donors and contractors (who have money) and leaders of dominant
political parties. People, agencies and institutions in both districts have the decision making power and the capacity to influence and intervene in any health policy or issue, simply because they have money or can exert influence. However, health staff with much experience and formal qualifications are often silenced and disempowered.

When the researcher interviewed headquarters staff and the Ministry of Health development partners, they understood the meaning and definition of power in the health sector to include: legislation and policies that refer to and control all health activities; the ability of managers and leaders in the Ministry of Health to make decisions that affect community health; something possessed by people who have money such as donors and political parties; and institutions that have charisma, for example Catholic Church and some traditional power structure in some villages.

Traditionally, in Timor-Leste people are influenced by men rather than women, as men are perceived to have responsibility to earn the money and who supposedly have influence, courage, experience, knowledge qualification and skills. Timor-Leste history and experience and the current governance focuses on power impacted by past colonizers (Portuguese and Indonesian), patriarchy and the now dominant political party. For example, Turner and Hulme (1997) state that in developing countries the nature of power has been influenced by international factors such as activity of colonial powers vested in the hands of small number of people. This top-down administration and management systems characterises the central government of Timor-Leste including the Ministry of Health and both districts. These power plays have affected the governance in health systems to accomplish health indicators and objectives as planned in both districts. Managers of both districts have a tendency to consult about a problem with a senior manager such as national director, director general, vice minister and minister to get feedback and instruction before making the decision. This shows that a manager or director in the Ministry of Health and both District Health Services cannot or will not make a decision on their own. This may be in part to avoid accusation of wrong doing at a later date.

35 Means the powerful personal quality that some people and institutions have to attract and impress other people.
A key person in the Ministry of Health said “In Ministry of Health normally we consult each other (director general, national directors and head of programs) before taking a health decision, but the final decision is undertaken by top decision makers the minister and vice minister” (Headquarter 1). It seems that this system points toward “fear of failure” or of “upsetting the minister” and leads staff to become risk averse.

**Similarities: Decentralization of power**

Decentralization of the health delivery services, and the lack thereof, was a big concern in both districts. Decentralization refers to the transfer of decision-making power and administrative matters from central government to the local government (Bossert 1998; Rondinelli, D.A. 1980). Similarly, most participants from the Ministry of Health and its partners noted that according to their understanding of decentralization of power in the health sector, the current level is insufficient. Decentralization comprises various components; political, administrative and financial, public planning management and services delivery (Akin, Birdsell & De Ferranti, 1987; Bossert, 1998; Jeppsson, 2001). Participants who serve at central administration of the Ministry of Health and its development partners were asked about the actual level of decentralization of power to the District Health Services and institutions under the Ministry of Health. Some stated that the Ministry of Health did not delegate full authority and responsibility or allow flexibility to make decisions and manage expenditure in line with community needs. A key person in the Ministry of Health commented:

…The behaviour of health managers needs to change, so that in coming years health management operates as we expect, … It always creates difficulties and obstacles in daily management in the field. From my point of view they (District Health Services and health institutions) need a strong and capable district advisor to assist them everyday (based in the district). However, they have the advisors but 3-4 District Health Services have one advisor, and the advisors are based in Dili and go to the district “if needed”. … Government should resolve this issue (the capacity of managers). This factor impacts on decentralization of the system … (Headquarter 4)
Another person who occupies a key position in the Ministry of Health stated:

There are five categories of budget. Namely: salary and wages, goods and services, capital minor, capital development and recurrent transfer. Salary, capital minor, capital development all centralized in central government. In all of these categories there is room for decentralization. The decision just needs to be made at the top and then health institutions under Ministry of Health will manage, but so far no one is approving this. Currently only goods and services are managed in the districts, but most things are centralized here (he pointed to his office table) such as finance and fuel. (Headquarter 13)

Legislation and policies play an important role in the Ministry of Health’s control and overseeing of health activities. The framework is very clear about the need for decentralization and that policy has been strongly promoted (Democratic Republic of Timor-Leste, 2002a; Ministry of Health Timor-Leste, 2002a). The establishment of District Health Management Teams (DHMTs), recruiting staff to these teams and subsequently supporting them has contributed to better structuring and functioning of the health system. District support advisors were recruited with the objective to support districts. The research found there has been a lack of engagement from some of the national managers in the district support.

Participants stated that since 2002 the Ministry of Health has hosted a council of directors meeting at the Ministry of Health central administration every week under the leadership of the minister and the vice minister. This has been an encouraging process. The Health Policy Framework 2002 is also presented to a number of ‘political’ bodies, such as the National Health Council and District Health Councils, who hold the power to make health related decisions in their area. These structures have not been well implemented. The reason of both districts for this was not clear, because the need for such structures has been very obvious.

Currently the Ministry of Health has not decentralized full authority, responsibility and flexibility to make decisions and manage expenditure to health institutions under the Ministry of Health including both District Health Services as decreed law (Democratic Republic of Timor-Leste 2002a, 2002b; Ministry of Health Timor-Leste, 2002a; World Health Organization, 1978). The key reason for this was due to the lack of human resources. Beetham (1991) emphasises that the preconditions for holding power include personal capacity, knowledge and skill.
However, without decentralization of power from the central administration of the Ministry of Health, local capacity and empowerment make a significant difference in the local health outcomes. The Ministry of Health is still structured and working the way it has in the past. For example all finances are managed vertically from the Ministry of Health to the District Health Services, which is contrary to the goals of decentralization as stated in Timor-Leste constitution and other official documents.

**Similarities: Catholic Church**

Due to the history of Timor-Leste, the Catholic Church has significant power to influence some health issues. The Catholic Church promulgates customs and traditions in Timor-Leste that presently play an important role in health policy development and implementation. The Catholic Church, supported by the traditional structures in the community, has a strong influence on any health activity related to family planning, HIV/AIDS and mother and child health in both districts. As a majority of Timorese (97%) identify as Catholic, the Catholic Church is respected by the Timorese government and community and has a strong influence on social issues including health issues in Timor-Leste. Traditional power structures are also respected in some villages in both districts and there is often mutual respect and collaboration between the representatives of the Church and of the traditional power structures. A participant from civil society and partner of the Ministry of Health observed:

The Catholic Church has a strong influence on the health policies in Timor-Leste, particularly those related to family planning and HIV/AIDS. The Catholic Church does not permit sex outside of marriage and abortion. Most ceremonies in Timor-Leste normally commence with a Catholic prayer and a new public or private office is always consecrated by a priest before using...

Representatives of the traditional power structure, such as descendants of liurai (king) and dato (aristocracy) have charisma and are respected by their local communities. In 2005 there was a big demonstration for about 18 days against government by the community and the Catholic Church, because the national curriculum for basic education did not incorporate the teaching of religion and Catholic doctrine in public schools. (Stakeholder 5)
Another partner of the Ministry of Health added:

The Catholic Church is always invited by Ministry of Health to participate in the development and implementation of health policies, specifically those pertaining to family planning, abortion and HIV/AIDS. Our roles are to provide suggestions, scrutinize if needed and ensure that the policy represents the identity of the East Timorese and respects human beings, as well as overseeing the policy implementation in the field. (Stakeholder 3)

The Catholic Church has its commandments, which must be obeyed by everyone who identifies as Catholic. Historically, the Catholic Church has a significant place in Timor-Leste, in the promotion and defence of human rights, dignity and value of each person especially during the occupation of Indonesia. The Catholic Church is revered in Timor-Leste but the potential that religion has to uphold values and spirituality in policy development has been neglected (Collins & Kakabadse, 2006). Some experts have argued that religion such as Catholicism and Eastern Orthodoxy discourages abuse by public officers (You & Khagram, 2005).

In Chega it is written that “The Church continues its mission to protect and promote human rights in Timor-Leste both through its services to the community in health, education and other areas and, where necessary, through public advocacy in defense of human rights” (Comissão de Acolhimento Verdade e Reconciliação de Timor-Leste, 2005). These are some of the reasons why the Catholic Church, with support from traditional structures has power to control and intervene in health programs, policy development and implementation related to both human life and human rights in Timor-Leste.

This has both negative and positive implications in terms of achieving health objectives, indicators and outcomes in health system. For example, the current fertility rate in Timor-Leste is 5.7 (Democratic Republic of Timor-Leste, 2009-2010). This means that between the ages of 15 and 49 years the average Timorese woman will bear five to six children. This is the highest fertility rate in South East Asia and Asia (Population Reference Bureau, 2010). Fertility is an important component of population dynamics that determines the size and structure of the population. It has serious implications for the health of women and children. Globally, strategies are being identified and implemented to gradually reduce the population growth rate through family planning programs.
For Catholic health professionals in Timor-Leste particularly in both districts the fertility rate poses dilemmas in their professional practice. On the one hand they have an obligation as health professionals to provide information about artificial and natural family planning methods in order to enable families to plan and space their children. This constitutes an important part of improving the health of women and children. On the other hand their religion opposes both the deliberate prevention of conception within marriage, and sexual relations outside of marriage. The Catholic Church does not forbid family planning. However it proposes that family planning methods should conform to the ideals and doctrines of the Church, in order to be acceptable rather than ‘sinful’ (Pope Paul VI, 1968).

Catholic health professionals in Timor-Leste and especially in both districts can provide information about natural and artificial methods of contraception. They should provide clear and accurate information about all methods including the function, advantages and disadvantages of the artificial methods to the married couple and individuals, but then advise their clients about the methods acceptable to the Church. This allows clients to make choices informed by both scientific knowledge and their own moral consciences. There are challenges for health professionals in Timor-Leste posed by the varying levels of education and commitment to religious law. But Catholic health professionals should make effort to achieve health objectives without undermining and offend the moral principles, dignity, identity and culture of Timorese families and society.

**Similarities: Gender and the patriarchy**

Gender equality is a new concept in Timor-Leste. Many, including staff and managers within the Ministry of Health continue to manifest a patriarchal attitude toward women and girls. The belief that only men have the capacity and right to make decisions is widespread and permeates general society even when female colleagues possess greater knowledge, experience or qualifications. The researcher identified that not one female health professionals occupied a position as the director or manager of a Community Health Centre in either districts. A middle level manager in the Ministry of Health commented:
The Timorese government campaigns everywhere about gender equality, but unfortunately, some Timorese maintain the understanding that the man is the person who leads and should dominate women and children at home. He is the person who has the responsibility to earn money for the family. Consequently, some men still hold this understanding even in the office. For example, in our office (MoH) in any discussion about health policy or programs, they always listen to men rather than women even when the women have greater knowledge and experience. (Headquarter 11)

A female participant of headquarters added:

…Whenever an important position is being filled they always appoint men not women, unless there are alliances caused by party membership. …Some men have less skills, experience and qualification than us … but they occupy the key positions here in Ministry of Health and its institutions (DHSs). If a woman does get chosen to occupy a key position it means she has really proved herself, whereas men who make serious mistakes are still appointed to positions of authority. (Headquarter 12)

It is not surprising that male decision makers in the Ministry of Health have doubts about women’s capacity and capability in Timor-Leste. Historically women’s human rights have been seriously undermined (Nelson & Consultants, 2008). Indonesian and Portuguese colonizers have played an important role in this. As a result, centuries of Timorese culture are permeated with patriarchal ideas about appropriate gender roles. The patriarchal system makes women become financially and socially dependent on men.

This is not limited to Timor-Leste, but rather is a worldwide phenomenon. In Korea, for example, women have always been subordinated to men and the men have created social structures in favour of themselves (Young uk, 2011). The values of the patriarchal system are instilled in children throughout the socialization process in Timor-Leste, beginning in the family and replicated in other sectors of society such as political structures, governmental and non-governmental organizations. Women participation in post conflict governance is vital, particularly in multi-ethnic and multi-cultural societies. When a group of citizens does not identify with the symbols, legal systems and institutions of a state, its legitimacy is seriously undermined (United Nations Economic and Social Affairs, 2010). This causes social turbulence.
that can slow down rebuilding and development processes or even contribute to violent conflict.

Ministry of Health data show that if a female leader is chosen she has to prove her capability twice as much as her male counterparts, although she may have greater qualifications, skills and experience than male counterparts. In Timor-Leste, women have played an important and effective role in the independence process: for example they engaged in negotiations with other associations inside and outside Timor-Leste and Indonesia to achieve consensus on independence. Women mainstreaming is a key strategy for the improvement of health outcomes and community wellbeing. In many cases, women are a strategic factor for peace in the political and democratization process (International Dialogue on Peacebuilding and Statebuilding, 2012). But the research shows that they tend to be marginalized in the health system development process and leadership initiatives in both districts, and also in the Ministry of Health. Special attention by political and government decision makers should be given to increasing the participation of women in health services, peace building efforts, and in leadership initiatives.

As a result of the patriarchal values and structures that permeate Timor-Leste’s culture and society today, government decision makers still doubt Timorese women’s capability to occupy key positions in the Ministry of Health and both District Health Services regardless of her actual capacity. However, the Timorese government has created through decree-law No. 16/2008 a position of Secretary of State for the Promotion of Gender Equality (SSPGE) to promote and defend gender equality (Democratic Republic of Timor-Leste 2008b). Various workshops, forums and campaigns are conducted by this institution to promote gender equality and governance in Timor-Leste, including both districts. The responsibility of promoting gender equality lies at all levels of government and society however and proves to be extremely challenging.

Lotfali (2006) has pointed out that there are various complex obstacles to engaging Timorese men in gender equality, for example, Timorese cultural traditions and perceptions. Therefore, Lotfali (2006) and Keating (2004) assert both formal and informal education on gender equality are needed to engage men and should incorporate all these aspects and be introduced by trainers who have strong experience, skills and background in equity issue. This research revealed that
Timorese women also tend to undermine the achievements and opportunities of other women and can promote disunity. Additionally, problems can arise when women who identify themselves as ‘educated’ or ‘important’ avoid contact with other women whom they consider as ‘uneducated’ or ‘unimportant’. This elitism encourages disunity among Timorese women themselves increasing the distrust or contempt that male leaders may have for female colleagues.

**Similarities: Relevant ministries, donors and partners**

The functioning of the health system in both District A and B are supported by other relevant public departments, donors, and partners, as health is not solely the concern of the Ministry of Health as health links directly with other social issues as well. Therefore, relevant ministries such as Education, Social Solidarity, Agriculture, and Infrastructure among others have influence on health policy development and implementation that is the social determinant of health. Additionally, funding is a principal resource in the development and implementation of any policy so donors, international agencies and NGOs always influence and intervene because they hold the money. A participant who holds a key position in the Ministry of Health articulated, “In the development and implementation of health policy, the most influential factor is donors and international agencies because of money. It could be the determining factor, it is very important…” (Headquarter 3). Another decision maker in the Ministry of Health noted, “… When partners and donors give money they often manage the programs directly….“ (Headquarter 1). However, direct technical and financial assistance to governments in post conflict countries can also have negative impacts (United Nations Department of Economic and Social Affairs & United Nations Development Programme, 2007).

The public sector (government departments and service providers) in developing countries recognizes that private sector and donors have important roles in planning and implementing development activities. The role pertains particularly to investment, innovation and management (Harding, 2010). After Timor-Leste attained independence in 2002, the Timorese government was faced with many challenges in the process of rebuilding government systems and in development processes generally. Ninety percent of revenue in East Timor comes from oil and gas (AusAid, 2009). A further challenge was the country’s dependence on oil with
weakness of the non-oil private sector. The Timorese government has many agreements with UN agencies, NGOs, donors and bilateral cooperation with some developed countries, to provide funding to rebuild the government system including the health system and promote governance and economic growth in Timor-Leste. However, the major concerns of developing countries include lack of predictability of donors’ continuing aid to support health plans and meet budgets (World Health Organization Regional Office for the Eastern Mediterranean, 2007). This approach is in conflict with the spirit of good governance. The United Nations Department of Economic and Social Affairs & United Nations Development Programme (2007) assumes that donors’ assistance in post conflict countries can destroy whatever administrative capacity exists to absorb and coordinate a large influx of funds, technical experts, and donor design.

The researcher found that some donors and agencies have specific objectives in both districts, so only provide budget allocations that conform to their priorities, and seem to care little about other community demands. For example, the aid focuses on treatment of certain illness and programs, but not for community health volunteers to conduct SISCa activities in villages and hamlets. Undoubtedly, they have the power to influence health issues and policy development and implementation in the field simply because they control the money. Experiences in post conflict and fragile states show that donors may work at cross purposes, focus their aid on what the government considers inappropriate functions, or pressure governments to attend to functions that political leaders believe have low priority within the country (United nations Department of Economic and Social Affairs & United Nations Development Programme, 2007).

**Similarities: Accountability and transparency**

Other similarities of governance compared between the districts include transparency and accountability. In both districts, participants said that transparency and accountability in the health sector were lacking. This was particularly true in the areas of human resources management, communication of health plans, budgets and reports on health policy implementation, and provision of health information to the public. Headquarters and its development partners have an understanding of
transparency as it pertains to the health sector. Their definitions include: provision of clear health information to the public through the media, Catholic Church and other channels; public access to documents outlining health policies, procedures and expenditure of funds; accountability and active resistance to corruption and abuse of the system. However, it is apparent that their understanding is theoretical and does not reflect the actual practice of the Ministry of Health. A majority of participants from headquarters and partners recognized that transparency was lacking and needs serious improvement in the Ministry of Health and its institutions including District Health Services. There are several reasons why there was a lack of transparency and accountability.

Human Resources in the Ministry of Health have no clear plan. For example they recruit some officials without clear job descriptions. Many staff are trained in various areas but not in accordance with the Ministry of Health expectations, particularly the local government district and sub-districts needs. The Ministry of Health needs further research to identify additional human resources required of the Ministry of Health including district and sub-districts. When the participants were asked about the processes of recruitment, allocation, distribution of positions and leadership in the Ministry of Health and particularly in both districts, a participant who occupies a key position in the Ministry of Health replied:

… Ministry of Health sometimes moves people from one position to another. Sometimes this is based on individual capacity but sometimes on politics and friendship. We need to have a clear policy and clear job descriptions. The MoH needs leaders who have qualifications, experience and also capacity to be a leader as well as capacity to write policy or attend to administration. We need clear policies so that individuals do not make decisions simply based on what they think is good at the time. (Headquarter 1)

Another senior staff in the Ministry of Health lamented:

The Ministry of Health’s human resources management and leadership are not transparent and this annoys some senior public servants in Ministry of Health and District Health Services. They do not consider senior staff’s experience and qualifications. Salaries are various but do not necessarily correspond to experience and qualifications. Rather they may be a reflection of the fact that a staff member is a relative or friend of those in power. Some
staff have just finished their study and have no background or experience in Ministry of Health. However, they occupy a level 4 or 5, compared to senior staff, who have experience and qualifications but are maintained at a junior salary. The MoH should promote and reward senior staff. We have Masters degrees but the levels of salary are still 3 and 4. We also have no clear job description and all this kills our motivation to serve our community. (Headquarter 14)

In an effort to increase the transparency of human resources management in health services, the Ministry of Health needs to establish a solid and thorough recruitment process to ensure the Ministry of Health employs staff who have qualifications, experience and capacity to lead and manage health system in both District Health Services and institutions.

The management of the financial system in the Ministry of Health and the participation of community leaders and other stakeholders in the development of plans and budgets for implementation in the field including both districts are not in place. The central and local administration (the Ministry of Health and both District Health Services) did not involve community leaders such as village leaders in the preparation of detailed implementation of plans and budgets. Community participation in local health planning is a key WHO strategy (World Health Organization, 2002). This aims to achieve health and appropriate improvement and development at the local level and enable community to become an integral part of the health decision-making and action process. The community is the best source of knowledge and information on health needs but also what and how they want to do to solve their health problem. Community participation is the key aspect that needed to strengthen governance in the health system and help local government become more accountable and transparent to public. Currently both districts only discuss the strategic health plan with community leaders and other stakeholders.

The researcher identified that information was centralized in Dili. Information was not trickling down to the grass roots in the way that the public expects. A partner of the Ministry of Health gave an interesting and simple example regarding the SISCa program “… educated people in the rural areas (districts) have information about SISCa, but others such as the elderly and farmers, do not know. This means that the quality and quantity of dissemination of health information is not
good” (Stakeholder 6). People expect that they gradually benefit from health policies and programs as a result of the spreading of health information. Another participant who is a development partner of the Ministry of Health observed:

…. Everything is centralized in Dili. Health campaigns are only done when a disease is already occurring among the community. From a media perspective there is lack of preventive action and health information provision to the public. I would like the Ministry of Health to have a regular program on TVTL, a public debate on heath issues including policies, programs and other health campaigns. (Stakeholder 7)

When the headquarters were asked if there is any formal letter to local government (district administrators and District Health Services) about the overseas referral system, it was reported by some health professionals in both districts that they were informed only verbally though they wanted a formal letter to support implementation in the field. A policy maker in the Ministry of Health replied:

We are not sure of our policy. Therefore we cannot inform the community. Our national hospital is not adequate to attend to some conditions, so we address our problem by sending patients overseas. We have to be careful because everyone wants to go overseas to have treatment. If our health service provision going well in Timor-Leste we would not need to send patients overseas any more. (Headquarter 1)

The importance of transparency lies in the fact that clear rules and openness diminish the possibility of misuse of public office (Hyden, Court & Mease, 2003) and resources. The implications of failing to address the lack of transparency in the Ministry of Health and its institutions involve both District Health Services, includes: reduction in the quality of health services to community; increase in corruption and nepotism in the Ministry of Health in Timor-Leste; creation of tension among health professionals and leaders; increase in power abuse by health decision makers; and facilitation of unequal access to health information and health services by communities in remote areas. Hyden, Court and Mease, (2003) have commented that corruption is mostly conducted by civil servants and encountered at the ministerial level.
Accountability of the Ministry of Health and its development partners was poor within the country. Some participants have limited understanding of accountability. They are unclear about what should be reported to the public but recognized the need for accountability to such as people and agencies, the Parliament Commission and service institutions under the Ministry of Health. The Ministry of Health and both District Health Services did not practice accountability in their relationships with other health actors in the field such as health providers in remote areas, community and community leaders, community health volunteers, local government officials (district and sub-district level), NGOs, donors and international agencies. However, Farazmand, (1997) has argued accountability in the public service is very important because there are many aspects of administrative work that are open to corruption and undermine the power and authority to the public interest. People accountable for their implementation and achievement are a vital principle of good governance (United Nations Development Programme, 1997) and systems of accountability are important to overcome corruption, collusion, nepotisms and misuse public office.

Accountability and corruption needs to be addressed in a country like Timor-Leste. Blunt (2009) stresses that in post conflict and fragile countries government is unable to offer basic services or maintain public order, let alone undertake anticorruption work. In developing countries involving post conflict societies, there is a need for a strong state to underpin the competence of the governing authority. This is necessary not just to provide security, protect human rights, and generate economic development, but also to extend basic services, control corruption, respond effectively to emergencies, and combat poverty and inequality (Rondinelli, 2006).

Participants (Headquarters) defined accountability as the presentation of general information about the health budget and activities through quarterly or annual reports. Currently these reports are only for certain recipients and not generally available. Additionally these reports did not give detailed information about budgets and expenditure in a transparent manner to the public. Information such as the amount of funds disbursed, for what activity, by whom, for how long,

36 A permanent commission among seven commissions is established insight of National Parliament specifically for Health, Social, Solidarity and Work.
guidelines for expenditure, and achievement (or non achievement) of indicators are often not included. Headquarters recognize that they currently have no mechanism to ensure accountability to the public. They were only accountable to institutions within the Ministry of Health and to parliament’s F commission.

Accountability is attended to through the presentation of quarterly or annual reports followed by discussion and/or through a regular auditing conducted by parliament. Accountability was also affected by the current financial system, which is not adequate in the Ministry of Health and both District Health Services. There was a lack of staff for the overseeing of health plans and budgets including a lack of accounting expertise. An overwhelming majority of participants recognized that the accountability system was overall poor from central government in general and especially in the Ministry of Health. With regard to the detailed implementation plan and budget, experience shows that the health financing system within the Ministry of Health was not adequate. Similarly there were problems with the health accounting system, which provides only functional budgeting. A headquarter respondent commented:

The disadvantages of the government accounting system include a lack of clear linkage between budget allocation and health program or activity. Budget allocation is the only link to functional line items, so people need to develop an internal health accounting system to link to the health programs and promote program based budgeting, because the current government accounting system is only based on functional budgeting. In my point of view we do not provide good accountability to the people or conform to international audits. We need to develop our health accounting system to respond to this situation… (Headquarter 4)

The Ministry of Health has not yet established an internal health accounting system. If this system were already established, the budget would automatically link to program components and activities. It will help staff (District Health Services and directors) prepare their proposals and requests based on a fixed budget, reduce unreasonable transfer of funds from one budget item or activity to another, and will make accountability easy. The central administration, particularly the Department of Finance, would benefit from such a system for verification and accountability as well. People could just click on the system to access reports pertaining to budget and
expenditure on activities. But this mechanism is not yet in place. The question is how the international technical and financial assistants contracted by the World Bank and other UN agencies have transferred their skills to Timorese health staff to support adequate financial management systems in both District Health Services and the Ministry of Health during the period of reconstruction, 2000-2009? The common reason was the lack of capacity and knowledge, including language skills of local staff to receive transformed skills. But participants from headquarter and both districts also lamented not all international technical advisors and experts had goodwill to transfer their skills to local counterparts. For example, participants noted that some advisors came to the office at 8am and just worked with their laptops and attended meetings until 5.30pm when they could return home. This was a daily routine activity of some advisors who returned to their home country when their contracts ended. This is a poor example international advisors left in Timor-Leste.

At the moment the Ministry of Health uses a flexible system, which entails giving staff cash who spend it at their own discretion. Some participants argued that the Ministry of Health’s system is still weak and needs improvement to be accountable to the public. However, in 2007 the Ministry of Health was presented with an award for the best performing financial management among other ministries in Timor-Leste (World Bank Group & Asian Development Bank, 2007).

An example of weakness of the financial system observed in both districts is the lack of similarity between the budget allocated by the Ministry of Health to the District Health Services and the proposed budget submitted by the local administration. The significant differences between the proposed and actual budget are often neither explained nor justified, due to the fact that the health plan and budget are prepared by the District Health Service but the budget is determined by the Ministry of Health. This has impacted in unexpected ways on financial procedures or mechanisms and disbursement of funds for activities, which have been planned by both District Health Services. Priority activities in both districts are often discarded because no budget is provided to implement them. Another aspect of leadership that undermines accountability is the tendency for politicians and top
decision makers to make \textit{planu hakfodak}\textsuperscript{37}. A participant occupying a senior position in the Ministry of Health stressed:

Our financial system is not going well. Our human resources for planning and budget are under strength. Secondly, plans may appear to be sustainable but in fact they are not. … Thirdly, the national plans were not good, not really responding to the set priorities. An example, health techniques named as \textit{planu hakfodak} (planning on the run/ startled plan/ situational reaction plan) for example, top decision makers always involve more than 3 or 4 staff for overseas visit and promised some ambulances and modern health equipments to community without a plan. (Headquarter 1)

These \textit{planu hakfodak} have huge implications for the quality of health service delivery to communities in both districts and for the unequal access to health care services and health inequity. This is because funds for both District Health Services’ programs were transferred and used by the central administration to overcome other unplanned activities in the Ministry of Health without communication to the District Health Services. Accordingly, communities and staff in remote areas of both districts suffer from an insufficiency of essential resources such as medications, health equipment, and other logistical support. As stressed by WHO (2007) governance in health systems needs to include mutual accountability for the development of equitable policy outcomes, transparency and sustainable approaches, and health legislation and measures to increase effectiveness. Much difficulty is created by the misuse of funds by health decision makers, abuse of power by political leaders at the highest levels, and the resulting lack of trust by the community, local government and health professionals. It has undermined the legitimacy of the Ministry of Health (Debiel & Terlinden, 2005).

\textbf{Similarities: Equity}

Both districts stated that they did not discriminate among patients and that they treat people equally regardless of gender, religion, socio-economic status, and

\textsuperscript{37} It is a plan made by political leaders and top decision makers within MoH. They make these sudden changes to plans and those in ground simply have to find a way to implement them.
political affiliation. However, according to the researcher’s observation and information obtained during the period of fieldwork, there was huge discrimination and health inequity in the health system in Timor-Leste generally, and particularly in both districts. The researcher argues that this inequity was affected by poor responsiveness (infrastructure and other basic needs), transparency and accountability of the Ministry of Health and District Health Services and a lack of professional ethics in the work place that impacted on the illegitimacy of health services in both districts. This also impacted on the social determinants of health (Marmot 2005), as these social disadvantages cause inequity in health accessed by a community. The consequences of this are ongoing inequity of health care, which contradicts the Timor-Leste Constitution (2002).

Equal access to public services by citizens is a critical indicator for legitimacy of the civil services (Hyden, Court & Mease, 2003). Globally health equity is affected by economic and political systems with health inequity caused by unequal distribution of resources: infrastructure; income; goods and services (Stewart, 2003; World Health Organization Regional Office for the Eastern Mediterranean, 2007). It is significant that low legitimacy can undermine effectiveness in the sense that citizens tend to withdraw support from governments that cannot provide basic services or create some level of economic recuperation and justice (Brinkerhoff, 2007; Goldstone, 2008). These social conditions can be easily prevented and stopped actually by local and central governments and their development partners in Timor-Leste, particularly in both districts.

Experience in post conflict states indicates that inequities occur as a result of inequitable provision of basic service, while improvements and changes in public services can be a factor in addressing fragility. Further, Meagher (2007) affirms that health service delivery can help to promote peace and reconciliation at the local level, and is an effective way to initiate engagement with communities particularly in post conflict states.

Therefore, the local and central governments particularly both District Health Services and its partners’ attentions should be given to the Asian Development Bank’s proposal that governments and their partners in post conflict states “… need to establish a basic policy framework, provide critical goods and services, protect and administer the rule of law, and advance social equity” (Asian Development
Bank, 1998, p. 15). Serious weaknesses in government capacity, leadership (including behaviour) and resources are the most difficult challenges of re-establishing and improving governance in post conflict countries (United Nations Department of Economic and Social Affairs & United Nations Development Programme, 2007; Farazmand, 1997; Hyden, Court & Mease, 2003).

**Differences: Dissemination of health policies, strategies and guidelines**

A difference was founded in the dissemination of health policies, strategies and guidelines between District A and B. The District A disseminated all health policies before implementing, however this did not occur successfully in B district. It is not surprising that B district did not meet health indicators and outcome that determined by the Ministry of Health. Also the local government including community leaders and communities of this district did not take part actively to support health programs and activities in the field, since they were not informed effectively of the objectives and targets of these health directives. The District Health Management Team of District B should be utilized by the Ministry of Health to disseminate health policies to stakeholders and community leaders within the district.

**Differences: Competence of local leaders**

Fieldwork revealed that the managerial and leadership competency of the director of District Health Service A has more experience and skills in this area, while the director of District Health Service B has low competency, despite both of them having the same qualifications. Both the directors have no formal qualification in management and have only graduated from Nursing School or Sekolah Perawat Kesehatan (SPK)\(^{38}\). It was clear from information from participants in District A, informal discussions with local communities and stakeholders, and researcher observation during the fieldwork, that the administrator of District A has a strong commitment, creativity and willingness to encourage other local officials and

\(^{38}\) *Sekolah Perawat Kesehatan* is equivalent to Nursing Certificate or high school level.
organizations to implement government plans including health programs. This indicates that local government officials take responsibility and offer good leadership in managing this district, which was evidenced in good performance and achievement of health indicators in District A. Leadership and governance functions are performed at lower levels (USAID, 2009). Achievement of health indicators is affected by the individual qualifications or lack of experience and skill, and motivation. It is mandatory for all managers (the Ministry of Health, personalized services, District Health Services, Community Health Centres and Health Posts) to participate in a short management training entitled “Community Health Centre Management and Leadership”, conducted by the Institute of Health Science (IHS) in cooperation with WHO. But there was no information available about the actual impact of such training on management and leadership performance or the achievement of health indicators and objectives in the field.

Headquarters expressed concern about the low level of capacity, qualification and experience of managers in the districts. However as headquarters themselves acknowledge, there are also many serving at headquarters the Ministry of Health who lack capacity to develop tools and guidelines to ensure the implementation of health programs in the field. On the other hand, an essential element for the accomplishment of post conflict rebuilding is the existence of competent and professional leaders in the local and central governments who are dedicated to transforming conflicts into peace (USAID, 2006; USAID, 2009). Thus, there is a need for training support in capacity building, including leadership and management in the health system at all levels throughout the Ministry of Health.

**Differences: Monitoring and evaluation**

Monitoring and evaluation are important aspects of responsiveness in governance of health systems. District B lacked monitoring and evaluation at all levels, while in District A a strong team comprised of all heads of programs conducted monitoring, supervision and evaluation of all programs every two weeks in the villages. Monitoring and evaluation are important aspects of the health policy process that assist in providing valuable information and giving guidance to
government or health implementers. They also assist the Ministry of Health department to improve governance (Birkland, 2005; Edwards, 1984).

The lack of monitoring and evaluation in District B leads to inadequate information regarding the efficiency, effectiveness and impact of programs in their area of jurisdiction. For example, there was a significant portion of the population in this district did not have access to information about HIV/AIDS and prevention of Tuberculosis. This information is needed to guide changes in implementation strategies or improving activities by health officials and implementers in the field to meet health and MDG objectives. This was in line with the report of the UNDP (2010) that some post conflict countries are not progressing toward MDG objectives and are mostly affected by poor human capacity in management and leadership.

As the local government and District Health Service in District B did not give importance to monitoring and evaluation health activities, they were unable to anticipate and prevent poor achievement of health indicators. By contrast in District A, constant monitoring and evaluation is a source of important information that contributes to the successful planning and implementation of health activities.

The researcher identified that the Ministry of Health did not have monitoring and evaluation tools or guidelines available. The Ministry of Health had just started to develop and integrate monitoring and evaluation tools into data collect. The Ministry of Health is waiting for the appointment of an advisor on monitoring and evaluation to help them to develop comprehensive monitoring and evaluation tools. This demonstrates that the managers and staff in the Ministry of Health and District Health Services still depend on the assistance of international advisors.

**Differences: Cooperation and participation**

Other differences of governance between health systems in District A and B were cooperation and participation. The researcher found there had been a lack of cooperation and participation in the District B. The reason was the local government officials (administrator of district and sub-districts including District Health Management Team) had poor awareness of the importance of supporting health staff in the provision of health services to community in the field. There was a lack of cooperation among them. This signified that the local government officials had poor
leadership, limited capacity, interest and willingness to manage and implement health policies and activities in their region to improve community health. However, they are elected to represent local communities, to provide appropriate social services including health services and respond to community needs and wellbeing in an effective and efficient manner. Improved cooperation will exist when a good relationship, consideration, respect and trustworthiness exist between the various parties, such as local government officials, implementers and especially the community as the primary beneficiary of the health programs. Evidence of governance in the public sphere is found when a wide range of organizations and institutions are linked together and engaged in public activities (United Nations Economic and Social Council, 2006).

The participation of community in health programs is also affected by the performance and attitude of health staff and local government officials. Local government officials (administrators of district and sub-districts including health officials) are the role models in a district, as the civil servants, village leaders and their communities try to follow the example of authorities in supporting health activities. Hyden, Court and Mease (2003) have identified that the behaviour of the civil servant is affected by that of the political leadership behaves. For example, if the elected politicians are corrupt and have poor ethical performance this tends to proliferate and expand to the civil services too. Another important factor is participation from the public, as they are the primary targets of health policies.

Health staff identified that they have a good cooperative relationship with Catholic Church, NGOs and private clinics in District B where health staff were assisted to influence community leaders (village leaders) and community to take part in health activities. It was clear that the lack of support of local government officials was a constant obstacle to the achievement of better health outcomes in District B.

An exemplar of cooperation and participation in health activities was found in District A. They also had a good cooperative relationship and coordination with all stakeholders in the health sector through Memorandum of Understandings signed by

39 Participation in term of development health plan and budget was lacking in district A (discussed in accountability and transparency). Participation here refers to communities’ involvement to support health programs in the field.
the Ministry of Health or District Health Service otherwise without Memorandum of Understanding. Many participants from headquarters observed that the Ministry of Health has established networks, signed agreements and MoUs with the partners both inside and outside the country before implementing health programs in the districts and sub-districts. However, a number of headquarters and development partners recognized that there was no MoU before developing and implementing health policies. One of the participants who is a partner of the Ministry of Health as well as a Catholic leader suggested:

…I suggest that for the future the Ministry of Health and Catholic Church sign an agreement or Memorandum of Understanding as the partnership between Catholic Church and the Ministry of Health, … An MoU gives a clear mandate and outlines the responsibility of both the Ministry of Health and Catholic Church during implementation of any health activity. …. The MoH needs to collaborate with all partners because health is not separate from other aspects of life. (Stakeholder 3)

The signing of the MoU is a critical aspect of cooperation and building relationships in the health system. It aims to promote a safe and coordinated system and clearly defines the roles and responsibilities of each part to achieve desired objectives as planned. It also helps avoid blaming each other during the process of implementation. The importance of signing a MoU to implement a project lies in the fact that it describes the need, the agencies involved, why it is necessary to work together and assigns responsibility (Ward, Kieman & Mabrey, 2006).

Cooperation in District A was manifest through a strong health network and good communication and contribution from all partners including village leaders and communities in the delivery of health services. Governance network refers to the set of connections of stakeholders through which they demonstrate their investment in the policy issues and capacity to contribute resources and competencies in the field (Torfing, 2005). This was demonstrated in District A and results in achievement of good health outcomes relative to District B. Buse and Walt (1996) and United Nations Economic and Social Affairs (2010) have argued that the involvement of different stakeholders facilitates health system function more effectively and in accordance with local priorities.
District A is assisted by an organization named ‘Pastoral da Criança’ (Children’s Pastoral) based in Brazil. This has been adopted by the Catholic Diocese of this region and makes a massive contribution to the reduction of mother and child mortality in this district. Participants of a pilot program in a sub-district stated they had no mother and child deaths during the year of 2008-2009. In Florestópolis-Paraná Brazil in 1983 the infant mortality rate was 127 deaths for every thousand children. Through assistance of the Pastoral da Criança fourteen years later that rate had rapidly declined to less than twenty deaths per thousand children (MacDonald, 2006).

Another important activity in District A is ‘community development’ created by local government. This program aims to empower communities to make decisions on their behalf and increase human and social capital (Becker, 1975) in terms of their knowledge, experience, education and competencies in various contexts including health and economics. An important part of human capital is relationships among community members and the ability to work together to solve local problems. Communities need to know the implications for their health and how to determine and promote successful health outcomes. Given the importance to health, the development of human capital underpins all activities. Through this program of community development District A has shown higher levels of knowledge and health awareness to support and take part in health system.

**Differences: Need for effective internal relationships**

District A has demonstrated a good internal relationship among health staff compared to District B. The poor internal relationship is found not only in District B but also in the headquarters of the Ministry of Health.

Some participants observed that cooperation does not only refer to MoUs, but also to good communication, coordination and relationships with partners. It was suggested that the Ministry of Health should improve internal relationships through increasing top decision makers’ skills in health management and leadership to ensure partners and staff trust the Ministry of Health. One participant who occupies a key position in the Ministry of Health observed:
Ministry of Health needs to provide a clear top-down guidance or instruction to guide them (top decision makers in Ministry of Health) to plan and approve activities. … Otherwise today they do this, tomorrow they have another thing to do without a plan. It creates confusion among the heads of department and implementers in the field. They (top decision makers in Ministry of Health) do not have good coordination, communication and relationships. This situation is not good for us as the implementers and staff are under their command to do our work. We need a harmonious place for work, good communication and relationships among ourselves inside an organization like Ministry of Health. … we have to show our good performance to ensure the trust of partners to have cooperation with us in delivery of health services to the community, because it affects our dignity and reputation. (Headquarter 6)

Another concern of headquarters and its development partners was how to create good communication and coordination among the staff in the Ministry of Health and District Health Services. A solution would be for the Ministry of Health to have a staff forum meeting, as happened in the past government, at least once a month to share information among decision makers and staff, and help each other to find solutions to problems. Staff meetings are an opportunity to discuss issues or problems, individually or collectively, that would benefit from the brainstorming, suggestions and input of the entire staff (Gross & Katcher, 1999). Participants from both districts and headquarters, including development partners, have an understanding of cooperation as it pertains to the health sector, which includes, for example, coordination, collaborative relationships, and signed agreements or MoUs with relevant ministries and bilateral supporters.

Why has District A managed to achieve four important aspects of the health system: dissemination of health policies, strategies and guidelines; competence of local leaders; monitoring and evaluation; and cooperation and participation, including strong internal relationship among health staff? Leaders and managers are crucial to an effective health system. The researcher found that the local leaders and managers of District A, even those with very basic formal qualifications, have the requisite knowledge and skills for leadership and management. However, the
managers in District A manifested the same problematic attitudes and behaviour as those in District B.

Chapter Six presents details of the way in which District A leaders and managers effectively built relationships with all participants in the implementation of health programs and successfully mapped activities to provide clear information about who was doing what. These relationships create an enabling working environment for health staff, partners, and local communities. Another factor contributing to success in District A pertains to availability of sufficient human and other resources. In District A, the Health Service has sufficient numbers of staff, logistical support, transportation, and equipment. These aspects are interrelated and combine to support the functioning of the health system in District A. The result is improved health services and outcomes.

Is the governance described in the Timor-Leste Health Policy Framework 2002 practiced? The evidence indicates that governance in both districts was poor. Thus the researcher argues that the elements of governance articulated in Timor-Leste Health Policy Framework 2002 are successfully implemented in neither A nor B districts. Although District A achieved some health indicators, it was not necessarily successful in the implementation of the Health Policy Framework as a whole.

The researcher assumes that the experiences of governance in health systems in the districts studied will be replicated in other District Health Services as well. Based on this assumption, it is suggested that the Timor-Leste Health Policy Framework 2002 has not been successfully implemented in District Health Services within the country. Poor governance in the health system critically affects health outcomes, equity, and the legitimacy of the health system.

CONCLUSION

Study of governance in health systems in Districts A and B, with consideration of its capacity to achieve health indicators and MDG objectives, demonstrated that there are similarities and differences in experience and history. The similarities and
The differences of governance in health system between the two districts also pertained to demography and geography, socio-economic background and basic human capital.

The similarities in governance elements in both districts include the lack of responsiveness of the District Health Service and the Ministry of Health and its development partners, lack of professional ethics of staff in district and national decision makers, manipulation of power and lack of decentralization, and a lack of accountability and transparency. The absence of these elements of good governance in both districts significantly impacted the efficacy and efficiency of the health system in the field including health equity and outcomes. Despite these common deficiencies, District A has struggled to achieve the target health indicators identified by the Ministry of Health, whereas District B has not. The achievement of District A was indicated through the implementation of four key aspects.

The differences in governance between the districts include dissemination of health policies, monitoring and evaluation, cooperation and participation of local leaders and communities. The capability of the local leaders including the administrator of the district and sub-districts, District Health Service officials, health managers and staff was critical to the successful realisation of health indicators in District A compared to the District B. Although District A successfully achieved health indicators, this does not mean that they also implemented governance in health system successfully and perfectly as indicated in Timor-Leste Health Policy Framework 2002.
CHAPTER 9: CONCLUSION

This chapter addresses the main findings of the study and draws out their implications for the health system under the conditions prevailing in Timor-Leste during the period of 2009 to 2012. The thesis explores the role of the central and local administration (Ministry of Health and District Health Services), as well as development partners who undertook the development and implementation of the country’s health policies.

An analytical framework was presented that illustrates the complexity of influences on governance at all levels, particularly in developing countries and more specifically in post-conflict and fragile states. This was used in an analysis of the development and implementation of the Timor-Leste Health Policy Framework 2002 with the consideration of context and an integration of the views of key contributors. The thesis explored the theoretical and practical components of good governance in the health system. These elements included structure, power, equity, ethics, cooperation, responsiveness, transparency, accountability, efficiency, effectiveness and participation.

The two objectives of this research were:

1. To investigate the significance of governance and power in relation to the development and implementation of health policies, structures and processes in Timor-Leste as prescribed in the TLHPF 2002; and

2. To analyse the significance of health governance and policies in terms of the delivery of health services in Timor-Leste, with particular reference to:
   a) the structures and processes that have been established, and
   b) the extent to which the structures and processes have enabled the delivery of health services and the achievement of health outcomes in practice.

The thesis examined governance in the health system in terms of the delivery of health services in two districts. This was presented through a progressive analysis and expressed in two case studies (Chapters Six and Seven) which described the
structures and processes that have been established, and the extent to which the structures and processes have enabled the delivery of health services and the achievement of health outcomes. One district revealed good performance in achieving health indicators and one district was shown to have poor performance.

MAIN FINDINGS AND THEIR IMPLICATIONS

Main findings

Timor-Leste’s Health Policy Framework 2002 (TLHPF) reported in Chapter Five is a foundation for all health micro-policies in Timor-Leste. It was developed by the Health Policy Working Group with assistance from international advisors as a part of the process of restructuring and rehabilitating the health system. The data confirmed that the development of TLHPF 2002 was dominated by international advisors and some senior English speaking Timorese staff of the Ministry of Health with other staff making a limited contribution, because of their limited knowledge and qualification of health policy processes and the English language. It was found that after the formulation of the TLHPF there was a lack of technical and practical guidance to support the effective implementation of the Timor-Leste Health Policy Framework 2002.

The policy analysis in both Districts A and B demonstrated that the development of health policies and procedures was dominated by powerful actors in central government (Ministry of Health and its development partners), including donors and contractors, the leaders of the political parties, and the Catholic Church on some specific health policies. Local government, particularly both District Health Services and their workforce had very little influence over the health policies and procedures. The result was that some of these policies were inappropriate to the situation in the districts, as each part of Timor-Leste has its own customs, traditions, and values.

The researcher identified that the District Health Services studied had limited qualifications, experience, capacity and knowledge to develop their internal guidelines and instructions based on health policies developed by the Ministry of Health. Some health policies and strategies from the Ministry of Health had no
guidelines. Some policies were provided with procedures and guidelines developed by the Ministry of Health but they have not been well executed for a range of reasons, including the lack of funding and the capacity and leadership of health managers in the field. District A did successfully disseminate health policies, strategies and procedures to all stakeholders such as NGOs, community leaders and the community itself within the area of their jurisdiction including remote areas before implementation. They also did the monitoring and evaluation of programs. This was not achieved in District B where the local administration did not actively support and participate in such activities. This limited the achievement of health indicators and outcomes in District B which in turn affected the sense of legitimacy of the health system and government administration.

Traditionally, men have held positions of power and influence in governance structures that have been based on those of colonizing countries, including Portugal and Indonesia. Top-down administration and management systems are still in use in the Ministry of Health. Female leaders chosen to occupy key positions in Ministry of Health have to prove their capability over and above their male counterparts despite greater qualifications, skills and experience than male counterparts. This research revealed that Timorese women also tended to undermine the achievements and opportunities of other women and can promote disunity, whilst supporting a culture of mistrust and disrespect established by male leaders for female colleagues.

The researcher found that policymaking and implementation were complicated, convoluted and unpredictable. Policy makers, actors and bureaucrats gave precedence to political ideologies rather than plans developed by local administration (two District Health Services). A major obstacle to progress and success was the disregard of the central government for local plans and budgets, with health plans developed by local administration (District Health Service) but the budgets decided by central administration (Ministry of Health). As a result, the local administration was obliged to implement health plans and activities defined by funding provided from the Ministry of Health, rather than on the identified needs and plans of the district and communities.

Theoretically, decentralization is an important objective promoted by the Timor-Leste central government, but it was identified that this was a big concern of both Districts A and B. The key reason for this was the lack of competent human
resources. The research revealed that the managerial and leadership competency of the director of District Health Service A is greater than that of the director of District Health Service B. However, while both of them had nursing qualifications neither of them had qualifications in management.

Responsiveness of the Ministry of Health, relevant ministries and its development partners were inadequate in both districts. This lack of responsiveness affected the structure, and effectiveness and efficiency of health systems. There were serious problems with infrastructure including poor road and bridge conditions in rural and remote areas; unreliable electricity; lack of clean water; lack of proper communication systems; lack of pharmaceuticals and other logistical support including effective financing, health equipment and medicines, and transport. The researcher identified that the lack of infrastructure hampered health service delivery in both districts. Another factor was the shortage of health professionals. As District B had the highest population and highest population density this posed a significant problem for the District Health Management Team (DHMT) in B. The researcher identified that this DHMT in collaboration with the central office of the Ministry of Health recruited more administrative than health professional staff.

The researcher found that the local administration in District B did not give importance to monitoring and evaluating health activities and therefore were unable to anticipate and prevent poor achievement of health indicators. Research identified that the Ministry of Health did not have monitoring and evaluation guidelines available.

Another example of poor responsiveness in the health system constituted the government’s lack of acknowledgment and reward of its staff. Both Districts A and B lamented the lack of these kinds of rewards and incentives. The researcher identified that the current salary of health professionals was considered very low. Under this condition health professionals were forced to supplement their incomes with additional paid work which often undermined their health employment.

The researcher identified that health professionals employed by the Ministry of Health, including the international health professionals working in the health facilities, did not always behave ethically. These attitudes impacted on health equity and resulted in discrimination such that some patients could not access good health care. The researcher also found poor professional ethics on the part of top decision
makers in the Ministry of Health. The researcher found three factors influenced professional ethics in the workplace: economic factors; the capacity of the government to respond to health staff and community needs; and the individual behaviour of the health professionals.

The researcher identified that transparency and accountability in the health system were lacking in both districts. The data confirmed that there were several reasons why there was a lack of transparency and accountability. Firstly, Human Resource managers in Ministry of Health had no clear plan. For example, many staff were trained in various areas but not in accordance with the Ministry of Health expectations, particularly the local district and sub-districts needs. Secondly, the management of the financial system in Ministry of Health and the participation of community leaders and other stakeholders in the development of plans and budgets for implementation in the field were not in place. The Ministry of Health and District Health Services did not involve community leaders such as village leaders and representative of vulnerable groups in the preparation of detailed implementation plan and budgets. Thirdly, the researcher identified that health information was centralized in Dili. Information was not trickling down to the grass roots in the way the public expected.

The researcher found that some participants had limited understanding of accountability. They were unclear about what should be reported to the public but recognized the need for accountability to people and agencies, the Parliament F Commission, and service institutions under the Ministry of Health. Headquarters recognized that they have no mechanism to ensure accountability to the public, as they were only accountable to institutions within the Ministry of Health and to the Parliament F commission. Some participants argued that the Ministry of Health’s system was still weak and needed improvement to be accountable to the public. Another feature of leadership that undermined accountability was the tendency for politicians and top decision makers to make planu hakfodak (surprise or sudden plans). These planu hakfodak had huge implications for the quality of health service delivery to communities, unequal access to health care services and health inequity.

The researcher found that there was a lack of cooperation and participation in District B. The reason was the local administration officials (district and sub-district administrators) had poor awareness of the importance of supporting health staff in
the provision of health services to community in the field. The researcher identified that the workforce had a good cooperative relationship with Catholic Church, NGOs and private clinics in District B where health staff are assisted to influence community leaders (village leaders) and the community to take part in health activities. It was clear that the lack of support of local administration officials was a constant obstacle to the achievement of better health outcomes in District B.

Exemplary cooperation and participation was found in District A. The research found that the administrator of District A has a strong commitment, creativity and willingness to encourage other local officials and organizations to implement government plans including health programs. This indicated that the local administration officials took responsibility and offered good leadership in managing this district, which in turn led to good performance and achievement of health indicators in District A. Cooperation was also manifest through the networks, signed agreements and MoUs between Ministry of Health and its partners both inside and outside the country. Cooperation in District A was manifested through a strong health network and good communication and contribution among all partners including village leaders and communities in the delivery of health services. This resulted in achievement of good health outcomes relative to District B. The researcher identified that District A was assisted by an organization named ‘Pastoral da Criança’ (Children’s Pastoral Care based in Brazil), adopted by the Catholic Diocese of this region that makes a significant contribution to the reduction of mother and child mortality rate in this district. A further important activity in District A was ‘community development’ created by local government. Through this program of community development the population of District A showed higher levels of knowledge and health awareness, in particular pregnant woman receiving antenatal care, mothers who receive Tetanus Toxoid injection, rate of births in health facility and percentage of the population who have heard of HIV/ AIDS.

One feature of the workforce in both districts was their stated conviction that they did not discriminate among patients and they treated people equally regardless of gender, religion socio-economic status and political affiliation. The researcher identified health inequity in both districts. The researcher found that inequity resulted from lack of responsiveness (poor infrastructure and other logistical support) provided by Ministry of Health and District Health Service and its development
partners to support health system in the both districts. Another reason for this health inequity was poor professional ethics. Some health professionals including international staff in health facilities prioritized patients who had high social economic status and leaders of political parties over people from the grass roots or rural communities. The consequences of this were ongoing inequity of health care, which contradicted the East Timor Constitution (2002).

**Implications for the health policy process**

Micro policies are health strategies targeting a specific issue such as Health Promotion, Malaria, Tuberculosis, or Reproductive Health. The implication for micro-policies lies in the fact that the Timor-Leste Health Policy Framework 2002 provided general guidance while micro-policies in specific areas require specific guidance for implementation. The achievement of policy objectives requires the development of appropriate rules, regulations or procedures and practices, which can be used to overcome problems and achieve objectives. Without these policy requirements decision makers would not be able to turn political discussion and policy statement into concrete social action (Bemelmans-Videc & Vedung, 1998; Ringeling, 1983; Schneider & Ingram, 1997). The Timor-Leste Health Policy Framework 2002 and micro-policies define aspects of governance but to date they have not been put into practice properly. The reasons were various but the single most important factor was the lack of policy rules and practices. This contravenes the statement of some policy makers that to achieve policy objectives, policy instruments (rules, tools and regulations) are required to regulate activities in the field (Bemelmans-Videc & Vedung, 1998; Salamon, 2002; Schneider & Ingram, 1997).

Another important factor was the domination of the development of health policies and strategies by powerful actors in the Ministry of Health and its development partners. This was reflected in the top down administration, management and decision-making typical of Southeast Asia including Timor-Leste. The result was that some of these policies were inappropriate to the situation in the districts, as each part of Timor-Leste has its own customs, traditions, and values. Agenda setting and policy formulation occurred in central government by elite health actors. However, these policies were implemented by local administrators and health
care providers. Consequently, local administration and its partners could not meet the health indicators and objectives decided by central government. This is not in line with the aim of a public policy, that to overcome and respond to the community demands, public opinion is an important aspect that needs to be considered by policy makers (Soenarko, 2003; Althaus, Bridgman & Davis, 2007; Birkland, 2005; Dye, 1972; Rhodes, 2000). It is evident then, that not all brilliant ideas from brilliant people are easily turned into action in the field. Cooperation and participation by the local administration officials and their community in the development of health policy is a key requirement to ensure the incorporation of objectives, traditions, customs and values of the local people (Panayiotopoulos, 2002; Althaus, Bridgman & Davis, 2007; Birkland, 2005). The process of policy implementation can often be as complicated and demanding as that of policy development. In reality not all policy implementation is complex or static. Policies can often drift from their original objectives or only partially realise their goals.

Health policy evaluation was not successfully conducted in district B. This activity provided opportunity to discover the impact of health policy on the ground. This information can in turn provide guidance to policy implementers to ensure better performance. It assists government, particularly local administration, to set priorities and contribute to improving good governance issues such as responsibility for and accountability to parliament, donors and public community (Birkland, 2005; Edwards, 1984). If policy evaluation is used it can provide information about the past and informs future action.

**Implications of governance for community health**

Over the past two decades issues of governance have attained importance in countries around the world. Governance has been an important concern for Timor-Leste, whether under colonization or after achieving independence. As a new, post-conflict and fragile state, Timor-Leste recognises the need for good governance that empowers its people through open and transparent public administration and financial management, political representation and leadership in public sectors.
including health. It is through the principles of good governance that effective and efficient public administration can be achieved (Panayiotopoulos, 2002).

There is no consensus on the definition of ‘fragile state’ but many academics and experts consider a fragile state to be one that is unable to perform basic functions such as maintaining security, enabling economic development, ensuring the essential needs of the population for education, infrastructure and healthcare (Meagher, 2007; Organisation for Economic Co-operation and Development, 2007). The research demonstrated that Timor-Leste meets this working definition of a fragile state and manifests the poor quality of health care services that lead to health inequity, especially for poor and peripheral communities such as Districts A and B.

Stewart (2003) has pointed out that health services are often not equally distributed to populations and are often weak for rural and poor communities. This will continue to limit District Health Services’ capacity to achieve health MDGs or even the goals set by Ministry of Health. District A performed well and achieved health indicators through good cooperation and a strong network with development partners. This district effectively disseminated health policies and conducted monitoring and evaluation of programs. However, many elements of governance remained a challenge for District Health Service A. Timorese people cannot progress without basic health and a good quality of life. Potable water and sanitation, gender equality, employment, housing and infrastructure are fundamental to human and social development. The researcher identified that the health sector in both districts suffered from weakness in infrastructure, pharmaceuticals and logistical provisions, training of staff, local financial resources and effective administration. There were few resources available for public health. However, these resources are crucial to conduct public health services and to ensure health equities (World Health Organization, 2011).

The weak performance of the health system in both districts was caused by myriad challenges and complexities of governance. Effective responsiveness and professional ethical behaviours of both central and local administration were needed to support health programs in the field which must be distributed fairly across the country. These have the intention to diminish the risk of conflict between groups and communities, and ensure health inclusion whilst achieving a local and national reputation that is trusted and respected by Timorese citizens and development and
international partners. Since, public distrust in government will undermine the legitimacy (Debiel & Terlinden, 2005; Pierre & Peters, 2000). Effective governance of the health system and “smart” governance for health and well-being are needed (World Health Organization Regional Office for Europe, 2011; World Health Organization Regional Office for the Eastern Mediterranean, 2007) and of great importance for community development (Pierre & Peters, 2000; United Nations Economic and Social Council, 2006). Without smart governance in health, health policy and decision makers including health professionals in Timor-Leste cannot fulfill their objectives and contribute to community health and wellbeing. It has become fashionable to say, the inconsistency, inequality of resources, inequity including ethical dilemmas of the health service, which is faced by the public requires putting health policy in an appropriate place to ensure the legitimacy of government and health system (Pierre & Peters, 2000).

The data confirmed that the health sector bureaucracy in Timor-Leste conjured feelings of frustration and disappointment among citizens, just as did the inefficiency and corruption of bureaucracy in 1960s and 1970s in the third world (Hirschmann, 1999; Narayan, et al., 2000). Weak governance of the health policy process and system in both districts threatens to destabilize the effective utilization of resources and delivery of health services. Health systems in post-conflict and fragile states like Timor-Leste, cannot operate successfully without adequate and effective rules of governance among health policy and decision makers, implementers and its development partners in both central government and local administration. As governance malfunction may require a deeper understanding of the history, culture, and existing legacy of colonialism within certain environments (Kaplan, 2008).

There are a number of UN Agencies, donors and NGOs to assist Ministry of Health in Timor-Leste. Donors seek to prioritize legitimacy and effectiveness of government including security and meeting immediate needs (Rondinelli, 2006). They prefer to invest their aid in the health system in countries with better policies and stable governance, rather than in post-conflict and fragile states like Timor-Leste, as they consider post-conflict and fragile states politically and financially risky. Carvalho (2006) has identified that fragile states are characterized by weak policies, institution and governance. Adequate and effective rules of governance have to be put into practice and respected by everyone. Another important factor is
stability of the state to allow the operation of health system. Improvement of
governance in the health system can increase trust in government and strengthen the
legitimacy of the state through development of human capital, and encourage
community oversight and monitoring of health activities (Kruk et al., 2010). The
weakness of poor governance for health as evident through this research, threatens
the legitimacy and efficacy of the government, particularly the Ministry of Health.
For example, the office of inspection and audit, supervised by Ministry of Health
itself, did not function well as it had few trained professional investigators and
limited power to prosecute. The office of inspection and audit cannot investigate top
health decision makers such as the minister and vice minister because this office is
structurally subordinate to the office of the minister and vice minister.
Decentralization is recognized by a number of academics as a crucial factor
contributing to good governance in developing and post conflict countries
(Brinkerhoff & Johnson, 2008; Hohe, 2004; Nyiri, 2001). This is an agreeable idea.
Decentralization aims to improve administrative and service delivery effectiveness;
decrease regional tensions; and more importantly to increase community
participation. Lack of human resources including managerial and leadership
competency were the main reasons why central administration the Ministry of Health
did not fully transfer authority to the District Health Services in Timor-Leste. The
research found that the Ministry of Health kept control over District Health Services,
granting very limited power to them. It can be argued that this granting of limited
power to local administration (DHS) also limits public control over health services,
which affects the legitimacy of the health system.

Local administration District Health Services A and B did not involve
community leaders and other representative of vulnerable groups in the development
of local health planning and let health staff work. Participation of all parts of the
community in the health system is a main pillar of democracy (World Health
Organization Regional Office for Europe, 2011). One measure being used by some
developing and post-conflict countries is decentralization (United Nations Economic
and Social Affairs, 2010). Decentralization can improve community participation and
guarantee accountability and transparency in a fragile state like Timor-Leste by
fostering ownership through the power to influence institutional processes. Timor-
Leste’s unique history, culture, politics, and traditions have impacted the
development of the health system and its governance at both the central and local level. Traditionally, each village in Timor-Leste has certain people who hold decision-making power. Therefore, decentralization and ‘community participation’ demand extra attention to ensure people truly represent local communities to ensure that the community respects the decisions made.

Some recommendations are made below on ways the performance of both the central and the local administration could be improved. The recommendations are for ongoing consideration within and beyond the Ministry of Health based on further detailed analysis, including reference to relevant comparative experience elsewhere in the world.

**RECOMMENDATIONS**

**Development of partnership with stakeholders to increase participation, cooperation and transparency.**

In order to achieve increased participation and cooperation Ministry of Health could involve local government District Health Service (DHS), health service providers and particularly local community leaders in the development of health policy, strategies, guidelines, procedures, plans and budgets (Walt & Gilson, 1994; Soenarko, 2003; Althaus, Bridgman & Davis, 2007; Birkland, 2005; Dye, 1972; Rhodes, 2000; Blakemore, 1998; Pierre & Peters, 2000; World Health Organization Regional Office for the Eastern Mediterranean, 2007; Ministry of Health, 2002). District Health Services active participation in the development of health policies and procedures to define health indicators is necessary. Local administrators are also in the best position to identify ways to achieve health objectives. The views of local people, who have experience, skills, and formal training, are valuable in the health policy development process. Local involvement in development of health plans and budgets can reduce duplication in health program implementation; can increase responsiveness to health priorities identified in the field; and can increase transparency. This could reduce corruption, abuse of power, and inappropriate expenditure of public funds in the health sector (World Bank, 2004; Siddiqi et al., 2009).
It is suggested that in the interest of achieving transparency, health information (policies, strategies, procedures and campaigns against diseases) should be spread periodically in local languages through a wide variety of channels (local radio, information booths at markets, easily accessible and understandable booklets and brochures) to ensure that all information reaches all citizens in urban and remote areas (Ministry of Health Timor-Leste, 2002a; Prichard, 2010; World Health Organization, 1978). Health information for dissemination should not just focus on health promotion but include policies and strategies, and procedures of referral. This could help to ensure the public is kept informed of health developments that relate to their concerns and allow them to make informed choices. Public debates on health issues, policies and procedures should be held periodically. This can contribute to effective health service delivery, nation building and sustainable development. The District Health Services need to seek out health information from the central administration.

In order to improve participation and cooperation, it is recommended that programs like Pastoral das Crianças and Community Development processes be adopted by District B and other District Health Services within the country. These programs can guarantee communities’ knowledge and awareness in improving human capital, health literacy and community wellbeing as well as encouraging good governance.

Reform of bureaucracy with the aim of increasing the efficiency and legitimacy of the Ministry of Health.

It is recommended that the government avoid basing health policies and budget plans solely on the opinions or interests of people who have power and money, such as donors, UN agencies, NGOs and political parties. Oligarchies, as small numbers of elites who make the decisions, should not have sole authority over health policy and outcomes.

To increase legitimacy, government could prevent policy development “on the run” and policy effectiveness and development that responds to the whims of politicians and senior bureaucrats. Political leaders who occupy high-level positions could be discouraged from planu hakfodak as well as unnecessary overseas visits and
meetings in order to reduce transfer of funds. All institutions under the Ministry of Health are advised to respect and execute budget items based on the budget plan formulated and approved for them to reduce fund transfer. A reform of bureaucracy could be beneficial. This would involve change to procedures, performance criteria, career incentives systems and job definitions (Hirschmann, 2000; Narayan et al, 2000) which could increase the legitimacy of the health system.

In order to improve the legitimacy of the health system and efficacy of the Ministry of Health, it is recommended that a professional and independent team of auditors provide an annual audit of the health system, report their findings to the public, and refer relevant cases to the Anti Corruption Commission. Despite the assistance of development partners such as UN Agencies, donors on legitimacy, security and effectiveness of government, a strong and effective support from donors for Ministry of Health and District Health Services initiatives are needed to improve responsiveness in improving communities’ health through equity and equal access to quality health services (Rugumamu & Gbla, 2003; World Health Organization Regional Office for Europe, 2011). Donors’ encouragement for innovation and evaluation of health interventions to enhance health literacy, community participation and engagement in health activities is another significant area to improve government legitimacy.

**Engagement must be ongoing: not just development of policy, but implementation, evaluation and feedback.**

In the future health policy makers need to take an holistic approach when developing a health policy, taking into consideration the whole cycle of the policy process including agenda setting, policy formulation, policy adaptation, policy implementation and policy evaluation (Althaus, Bridgman and Davis, 2007; Palmer and Short, 2003; Soenarko, 2003). Further, to achieve policy objectives require that government establish rules and regulation to regulate activities and operational aspects of government in the field (Walt et al., 2008).

In the development of future district strategic health plans and budgets, District Health Services and its partners need to consult and involve all stakeholders including community leaders, representatives of vulnerable groups, partners such as
the Catholic Church, private clinics and other NGOs which implement health programs within the district (Ministry of Health Timor-Leste, 2002b; Prichard, 2010; World Health Organization, 1978). To guarantee health access and equity by all citizens, it is suggested District Health Services and the central government including its partners have a framework to improve local infrastructures and other health logistical support in the field. This is the responsibility of the government to facilitate health staff working effectively and efficiently also progress governance in health system (World Health Organization Regional Office for Europe, 2011).

Implementing smart governance for health and wellbeing through whole of government and society using five methods (World Health Organization Regional Office for Europe, 2011) in the next Health Policy Framework is recommended. Access to the means to ensure good health is a human right, an essential component of wellbeing and a social justice and equity issue. Health is also recognized as a key resource of other systems, such as the economic, environmental, educational, transportation and food supply systems (World Health Organization Regional Office for Europe, 2011).

The researcher recommends that District Health Services particularly District B disseminate health policies before trying to implement them and to actively monitor and evaluate health programs in the field (Birkland, 2005; Walt et al., 2008; Soenarko, 2003).

**Accountability for expenditure.**

To meet the need for accountability of the Ministry of Health to the public, partners, workforce and community it is recommended that a website be developed to provide information about expenditure of public money. This website would be easy for the public to access and would serve as a place where the quarterly or annual reports could be posted for access by staff in remote areas. This method is to empower the community and public own checks and balances as well as to monitor the effectiveness of public services (World Bank, 2004). In addition to this, an internal financial system could be developed to reduce the delay in delivery of the budget requested by District Health Services and other health institutions. This internal system could also increase the capacity of human resources in accounting,
planning and other crucial areas necessary to effective management and governance (Agborsangaya-Fiteu, 2009; Ministry of Health, 2002).

**Increase power and capacity of local health governance.**

It is recommended that full power and responsibility for decision making and problem solving be delegated to District Health Services, Community Health Centres and Health Posts. This is because decentralization as an effective mechanism for supporting peace in post conflict countries also builds a situation of engaged governance, where the concern of everyone is not who has power over whom, but how the power is exercised for the wellbeing of all the people (United Nations Economic and Social Affairs, 2010). Local health officials would then have the power and responsibility to find solutions and overcome barriers which impact on the quality of health services and community wellbeing in their area of service (Ministry of Health, 2002; Agborsangaya-Fiteu, 2009). The delegation of power to manage money at the operational level would not be restricted to emergency situations nor pertain to only a portion of the budget. The local authorities’ role at local level can be strengthened through increased flexibility and power to manage expenditure including some procurement funds. Where possible, the health plans, funding, which is transferred to local health administration District Health Services should be based on the district health plans and in line with districts’ objectives and needs in order to foster better decentralization. If the Ministry of Health maintains responsibility for procurement of supplies, it would do well to base them on the guidelines provided.

Another critical priority is development of human resources in health, where shortages of qualified staff impact the structure of health system. Health policy process training, additional capacity building and up skilling on up to date health services development are important aspects that need urgent attention of Ministry of Health, so that health staff will appropriately manage health needs of the community (United Nations Department of Economic and Social Affairs & United Nations Development Programme, 2007; United Nations Economic and Social Affairs, 2010; World Health Organization Regional Office for Europe, 2011). It is important for all health professionals from central (MoH, personalize services, including national and referral hospitals) to local administration District Health Services and health facilities
to be provided regular refresher training on professional ethics (Farazmand, 1997). It is suggested that the trainers could be include the Catholic Church as this a respected moral institution in Timor-Leste. Documents outlining professional codes of conduct need to be visible in health facilities to improve professionalism and provide good quality of service, and to decrease health inequality and inequity. Similarly it is recommended that there be clear consequences for those who fail to behave ethically in a professional setting. A regular refresher training and workshop in smart governance for health (World Health Organization Regional Office for Europe, 2011) for all staff of both central and local administrations would be constructive. Behaviour of the civil servants is affected by the behaviour of political leaders. If the elected politicians are corrupt, this tends to proliferate and expand to the civil service (Hyden, Court & Mease, 2003). Therefore, Timorese citizens including health professionals need to be educated (civic education) to take due care when exercising their right to vote for political leaders.

**Local leadership and effective financial management.**

For health managers (District Health Services and health institutions) additional training on leadership, managing development and implementation of health plans and budgets including execution, acquittal and report writing would be valuable and would foster the progressive increase in District Health Service power and capacity to direct their own administration and finances (Agborsangaya-Fiteu, 2009; Rugumamu & Gbla, 2003; United Nations Department of Economic and Social Affairs & United Nations Development Programme, 2007). Further, decrease Ministry of Health control over local administration. Leadership and effective systems of political empowerment are also essential to ensure health system development and social inclusion. Local government (both districts) needs to demonstrate their capability to win the confidence of the central government. It is also recommended that District Health Services submit their financial reports in a timely manner so as not to delay the next fund disbursement.
Employment based on merit.

Recognition of prospective employees’ work experience, qualifications, training, and skills are essential when choosing new staff to occupy a key position in Ministry of Health or District Health Service. It is inappropriate that employment be based on family-ties, special relationships (nepotism) or political affiliation and the importance of gender equality and equity requires attention (United Nations Economic and Social Affairs, 2010). In seeking to fill permanent full time positions, priority should be given to applicants who have been engaged and experienced in Ministry of Health as temporary staff or health volunteers. This aims to diminish harmful to the functioning of the public health service and avoid conflict. It is recommended that vacant positions be publicly advertised through media and announcement boards in the districts or at the local level. The Ministry of Health is advised to consult the District Health Service and local government when a change in position or location is planned for local health staff.

Audit of current health staff.

Another way to improve transparency is to rewrite current job descriptions and to audit health staff throughout the country, because some districts have a good proportion of health professionals and staff to the population and some districts do not. The audit of current health staff to ensure workforce numbers and distribution should be based on population numbers and health need, not personal opinion or history. There is a need to correct the balance between administrators and health practitioners. Currently the proportion of administrative staff to health professional staff is about 2:3. In the future it would be good to change this to one administrative staff per three clinical staff (Ministry of Health Timor-Leste, 2007a; Ministry of Health, 2007b; Ministry of Health, 2008a).

Staff be rewarded and receive salary increases for longevity of employment, as planned and promised by government Carrier Regime (Ministry of Health, 2007b). This would reduce staff turnover and poor performance. It could also reduce corruption and misuse of government resources as staff would be less tempted to use work time, transport and equipment to do other work providing additional income.
FURTHER RESEARCH

To support these recommendations there are several areas in need of further research. Additional studies are essential to guarantee the improvement of quality health service and community health and wellbeing, as well as to achieve the best outcome and the legitimacy of health policies and governance. It would be beneficial to explore the actual impact of ‘Community Health Centre Management and Leadership’ which is currently a mandatory training for all managers (Ministry of Health, Personalized services, District Health Service, Community Health Centre and Health Post). Further research could identify additional human resources (health professionals and support staff) required at the national, district and sub-district levels. A study of the ethical beliefs and practices of health professionals may identify ways to improve them. Another important study would compare centralization versus decentralization and the cost benefit for both central and local government. Research similar to the one just conducted in District A and District B, on governance in the health system, is needed for other districts.

CONCLUDING OBSERVATION

The objectives of this research were fulfilled by collecting empirical data from participants of both Districts A and B, Ministry of Health headquarters and its development partners. The researcher analysed the way in which the Timor-Leste Health Policy Framework 2002 and micro health policies were developed and implemented, with a focus on governance at the local (District Health Services) and central levels (the Ministry of Health). The researcher revealed the resources currently in place to support health services delivery in terms of health policies, strategies, procedures, infrastructure, and logistical support; explored the way in which health structures and processes have been established; and considered the important issue of legitimacy in governance. The findings are important and considerable in that they illuminate ways of understanding the health policy process and governance in Timor-Leste.

The identification of deficiencies in the policy process and governance of the health system by health policy makers and their partners, including implementers, is required so as to improve health MDGs and health equity and well-being of all
citizens, particularly the poor and those in geographically remote areas. Analysis of health governance and policy highlight the importance of investing in health offices, facilities and services. There is much to be accomplished in terms of improving local participation and enhancing state stability and capacity. The complexities of the health policy process and governance as described in Chapter Two confirm that there is more than one model and approach to achieve high quality health care service and outcomes in remote areas, particularly in a post conflict and fragile state like Timor-Leste.

Recommendations for both the central and local administration are presented and require further research. Much effort is needed for Timor-Leste to move from a post-conflict and fragile state to a more stable state. The findings, analysis and recommendations of this research can all make a contribution to this process.
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APPENDICES

APPENDIX 1: STRUCTURE OF THE DISTRICT HEALTH SERVICES

- Health promotion and Education
- Communicable Disease Control
- Non Communicable Diseases
- Maternal and Child Health
- Environmental Health
- Laboratory and Pharmaceutical Services

- Administration
- Planning and Finance
- Human Resources
- Logistics & Patrimony management
- Health Information System & Epidemiological Surveillance

Sub District Community Health Centers

Mobile Clinics

Health Posts
APPENDIX 2: STRUCTURE OF THE MINISTRY OF HEALTH
APPENDIX 3: THREE INTERVIEW GUIDES

1. Central government Ministry of Health (headquarters) and its development partners

Structure

What research and evaluation studies does the MoH/government use when they formulate policies, strategies, regulations, plans, guidelines, and standards of resource and spending?

How are public health services organized and financed? Are they organized in ways that offer incentives to the public, NGOs and private providers to improve performance in the delivery of health services?

What structures have been in place for the development and implementation of the TLHPF 2002?

What are the implementation mechanisms? To what extent are they in line with the district objectives of health policy?

In what ways does the implementation of the TLHPF 2002 and related policies take into account the unique historical, cultural and social complexities?

In what ways does the government and its partners advocate and explain health policies to the public and health providers before policy implementation?

Power

Who has influence on legislation pertaining to health?

What is the capacity of stakeholders to advocate and be involved effectively with government in the development of policies, plans and budgets for health services?

To what extent are the private sector, civil society and stakeholders consulted in health services decision making?

What roles have the relevant ministries such as Departments of Justice, Social and Solidarity, Education and Infrastructure played in the development and implementation of health policies?
What role has Parliament played in the development and implementation of health policies?

In what ways has the media been involved in the development and implementation of health policies?

What is the actual level of decentralization?

**Ethics**

What ethical principles are included in the TLHPF 2002?

Are there any policies or strategies for improving and promoting ethics to staff and students in health services and research?

To what extent are the quality of health services and the satisfaction of users valued by the MoH?

To what extent do health workers use evidence of program results, evaluation, patient satisfaction reports and other health related information to improve the services they deliver?

What importance is attached to ethics in health research and services?

**Responsiveness**

What are the existing procedures of social protection in cases were there are financial barriers for the patients, especially the poor? What are the targeting mechanisms?

What instructions, protocols, standards and codes of conduct including certification procedures, have been developed for, and disseminated to, training institutions, health services facilities, and health providers?

To what extent are the allocation and utilization of resources regularly tracked and information on results made available for review by the public and concerned stakeholders?

What systems exist for reporting, inspecting and adjudicating the misallocation or misuse of resources?

How is the capacity of the MoH for implementation measured? (For example, in terms of regulatory, monitoring, financial and human resource management?).
To what extent are regulations related to health service delivery, infrastructure, technology, human resources, pharmaceuticals, logistics (transportation, communication, clean water, electricity) in place?

What are the desired outcomes of the health policies?

How do the MoH and partners analyze the possible impact of the health policies on rural areas?

**Equity**

Is there gender equity in opportunity to improve or maintain their health and participate in health decision-making?

Are there procedures and systems that clients, providers and concerned stakeholders can use to fight bias and inequity in accessing health services?

Are there any social protection schemes in place to address financial barriers for the community/poor?

What policies are in place for discovering issues of in/equity in provision and financing of health services and resolving them?

What are the differences in access to care by gender, ethnicity, religion and others?

**Cooperation**

What forums and procedures exist to give the public, technical experts, and local communities opportunities to provide input and information into the development of priorities, strategies, plans, and budgets?

Do the MoH and health provider organizations (public and private) regularly organize debates or forums to solicit input from the public and concerned stakeholders (vulnerable groups, groups with particular health issues, etc.) about priorities, services and resources?

In what ways has the government interacted with religious leaders when developing and implementing health policies?

What arrangements exist to help voluntary and private organizations, providers, patients and other concerned stakeholders when regulations, protocols, standards, or codes of conduct are not complied with?
Which other ministries are involved with the MoH in the determination of health policies and programs?

Is an updated registry maintained on bilateral and multilateral partnerships between the MoH and its technical advisers?

How are the administrative and fiduciary aspects of programs and specific projects managed? (For example: the Global Fund, the Program of Rehabilitation and Development in the Health Sector, and other bilateral or multilateral projects/programs).

**Transparency**

To what extent are civil society organizations (including: professional associations, specialized health related NGOs and the media), provided oversights of the ways health services are delivered and financed?

What information about the quality and cost of health services is publicly available to help patients make choices as to where they want to go for health services?

How soon is information from the financial audit available after the funds are disbursed?

Is enough information provided to the public to understand and monitor health programs including recruitment for new staff?

**Accountability**

To what extent, and in what ways, are decision makers in government (MoH), DHS and health providers accountable to:

The community?

Parliament?

Professional bodies?

Health workforce in rural areas

Others?

**Effectiveness and efficiency**

What is the turnover of the leadership at the MoH and districts?
How are the district managers appointments or transfers related to their capacity in implementing health policies?

What capacity building initiatives are being taken to increase the quality of staff in hospitals, CHC and HP? (Including formal education and specific training programs).

What are the existing barriers to the implementation of health policies?

What are the appropriate means of overcoming these barriers?

2. Local administration officials and District Health Service including health workforce

Structure

What are the implementation mechanisms? To what extent are they in line with the districts’ objectives of health policy?

What structures have been in place for the development and implementation of the TLHPF 2002?

What is the total number of staff including support staff in CHCs and HPs?

In what ways does the implementation of the TLHPF 2002 and related policies take into account unique historical, cultural and social complexities?

Power

Who has influence on legislation pertaining to health in district level?

Which stakeholders have regular opportunities to meet with managers of health services organizations (hospitals, health centers and clinics) to receive information and raise issues about health services efficiency or quality?

In what ways are district administrators responsible for the provision of health services?

What roles are played by health providers in peripheral districts?

What is that actual level of decentralization?

Ethics

Is there any code of conducts for health professional and staff in the field?
Are there any policies or strategies for improving and promoting ethics to workforces, staff in health services?

To what extent are the quality of health services and the satisfaction of users valued by the DHS?

To what extent do health workers use evidence on program results or evaluation, patient satisfaction and other health related information to improve the services they deliver?

What importance is attached to ethics in health research and services?

**Responsiveness**

What instructions, protocols, standards and codes of conduct including certification procedures, have been developed for, and disseminated to, health services facilities, and health providers?

To what extent are the allocation and utilization of resources regularly tracked and information on results made available for review by the public and concerned stakeholders including health workforce in local level?

What systems exist for reporting, inspecting and adjudicating the misallocation or misuse of resources?

To what extent are regulations related to health service delivery, infrastructure, technology, human resources, pharmaceuticals, logistics (transportation, communication, clean water, electricity) in place?

**Equity**

Do women and men have the same opportunities to improve or maintain their health and participate in health decision making?

Is there equal access to health care services by communities?

Is the same quality of health care services accessed by communities?

Are there procedures and systems that clients, providers and concerned stakeholders can use to fight bias and inequity in accessing health services?

Are there any social protection schemes in place to address financial barriers for the community/poor?
What policies are in place for discovering issues of equity in provision and financing of health services and resolving them?

What are the differences in access to care by gender, ethnicity, religion and others?

**Cooperation**

What forums and procedures exist to give the public, technical experts, and local communities opportunities to provide inputs and information into the development of priorities, strategies, plans, and budgets?

Who are the partners of DHS?

In what ways has the local government DHS interacted with its partners including religious leaders, community leaders, and health volunteers when developing and implementing health policies including monitoring and evaluation programs?

How is the relationship between DHS, staff, and other local officials at the district level?

Are there any regular meetings with partners to follow up the progress of the health policy implementation?

**Transparency**

To what extent are civil society organizations (including: professional associations, specialized health-related NGOs and the media), provided oversight of the ways health services are delivered and financed?

What information about the quality and cost of health services is publicly available to help patients make choices as to where they want to go for health services?

How soon is information from the financial audit available after the funds are disbursed?

Is enough information provided to the public to understand and monitor health programs including recruitment for new staff?

**Accountability**

To what extent, and in what ways, are decision makers in government (MoH), DHS and health providers accountable to:

The community?
Parliament?

Its development partners

Professional bodies?

Health workforce in peripheral areas

Others?

**Effectiveness and efficiency**

What is the turnover of the leadership at the MoH and districts?

How are the districts managers appointed or transferred related to their capacity in implementing health policies?

What capacity building initiatives are being taken to increase the quality of staff in hospitals, CHC and HP? (Including formal education and specific training programs).

What are the existing barriers to the implementation of health policies?

What are the appropriate means of overcoming these barriers?

**3. Community leaders, community and community health volunteers**

**Community participation**

Why is community participation in health activities important?

Are there differences in the levels of community participation in the development and implementation of health policies?

What is the extent of community participation in health services?

How does the community become actively involved and contribute to health policy development and implementation?

What are the observations about the health care services delivered by health professionals in the field? (For example, ethical issues, political affiliation, health equity and community empowerment.)

What are the observations about responsiveness of the central and local government in supporting health activities in the field? In terms of health facilities, road
conditions and transportation, communication systems, clean water and other logistical support.

What is the health significance of traditional structures in villages?

In what ways do traditional structures influence villages’ decision making in relating to health matters?

What were the key aspects of health services delivery during the Portuguese and Indonesian eras?

How do these aspects contribute to the current health policy process?
APPENDIX 4: ETHICAL CLEARANCE

10 August 2009

Mrs Ana Soares
Charles Darwin University
Graduate School of Health Practice
North Flinders House 3.1.17
Casuarina NT 0909

Dear Mrs Soares

RE: APPLICATION FOR ETHICAL CLEARANCE, REFERENCE NO. H09045.

The Charles Darwin University Human Research Ethics Committee has approved your application for ethics clearance for your project titled Development and implementation of Timor Leste Health Policy Framework 2002. Please find attached a notice of clearance.

The expiry date of ethics approval for your project is 10 August 2010. It is the responsibility of the researcher to ensure that ethics approval is renewed prior to the expiry date. If renewal is necessary, you will need to submit a progress report including a statement of compliance with ethical requirements, and detailing any proposed or actual changes to the project, which may affect its ethical acceptability. Renewal/Final Report forms are available from the Web at: http://www.cdu.edu.au/researchoffice/renew_final_04.pdf or from the Research Office.

If any significant alterations to your project are contemplated, or if any matters arise which may conceivably affect the continued ethical acceptability of the project, you are required to immediately notify the Human Research Ethics Committee by letter.

Our best wishes for the success of your project.

Yours sincerely,

Plaxy Purich
Executive Officer

for Professor Robert Wasson
Chair, Human Research Ethics Committee
APPENDIX 5: INFORMED CONSENT FORM FOR HEADQUARTERS MoH, RELEVANT MINISTRIES, PARTNERS AND HEALTH PROVIDERS

Informed Consent for Headquarters MoH, Relevant Ministries, Partners and Health Providers


Chief Investigator: Ana Isabel F. S. Soares

I __________________________ agree to participate in the research project.

I understand that my participation in this research will include an interview that is likely to take about 45 minutes.

I agree that this interview can be audiotape recorded. I understand that the recording will be deleted after the interview has been transcribed, translated and endorsed.

I agree to the researcher visiting me in my office and watching my work during the research. The visit will be between September 2009 and May 2010, which will culminate with a two hour focus group discussion.

I am aware that I can contact the researcher or the Executive Officer, Charles Darwin University Human Research Ethics Committee, if I have any concerns about the research, such as if I feel in anyway threatened by my participation in the study.

I also understand that I am free to withdraw my participation from this study, or to decide not to answer particular questions, at any time without giving a reason. This right is not in any way dependent on, or affected by, whoever nominated me to participate in the study. I expect the researcher and/ or interpreter to answer all of my questions fully and clearly.

I agree that the research data gathered from this study may be published in a form that does not identify me in any way. I have had my involvement described to me by the researcher verbally and I am satisfied that the researcher will respect my rights and involvement in accordance with the above agreements, understandings and expectation.

Participant’s signature: __________________________ Date: __________________________

Position: __________________________ Department: __________________________

District/ Sub-District: __________________________ Researcher: __________________________

Note: If you have any questions about the research or wish to withdraw from the study, please contact the researcher, Ana Isabel F. S. Soares (ph: +61 413610141/ Australia or +670 7298114/Timor-Leste/email: ana.soares@cdu.edu.au). You can also contact the Executive Officer, Charles Darwin University Human Research Ethics Committee, Darwin, NT 0909, Australia, by phone: +61 8 8946 7064, fax: +61 8 8946 7199, or email: cdu-ethics@cdu.edu.au. The Executive Officer can pass on any concerns to appropriate officers within the University.
APPENDIX 6: INFORMED CONSENT FORM FOR COMMUNITY PARTICIPANTS

Informed Consent for Community Participants


Chief Investigator: Ana Isabel F. S. Soares

I __________________________ agree to participate in the research project.

I understand that my participation in this research will include an interview that is likely to take about 45 minutes.

I agree that this interview can be audiotape recorded. I understand that the recording will be deleted after the interview has been transcribed, translated and endorsed.

I am aware that I can contact the researcher or the Executive Officer, Charles Darwin University Human Research Ethics Committee, if I have any concerns about the research, such as if I feel in anyway threatened by my participation in the study.

I also understand that I am free to withdraw my participation from this study, or to decide not to answer particular questions, at any time without giving a reason. This right is not in any way dependent on, or affected by, whoever nominated me to participate in the study.

I expect the researcher and/ or interpreter to answer all of my questions fully and clearly.

I agree that the research data gathered from this study may be published in a form that does not identify me in any way. I have had my involvement described to me by the researcher verbally and I am satisfied that the researcher will respect my rights and involvement in accordance with the above agreements, understandings and expectation.

Participant’s signature: ___________________________ Date: ___________________________

Position: ________________ District/ Sub-District: ___________________________

Interpreter’s/ research assistant’s name and signature: ___________________________

Researcher’s name and signature: __________________________

Note:
If you have any questions about the research or wish to withdraw from the study, please contact the researcher, Ana Isabel F. S. Soares (ph: +61 413610141/ Australia or +670 7298114/Timor-Leste/email: ana.soares@cdu.edu.au).
You can also contact the Executive Officer, Charles Darwin University Human Research Ethics Committee, Darwin, NT 0909, Australia, by phone: +61 8 8946 7064, fax: +61 8 8946 7199, or email: cdu-ethics@cdu.edu.au. The Executive Officer can pass on any concerns to appropriate officers within the University.
APPENDIX 7: PLAIN LANGUAGE STATEMENT

Plain Language Statement


Chief Investigator: Ana Isabel F. S. Soares

I invite you to participate in this study. You are free to refuse, irrespective of who has nominated you to participate. If you agree to participate you are free to withdraw at any time.

Purpose of the study: You are invited to assist me study the roles of the Ministry of Health (MoH) and its partners to strengthen health services delivery systems at the national, district and sub-district levels. This study looks at how health care is managed in Timor-Leste. It addresses various matters: structures, power, equity, ethics, cooperation, responsiveness, accountability, participation, effectivenes and efficiency, and transparency which affect how health providers deliver their services to the community in Timor-Leste. The aim of this research is to improve the health status of the Timor-Leste people.

Benefits of the study: This study will help the Timor-Leste government ensure that health services are equally available to all people, without discrimination on the basis of gender, age, place of residence, socio-economic status, political affiliation and religious beliefs.

What would be expected of you: You will be invited to take part in an interview of about 45 minutes or discussion group for approximately 2 hours. You will be visited and observed in your work place.

Discomforts/Risks: There are no special risks related with this study. If you prefer that I do not record your interview or take notes during the interview, please inform me. If you feel in anyway threatened by this research, please make it known, so that your concerns can be addressed appropriately. You can decide at any stage to continue or withdraw from the study.

Confidentiality: You will have your name removed from all documents and other material so that it will not be possible to identify you or any other person in the research. If you allow me to make a tape recording this will be kept confidential and only used by me to confirm information. The information, your name, and related places and organizations will be kept secret and de-identified using a code only known to me.

Results of the study: The results will be reported in a university thesis, and also in the Graduate School for Health Practice’s (GSHP) newsletter, in journal articles (including the Bulletin of the MoH Timor-Leste), and in seminar presentations organized by me and the MoH Timor-Leste.

Persons to contact: If you have any questions about the research or wish to withdraw from the study, please contact the researcher, Ana Isabel F. S. Soares (ph: +61413610141/ Australia or +670 7298114/ Timor-Leste/ email: ana.soares@cdlu.edu.au). You can also contact the Executive Officer, Charles Darwin University Human Research Ethics Committee, Darwin, NT 0909, Australia, by phone: +61 8 8946 7064, fax: +61 8 8946 7199, or email: cdu-ethics@cdlu.edu.au. The Executive Officer will pass on any concerns to appropriate officers within the University.
Appendix 8: Endorsement Letter from Ministry of Health Timor-Leste

IV GOVERNO CONSTITUISIONAL
MINISTÉRIO DA SAÚDE
Gabinete do Ministro

Ref. MS/Aux/09- 457
Dili, 28 July 2009

To : Ana Isabel de Fatima Sousa Soares,
    PhD Candidate, Institute of Advanced Studies
    Graduate School for Health Practice,
    Charles Darwin University, Darwin Australia.

Dear Mrs. Soares,

RE: MoH Endorsement to Conduct Research in Timor-Leste

The research proposal by, Ms Ana Isabel de Fatima Sousa Soares, “Development and Implementation of Timor-Leste Health policy Framework 2002: A Governance Analysis” has been analyzed by the Ministry of Health, Democratic Republic of Timor-Leste.

The ethics analysis is based in the following guiding principles:

- Individual autonomy (the ability to make decisions for oneself)
- Beneficence (the obligation to “do good” for others)
- Non-maleficence (the obligation to avoid causing harm to others)
- Justice (the value of distributing benefits and burdens fairly)

The research will have an analytical component, data collection and case studies. Both qualitative and quantitative methods will be used. The interviews will be voluntary and with full confidentiality, ensuring that no harm will be done to any participant. The study will be of potential benefit to the health system and to the population at large. It will not impose any unnecessary burden to the health system or to the participants.

We find the proposed research to adhere to all these ethics principles and give our approval to the research.

The Ministry of Health will provide all necessary support to this important research, which can contribute to further improvement of the health system in Timor-Leste, with benefits for the entire population.

Yours Sincerely

Dr. Nelson Martins, MD, MHM, PhD
Minister of Health