THE ROLE OF INTERNATIONAL NGOS IN HEALTH SYSTEMS STRENGTHENING: THE CASE OF TIMOR-LESTE

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Achieving the United Nations Millennium Development Goals for health will require that programs supporting health in developing countries focus on strengthening national health care systems. However, the dominant neoliberal model of development mandates reduced public spending on health and other social services, often resulting in increased funding for nongovernmental organizations (NGOs) at the expense of support for government systems. East Timor, later Timor-Leste, is an example of a post-crisis country where international NGO efforts were initially critical to providing relief efforts to a traumatized population. Those groups were not prepared to help develop and support a standardized Timorese national health plan, however, and the cost of their support was unsustainable in the long term. In response, local authorities designed and implemented a post-crisis NGO phase-over plan that addressed risks to service disruption and monitored the process. Since then, some NGOs have worked collaboratively with the Ministry of Health to support specific efforts and initiatives under a framework provided by the ministry. Timor-Leste has shown that ministries of health can facilitate an effective transition of NGO support from crisis to development if they are allowed to plan and manage the process.

Global health activists are increasingly aware of the need to strengthen government health systems in developing countries in support of a sustainable response to the health needs of a globalized world. There is widespread and growing support for the realization that strengthening the capacity of the state to regulate, provide, and expand the provision of care will be necessary for the achievement of

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the Millennium Development Goals (1, 2). Strengthening local health systems requires that the people and institutions of each country or region are deeply involved in and have the means to direct the development process. This challenge is particularly acute in post-conflict or post-disaster settings, where the immediate need for relief assistance often takes precedence over developing locally determined public systems of care.

At the same time as the need for stronger national health systems is recognized, developing country governments are under pressure from international financial institutions such as the International Monetary Fund and World Bank to reduce health expenditures (3). The neoliberal model of international development that they promote emphasizes the need for "reforms" such as free markets and privatization of essential public services. As a result, funding for local and international nongovernmental organizations (NGOs) has grown dramatically. NGO projects supported by the World Bank, for example, increased from 20 percent of the total health funding to 52 percent in just 10 years, between 1989 and 1999. Similar changes occurred in U.S. government funding, where the proportion of international health assistance going to NGOs nearly doubled from 13.1 percent of the total in 1990 to 24.9 percent in 2006 (4).

NGOs have some clear advantages in responding to urgent problems such as natural disasters and other emergency situations, when they can garner private resources and move into place quickly. NGOs also tend to be more flexible than governments, and can often be more innovative in responding to health needs. In the first week following the January 2010 earthquake in Haiti, for example, the American Red Cross raised more than US$30 million with an innovative text-messaging donation scheme (5).

A range of concerns has been expressed about the preferential funding of NGOs in global health, however. Although they may aim to support national health systems, their control over the actual funding has questionable effects on the status of the government as decision maker. Nongovernmental groups are accountable only to their donor base, which may range from individual donations to grants or contracts from foundations or aid-giving governments. Because individual donors often have little understanding of real health or development needs in poor countries, many NGOs have learned to develop their donation programs in ways that allow the flexibility to address locally determined priorities. However, they are still not accountable for that support to the countries or populations they serve, so accountability continues to rest outside the countries and populations that are the "recipients" of the support.

Other questions have been raised about local consequences of the proliferation of NGO projects. Many countries have massive numbers of international NGOs, which can make coordination by local authorities extremely challenging. Heavy support for the nongovernmental sector often means that proportionally less support is available for public-sector health systems—specifically for ministry of health policy development and service delivery. Some NGOs working in

health develop their own boutique, small-scale but parallel health care systems, at times because of donor mandates for measurable, short-term results. Those well-funded parallel systems then compete with efforts to strengthen the public sector (2). Because of their relatively narrow "project" focus, NGOs may lack a broad perspective on health and development. The need to show quick results to funders can obscure the larger goal of promoting sustainable, scalable systems that will function over the long term. This limitation is particularly true in post-conflict or natural disaster situations when relief agencies focus on immediate needs rather than long-term health development.

Genuine progress in meeting the health needs of the people of the global South will require that all organizations involved have the commitment and skills to support sustainable, national-scale programs that reach entire populations. This article discusses the role of health NGOs and their relationships with the national health authorities in a post-conflict country, Timor-Leste, formerly known as East Timor. We describe an important potential role for NGOs in health systems strengthening, making use of their advantages and minimizing the threats they can pose to the development of sustainable public-sector health systems. We present examples from the experience of an international NGO, Health Alliance International, which has worked for the past 10 years in support of the Ministry of Health of Timor-Leste.

BACKGROUND

East Timor, half an island north of Australia, was a backwater Portuguese colony for more than 400 years. It was invaded and illegally occupied by Indonesia in 1975, with tacit support from the U.S. government (6). Under Indonesian domination, nearly one-third of the population perished from direct warfare, starvation, or disease. The Timorese maintained an armed resistance throughout the 24 years of Indonesian occupation and, in the process, suffered well-documented human rights abuses (7). On the coattails of the 1997 Asian economic crisis and the subsequent political turmoil within Indonesia, the Timorese people were granted a Popular Consultation in August 1999 in which they could vote for greater autonomy while staying part of Indonesia or for independence. The Timorese people overwhelmingly chose the latter. Directly following the vote for independence, pro-Indonesia Timorese militia supported by the Indonesian military orchestrated a premeditated campaign of retribution, which resulted in the destruction of 75 percent of the country's infrastructure and the forcible displacement of several hundred thousand Timorese (7). The social and political turmoil and excesses of violence, both leading up to and following the 1999 vote, have had a grave impact on the political, social, and economic development of the country. Emerging from the ashes, Timor-Leste, as the new country is called, achieved full independence in 2002. Among the many challenges the fledgling nation faced was the development of an effective government infrastructure.

For more than two years (September 1999 to May 2002), the country was under the administration of the United Nations (UN) Transitional Administration in East Timor (UNTAET). UNTAET combined peacekeeping operations and an administrative mission. During its tenure, UNTAET conducted a needs assessment, coordinated two elections, and facilitated writing the Constitution, with the stated aim of preparing Timor-Leste for self-governance. Soon after the 1999 vote, international aid dollars began flowing into the new country. Following patterns in other developing countries, the funds were accompanied by the influx of multilateral institutions, including UN agencies, international NGOs, international financial institutions, and bilateral development agencies.

Development was extremely challenging in a setting of near-total absence of infrastructure, the lack of any legitimate government with which to work, and lingering instability in some regions that continued for several months after the vote. The utter collapse of public administration and very limited availability of human resources for the public service sector, combined with the humanitarian crisis that caused extensive internal and external displacement of thousands of Timorese, made it a very difficult post-conflict environment. Even considering the difficult circumstances, however, a number of Timor scholars and activists have commented on the relative lack of involvement of Timorese in the early stages of the broader development process. Speaking at an international conference in 2006, Timorese activist Guteriano Neves criticized UNTAET for the lack of opportunities for Timorese voices to be heard during the early nation-building phase, saying, "The mission and process were designed by the UN in New York, far away from Timor-Leste. In designing the mission…the UN tended to assume Timor-Leste conditions were the same as other post-conflict countries where the UN had been involved." He also noted that the initial Joint Assessment Mission in 1999, coordinated by the International Monetary Fund and the World Bank, was carried out "with little consultation with or participation from the Timorese people" (8).

Other scholars noted the near-total lack of Timorese participation in the initial assessment. However, one critic of the assessment process commented that because the health sector had earlier and greater involvement of Timorese professionals in its development, it was among the most successful of the government ministries. According to Schenk, "The health sector showed a rather positive development in the arena of capacity building and service delivery due to the following factors: Timorese staff had taken over responsibility in an early stage and the process of 'Timorisation' started early in the Ministry of Health. Moreover, coordination mechanisms with all involved organizational bodies assured smooth service delivery" (9).

Supporting that observation, a 2011 evaluation of the effectiveness of the World Bank Group programs in Timor-Leste, which found them to be "moderately unsatisfactory" relative to their overall objectives, rated the health sector support more highly (10).

THE CONTEXT OF HEALTH NGO INVOLVEMENT IN TIMOR-LESTE

During conflict and immediate post-conflict situations, nongovernmental groups are often the only institutions able to provide health care services (11). When the post-vote violence abated in East Timor in late September 1999, international health NGOs arrived to provide much-needed emergency health services in a chaotic environment where effective coordination and planning were challenging at best. In February 2000, with the establishment of an Interim Health Authority (IHA) comprising Timorese and UN staff, the end of the emergency phase was declared and a more systematic, long-term approach to the provision of health services and development of the health system was adopted.

Between September 1999 and July 2001, there were no government-provided health services in the country. Health services for the entire country were provided by 15 international and six national NGOs, 23 Catholic clinics, and four peacekeeping contingents. The World Health Organization played a coordinating role in addressing public health risks, and UNICEF coordinated the re-establishment of maternal and child health care, including immunization and emergency obstetric care through the network of health NGOs.

In those first months following the vote, international health NGOs working throughout the country demonstrated remarkable capacity to respond rapidly. What they had found on arrival was sheer destruction. More than one-third of the health facilities were totally destroyed and virtually all equipment and supplies had been damaged or looted. Doctors and senior health management personnel, nearly all Indonesian, fled the country (12). The work of the NGOs during this emergency phase was critical in providing health services to a traumatized population and they were able to be logistically self-sufficient in addressing pressing health care needs.

However, despite the fact that most of the international health NGOs were highly competent in emergency situations, most lacked the capacity to incorporate longer-term development perspectives into their work. In addition, their operations were enormously costly as well as individualistic in their approaches. Povey and Mercer noted that while the NGOs brought great experience to bear on the East Timorese tragedy, they were "often unable to alter their practices to conform with plans for the nation's future" (13).

In fact, the direct delivery of health services by international NGOs was also financially unsustainable, given the gloomy fiscal outlook of the country at that time, with both recurrent expenses and capital investment needed by the new nation primarily dependent on donor donations. The recurrent health budget for fiscal year 2001 was US$3.9 million, and the Trust Fund for Health established in 2001 by a group of donors pledged a total of US$12.7 million for the health sector over three years. The expensive provision of health care by

international NGOs was drawing down the Trust Fund at a rate of US$6.2 million per year (14). The human resources skill mix, technology, and logistical capacity of the international NGOs were unlikely to be sustained by the scarce resources available at that time.

HEALTH NGOS AND TIMORESE HEALTH AUTHORITIES

Officials of the IHA were acutely conscious of the need to move beyond the emergency phase and rapidly launch the foundation of an appropriate national health system. However, they faced the dilemma of how to move away from the continuation of NGOs as the leading provider of health services in the face of limited Timorese human resource capacity to assume that responsibility. With the support of the World Bank (the fiduciary agent for the Trust Fund for Health), the IHA decided to implement a gradual phase-out of the NGOs that were directly involved in district-level health service provision. The plan was to first assign responsibility for health service provision in each of the 13 districts to a lead NGO, through a memorandum of understanding based on District Health Plans that were developed jointly by the NGOs and Timorese Health Authority focal points at the district level. Timorese health authorities would then gradually phase in responsibilities for the health care system through the establishment of District Health Management Teams and the recruitment of clinical staff for the provision of health services in all 13 districts.

Both steps were carefully designed and negotiated so that NGOs would maintain service provision, while preparing the handover of responsibilities to the newly established District Health Management Teams over a period of one to two years, depending on the readiness of each district.

The IHA, by then transformed into the Division of Health Services (an embryo of the future Ministry of Health), began the process of phasing out NGOs as providers of health services in mid-2001, two years after the vote for independence. They initiated intensive discussions with NGO staff in every district to delineate a phase-out matrix as a tool to implement and monitor progress. The development of this matrix included the following steps:

1. Conducting in-depth participatory assessments to identify potential disruptive risks to service provision.
2. Devising strategies to mitigate those risks.
3. Establishing an ongoing monitoring and supervisory mechanism to facilitate the phase-out process.

The targeted date by which the phase-out process would be completed was to occur six months later on December 31, 2001.

A NEW FRAMEWORK FOR COLLABORATION WITH THE HEALTH SECTOR

The reaction among health organizations to the decision to phase out NGOs as leading health service providers varied from mild concern to writing letters of protest to the UN Administrator and donor institutions, and even in some cases trying to resist the phase-out plan. Donors were not at all convinced about the wisdom of the decision, and all reactions had a common denominator: the persistent belief that Timorese were not ready to maintain the provision of health services without the presence of international NGOs. The only open support for this decision came from the few international staff who worked closely with their Timorese counterparts in the Division of Health Services (14).

Despite resistance, the process moved forward. By the original target date, the end of 2001, health services provision in all 13 districts was being carried out by the newly established Ministry of Health (MOH). There were no abrupt disruptions of services, and even though the output of service provision was still far behind initial targets, reports showed that some districts performed even better on some of the output indicators after the NGO phase-out than during the NGO period. For example, in the District of Covalima, outpatient visits increased and drop-out rates for the third DPT immunization decreased between 2001 and 2002 (15).

After concluding the phase-out process, the MOH issued guidelines for health NGOs, emphasizing the preference for cost-effective interventions that were considered gender-sensitive and involved local people and organizations. In line with national health priorities defined in the National Development Plan and Health Policy Framework, these interventions were directed to cover difficult-to-reach populations and geographical areas. The preferred approaches included health promotion and education, community participation in health, operational research, and interventions to deal with specific diseases such as HIV/AIDS, malaria, TB, and leprosy. Secondment of medical or technical staff to the MOH was encouraged to support capacity among Timorese professionals. Every health NGO willing to comply with these principles was asked to submit a proposal for formal MOH approval. A focal point was established within the Ministry to manage NGO partnerships.

Under this framework, the MOH initiated a new phase of collaborative partnerships with like-minded NGOs to develop the health sector in Timor-Leste. Although many of the international NGOs had ceased health work in the country, as of 2010 there were 60 national and international NGOs working with the MOH under these new guidelines in areas such as nutrition; maternal, newborn, and child health; family planning; delivery of primary care and specialized services; mental health; and interventions for HIV/AIDS (16).

One measure of the success of the current approach came by comparing the results of national Demographic and Health Surveys conducted in 2003, soon after

the new NGO policy was adopted, with the results from that same survey conducted six years later in 2009. There were impressive increases in utilization of health services under this collaborative system. For example, women attending prenatal care increased from 60 percent to 86 percent; the use of skilled birth attendants for deliveries increased from 19 percent to 30 percent; contraceptive use more than doubled from 10 percent to 22 percent; and children who are fully immunized increased from 35 percent to 53 percent. In addition, statistics for child mortality have shown impressive progress in the past six years. The infant mortality rate decreased from 60 to 45 per 1,000 live births and mortality of children under the age of 5 decreased from 83 to 64 per 1,000 live births (17, 18). Though much remains to be accomplished, the NGO-MOH partnership is strong and will be an integral part of future improvements in Timor-Leste.

In 2008, the MOH moved to implement a National Health Strategic Plan covering a five-year period, 2008 through 2012 (19). In this five-year plan, the NGO partnership framework was further strengthened by defining a mechanism for better coordination in the health sector. A newly established Department of Partnership Management would coordinate an Annual Health Sector Review to be held every June, with the participation of all stakeholders, including health NGOs and the donor community. These annual reviews aim to monitor progress in the health sector and identify weaknesses to be addressed during the next planning and implementation cycle. The results and recommendations of the sector reviews are incorporated into annual MOH action plans. The annual action plan is financed through the General State Budget and the Combined Sources Budget, which specify financial and technical inputs from various donors and stakeholders, including health NGOs. The annual MOH-led health sector review, which continues to take place every June, convenes organizations working in health in Timor-Leste to set priorities and coordinate activities planned for the coming year. This strengthened partnership has established a fertile environment of collaboration among all health sector stakeholders in Timor-Leste and assures that the MOH maintains a stewardship role.

A PARTNERSHIP MODEL

Health Alliance International (HAI) provides a case example of how the MOH-NGO partnership model works in practice. HAI, a United States-based international NGO with health programs in several countries, began operations in East Timor in early 1999 with support for maternity services in Dili, the capital. In 2004, the United States Agency for International Development (USAID) awarded HAI a grant to support the new Timor-Leste MOH to improve the quality of maternal and newborn care in six districts of the central region of the country, followed the next year by funding for family planning.

HAI's primary mission includes the promotion of policies and programs that strengthen government primary health care systems and decision making by

national MOH staff. This contrasts with a more typical development model whereby external organizations, usually from the North, have control of project budgets and are perceived by themselves and by those with whom they work as holding the balance of power in decision making (20). Over the more than 10 years that HAI has been active in Timor-Leste, it has built strong relationships with MOH counterparts at the central, district, and subdistrict levels and implemented programs in collaboration with the MOH at every stage. HAI is often the only NGO included as a responsible party in national planning meetings and documents, cited, for example, as a provider of technical assistance for maternal and child health and family planning in the Health Sector Strategic Plan, 2008–2012 (19).

There was a unique synergy between the core values of HAI and the MOH leadership in Timor-Leste, which sought to oversee and effectively coordinate the activities of international health NGOs working in the country. HAI has become a key partner in the development and deployment of Timor-Leste's maternal, newborn, reproductive health, and family planning programs and policies. The first Minister of Health commented on the comprehensive collaboration between HAI and the Timor-Leste MOH when he remarked in a presentation at the 2009 12th World Congress on Public Health in Istanbul that, "Health Alliance International is one of the health NGOs doing impressive, outstanding, and excellent work in Timor-Leste, which reflects their deep commitment to a collaborative partnership in the development of the health sector in Timor-Leste" (14).

The Timor-Leste national family planning program provides an instructive example of MOH-HAI collaboration. The 2003 Demographic and Health Survey revealed that the country had the highest fertility rate in the world at 7.8. Not surprisingly, contraceptive prevalence in the country was very low at only 10 percent. When that information became available, the MOH and HAI began joint efforts to strengthen the national family planning program, integrating it carefully into existing maternal and newborn care efforts that provided a range of reproductive health services. HAI contributions since then have included:

1. An extensive qualitative assessment of community experiences, knowledge, beliefs, practices, and needs vis-à-vis childbearing and contraception, which helped shape the MOH approach to family planning. The input and participation of community members were critical at this juncture, particularly because during the Indonesian occupation, "family planning" was widely seen as a coercive attempt to limit the size of the Timorese population and not part of a woman's and couples' reproductive rights. Because many families did not favor the notion of limiting family size but were receptive to the idea of spacing births and learning more about contraceptive methods, child spacing was emphasized, as well as the health benefits to mother and infant of well-spaced births.

2. Training and supportive supervision of MOH midwives to build their capacity to deliver quality services, including improving communication skills. HAI midwives became "master trainers" for the national program so that they could train and supervise newly trained midwives in procedures such as intrauterine device (IUD) and contraceptive implant insertions.
3. Development of health promotion materials for national use. Although community-level efforts to promote health and engage with communities were included in the job descriptions of district health staff, there was an initial lack of appropriate materials to facilitate their working with community members effectively. HAI and the MOH jointly produced flip charts, posters, training plans, and several films in DVD format designed to inform and motivate families about maternal/newborn care and family planning. With the use of generators, DVD players, and flat-screen televisions, the films have been shown across the country in some of the most remote locations. Showings are followed by interactive discussions with participants. The first family planning film was also shown on national television in 2010 in a time slot just before the World Cup semifinal, to an estimated audience of 150,000.
4. The introduction of operations research training to support quality improvement of MOH programs. Recognizing that research and evaluation are key components of an effective health system, careful assessment of local program efforts has been a priority of the Timor-Leste MOH. A 2012 article in the journal *Health Research Policy and Systems* co-authored by the Minister of Health expressed concern that most research in Timor-Leste had been conducted by universities from outside the country. But the authors also stated, "A notable exception was the regular in-country research conducted by the non-governmental organisation Health Alliance International (HAI), which was used to evaluate the effectiveness of their maternal and child health interventions" (21). To augment local capacity building in this area, HAI and the Timor-Leste Cabinet for Health Research and Development conducted an operations research workshop for district-based multidisciplinary health staff, and plans for additional training are ongoing.

There are of course multiple challenges for both ministries of health and NGOs when they work together in true collaboration, particularly in post-conflict situations. Government health staff in both stable and crisis situations are often overwhelmed with a wide range of responsibilities, including demands from multiple donors, making it sometimes difficult for them to be actively involved in new initiatives. Formal MOH review and approval of the family planning film, for example, took several months due to the many competing priorities of MOH staff.

Programs need to be able to respond to changing conditions, and partnerships with government in particular mean that changes in national leadership and

conditions such as civil unrest may require temporary shifts in strategies or timelines. The political stability of Timor-Leste was threatened in 2006 with several months of violent conflict that made district travel impossible and led to the delay of important project activities. HAI was fortunate that both the MOH and its funders, USAID and AusAID, understood the need for flexibility as a result of political unrest and other changes in local conditions.

In effective partnerships, the concerns of national authorities, which may be different from those of the NGO, need to be respected. In Timor-Leste, the influence of the Catholic Church is considerable, and some officials were concerned that it would pose a challenge for the family planning program. However, dialogue and joint efforts with the MOH and church representatives in reviewing program materials, such as the family planning films, have proven successful in the Timor context. Catholic clerics were ultimately included in the films to explain "natural methods" of family planning, giving added credence to the program and assurance to health staff and community members who feared church disapproval.

CONCLUSION AND LESSONS LEARNED

The Timor-Leste experience has demonstrated that there is an important role for international NGOs in promoting health systems development when national health authorities take the lead. It provides evidence that NGOs can make use of their abilities to innovate, initiate new program ideas, and provide technical assistance as part of support for government health services, rather than by developing a parallel or competitive system. In Timor-Leste, the MOH continues to provide and enforce clear guidelines for international NGOs, strengthening the processes under which they operate in the health sector. For example, annual budgets and work plans are required that identify activities in support of government functions. National health authorities thus actively guide the coordination and partnership process in line with the priorities of the country.

The experience in Timor-Leste has led to the following conclusions:

1. Managing the participation of health NGOs during the transition from emergency to development of the health system requires that national authorities carefully design processes involving participatory assessment of the risk of disruptions to the health care system, risk-mitigating strategies, and clear mechanisms for supervision, monitoring, and accountability of NGO activities.
2. National health authorities need to define what is needed from health NGOs and must have the power to make decisions about the health system for their own country.

3. Direct delivery of health services by NGOs without accountability to government tends to be costly, of varied quality, and unsustainable for many resource-poor settings.
4. NGOs can contribute with their flexibility, innovations, evaluation resources, and technical expertise to support national health system strengthening as long as their relationship with national health authorities and the planning process are well-defined and mutually acceptable. True MOH-NGO partnerships require mutual respect and genuine collaboration in all efforts.
5. Funding for this approach to health systems strengthening needs to be flexible enough to allow changes in work plans based on changing needs of the MOH and the country.

The Timor-Leste experience suggests that ensuring the self-determination of national health authorities is a viable way forward in the development and strengthening of health care systems in resource-poor settings.

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