Case study Timor-Leste

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Context: (country and area where the intervention was initiated and the 'intervention level')

In 2002, Timor-Leste a small country of approximately 1.2 million people was officially recognized as an independent nation after 25 years of Indonesian occupation and five hundred years of Portuguese colonial rule. In 2006, four years after independence, Timor-Leste fell into violence and instability. Various factors led to the post-independence unrest. Expectations of independence had been high. Economic factors included a lack of development despite growing wealth in the form of a petroleum fund. Youth unemployment was high. Veterans who had participated in the struggle against the occupation felt disenfranchised and without economic opportunity. Important social challenges included the selection of a national language that a minority of the population spoke. Mistrust was a growing problem, as elitism emerged, and particular groups were being favored. Conflict peaked after the fatal shooting of several police officers the country plummeted into widespread violence and the demise of the first elected Government. Still traumatized by the violence and killings in 1999 after the referendum vote for independence from Indonesia, the Timorese fled their homes and re-grouped in camps for safety. The internally displaced camps remained well into 2008.

The health system under the Indonesian Government was highly centralized. All senior health personnel were Indonesian. Although there is little documented literature from the occupation period, it appears the health system in Timor was chronically underfunded compared with other Indonesian provinces and that health services were of poor-quality and unresponsive to the needs and demands of the population[i]. Health services were underutilized, suggesting access issues or a lack of confidence in the health system. A visit to the doctor was usually a last resort. Drugs would be given solely on the basis of a clinical diagnosis; available tests would not be ordered for East Timorese. Many locals relied on traditional medicine to drive out the particular '*horok'*, or evil spirit, troubling the patient. When the Indonesians withdrew in late 1999, they destroyed over 80% of the health's infrastructure and equipment and left the system depleted of senior staff. Only 16 doctors remained in the country[ii]. Timorese health workers had not held positions of leadership and lacked management skills.

In the early reconstruction process, international NGOs provided most of the health service delivery in the districts, while the interim health authority (a mix of 29 Timorese health professionals at the national level and 6 UNTAET[iii] health staff[iv]), grappled with developing the health system. National ownership was essential and the early architects of the health system took the decision not to build back what was there before but set about establishing a health system that was responsive to the needs of the Timorese. System development was slower than anticipated, particularly by the international community, but also by the MOH, predominantly hampered by lack of capacity and the broad range of skills required for a health system development. The reconstruction efforts appeared highly centralised from a citizen perspective and districts lagged behind in the development efforts. In 2007, still raw from the crisis of 2006, the IV Constitutional Government was sworn in[v]. Dr. Nelson Martins, the New Minister for Health, had significant challenges with which to contend. The Ministry for Health (MOH) was politically charged, weak and inexperienced. The national budget allocation for health was on a downward trend since 2005[vi]. Timor-Leste had some of the worse health indicators in the Asia Pacific Region, including for maternal and child mortality. The political instability of 2006 had dissipated but not completely disappeared, and many Timorese, including staff from the MOH, were still living in internally displaced camps. The MOH knew that the significant mistrust of health services during the Indonesian occupation had not fully resolved and utilization rates were still poor. Dr. Martins recognized that to need improve health outcomes for the people of his country he would need to evoke their trust. Committed to assisting the new administration with regaining political stability, Dr. Martins set about revitalizing the health system by focusing a visible health service delivery model at the community level or the village (suco) in order

to inspire trust in the system and in modern medicine. It is against this backdrop that *Servisu Integrado Saude Communitaria* (SISCa) was conceived.

Brief Description of the Intervention

Servisu Integrado de Saúde Comunitaria (SISCa) is a mobile outreach health service delivery approach designed to increase utilization of health services. It is a nationwide program of monthly outreach visits to every *Suco.* It provides an integrated service delivery platform of a wide range of basic health services, preventive and curative, including immunization and contraceptives, and undertakes health promotion activities. Some 442 SISCas are currently operate across the country and are staffed by MOH sub-district health posts and a program of PSF volunteers.
The service is delivered by MOH staff, with the support of community volunteers and NGOs and consists of six primary health care interventions that focus on Millennium Development Goals:

1. Registration and community data (registers attendees at the SISCa and the data contributes to the Family Health Register, a community health surveillance system.
2. Nutrition and Growth Monitoring – provides on-going grow monitoring for under twos and micronutrients, food supplementation, Vitamin A.
3. MCH (ANC and immunization) – provides family planning, antenatal and post natal services and immunization, contraception, cord care and delivery kits, ITNs, EPI
4. Hygiene and Sanitation – food preparation, hand washing, latrine designs.
5. Curative – antibiotics, Active Management of Tuberculosis (AMTB) diarrhea management.
6. Health Promotion and Education – includes but not limited to family planning, TB, malaria prevention, safe motherhood, antenatal care birth planning and appropriate care seeking for birthing promotion of exclusive breastfeeding

SISCa was created to be visible to all and to ensure equitable, efficient, sustainable and visible health services for all people, and address accessibility issues. [1] To increase demand for health services, the MOH realized that community participation and inter-sectoral coordination between district health projects and NGOs would be essential to the implementation success. The MOH was dependent on the coordinated efforts of NGOs and projects working in the districts for support. The MOH believed that exposure to health services by those who would not normally access health services would enhance confidence in health services and would increase utilization over time. In addition, developing and maintaining political legitimacy and stability were strong motivators for the Government of Timor-Leste (GOT) during this time. The GOT wanted a health program that would show the government's efforts for improving the lives of the people. SISCa was promoted widely on television, radio and through mass media. In spite of criticism by international partners and MOH colleagues on the way in which SISCa was rolled out without implementation guidance, the Minister defended his position not to pilot the intervention. The rationale for widespread implementation without pilot testing was to respond to the immediate health needs of the country.

SISCa was designed for members of the community, including men and the disabled, and curative services were at the forefront. Timorese ownership of the new health system was an important goal of the MOH. There was emphasis on encouraging community participation for decision making on their health needs. Engagement of the community leaders (*Chefe de Suco*), members of community councils (*councelho do suco*) and community health volunteers (*Promoter Saude Familiar* (PSFs)) was pivotal to the effectiveness of community engagement of SISCa. The emphasis on health promotion has been pivotal in augmenting community understanding of prevention and use of health care services. Engaging the *Chefe de Suco* on the importance of his/her role in their community's health system, through reinforcement of health promotion messages and active engagement in reporting on the family health register, was essential. The PSF's role was to support the communities to maintain healthy practices. Overall, the community participation component of the program has been important for delivering health interventions in a manner that is culturally relevant, appropriate and acceptable, and that meets health needs.

Brief description and reflection on the challenges encountered.

The concept of SISCa was grounded in good theory. Implementation encountered challenges. The national health budget allocated to goods and services was not equipped to fund the implementation of the program on a national scale. The program was implemented with the existing MOH funds. The operational costs of SISCa

[1] HE Minister of Health: Revitalization of Primary Health Care through SISCa Minister for Health RDTL)

were not considered. By mid-2008, the first year of program operation, the entire budget allocated to district service delivery ran out. This was rectified when the World Bank agreed in 2010 to finance the operating costs of SISCa. SISCa was allocated a budget of $35 per SISCa community outreach visit. This was to cover the costs of the community volunteers. In reality the budget covers mostly fuel costs. Some costing exercises of SISCa indicate that it costs the MOH approximately $250.00 per SISCa community outreach visit[vii]. The new cost has not been accounted for in the budget. In addition, transport, centralized fuel purchase and inability to maintain vehicles in the districts hamper implementation. The MOH relies on support of NGOs and partners working in the districts for logistical support.

Reflection on the (possible) contribution to conflict transformation

Timor-Leste's experience is an example of a new country emerging from conflict that opted to build a new health system, rather than continue health programming through an inherited system. Timor-Leste pursued this path despite minimal capacity. The MOH chose to rapidly scale-up of health services on a national scale to meet popular expectations using a community-based approach for health service delivery. Early results of the SISCa show a dramatic reduction of child deaths, and a raised profile and greater legitimacy for the MOH. The program has also contributed to nation building, and has bridged the political divide between Eastern and Western Timor-Leste. A key component for success of the program has been geographic equity of the intervention as demonstrated through nationwide roll-out of the program. The Minister has shown his personal commitment to the program by visiting all Districts during the roll out and through various stages of his five year term. Anecdotal evidence points that "...Wherever one would travel in Timor-Leste and ask people what public service had become most effective; the answer was unanimously, health"[viii]. While the MOH continues to face challenges in terms of institutionalizing policies for strengthening human resources and improving maternal health indicators, looking back from where the MOH started, the MOH's ability to establish itself within a new government and with the people of the Timor-Leste over a very short time period is a tremendous achievement.

Evidence of impact of intervention on health, health system and/or conflict transformation

The SISCa program is noteworthy for providing health services to communities less likely to access health services. Data from the Demographic and Health Survey (DHS) 2010 indicate significant improvements in health outcomes at the national level. In approximately seven years, under-five child deaths have declined by 24 percentage points, there has been a 28 percentage point increase in immunization for DPT3 coverage and a 10 percentage point increase in contraceptive prevalence rate. The steady decline in the under-five mortality rate was reported by the Child Health Epidemiology Reference Group (WHO and UNICEF) as the biggest reduction by a country world-wide at any time between1990-2010[ix].

Indicators	**DHS 2003**	**DHS 2009-2010**
Total Fertility Rate	7.8	5.7
Contraceptive Prevalence Rate	10%	20%
Maternal Mortality Ratio	420-800/100,000	557/100,000
Neonatal Mortality Rate	42/1000	33/1000
Infant Mortality Rate	60/1000	44/1000
Under Five Mortality Rate	107/1000	83/1000
% of children (12 -23) immunized for DPT3	51%	79%

[i] Rosser, Andrew (2007) 'The First and Second Health Sector Rehabilitation and Development Projects in Timor-Leste', *Aid that Works: Successful Development in Fragile States,* World Bank publication, p123

[ii] Tulloch, J, 2003 et al: Initial steps in rebuilding the Health Sector in East Timor

[iii] United Nations Transitional Government in East Timor

[iv] Tulloch J et al, 2003
[v] Two transitional governments were formed between June 2006 and August 2007
[vi] The MOH budget as percentage of the central government's budget has gone down from 10.8% in 2005/06 to 5.6% in 2010 (World Bank Expenditure Review, 2010)
[vii] Health Alliance International, 2010
[viii] Focus Group Discussions, 2011
[ix] http://www.unicef.org/media/files/Child_Mortality_Report_2011_Final.pdf