FINAL REPORT

EVALUATION OF ECHO'S HUMANITARIAN AID IN FAVOUR OF THE TIMORESE POPULATION IN EAST TIMOR AND WEST TIMOR

HEALTH AND NUTRITION REPORT

GLOBAL PLAN JULY 1999-DEC 2000

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EXECUTIVE SUMMARY

EVALUATION OF ECHO'S HUMANITARIAN AID IN FAVOUR OF THE TIMORESE POPULATION

Country of Operation: EAST TIMOR & WEST TIMOR

Name of partners : ACF F, AMI F, CESVI, CAM, CIC P, Cordaid, HNI, IMC, IRCT, MDM F, MDM P, Merlin, MSF B, OIKOS, World Vision

Operation contract n° :
ECHO/IDN/210/1999/02000
ECHO/IDN/210/1999/03000
ECHO/IDN/210/1999/04000
ECHO/IDN/210/1999/05000
ECHO/IDN/210/2000/01000
ECHO/IDN/210/2000/02000
ECHO/IDN/210/2000/03000
ECHO/IDN/210/2000/03000

Dates & duration of the operation : 1 July 1999-31 December 2000

Amount: EURO 28,637,000.

Health & Nutrition

After the three-week rampage by Indonesian supported militias, in August 1999, East Timor's health sector infrastructure was largely devastated and most of the 160 mainly Indonesian doctors left the country. The country was left without managerial capacity to run the health services. Disastrous outbreaks of communicable diseases were likely to occur under the unfavourable circumstances. The Indonesian health system in West Timor was less affected by the events in East Timor, but faced an enormous influx of refugees. In this vacuum ECHO played a crucial humanitarian role in the health sector by financing its partners, mainly the international NGOs. The EC made eight financial decisions both for East and West Timor and some 14 million Euro was focused on health and nutrition projects.

DESCRIPTION OF THE EVALUATION

Dates for the evaluation: 28 February – 30 April 2001 (Fieldwork 5–23 March 2001)
Report no.: ECHO/EVA/210/2000/01015
Name of Consultant: Robert Soeters (QUEST-Consult)
Purpose & Methodology: Evaluation of the ECHO support to the Health & Nutrition Sectors during the emergency phase in East Timor and the implications of this for exit strategy of ECHO. The methodology consisted of briefings at ECHO in Brussels, documentation search, discussions with the implementing partners, the ECHO correspondent in Dili and relevant stakeholders and several field visits.

CONCLUSIONS

The assistance provided by ECHO funded NGOs to West Timor was useful -but after the murder of three UNHCR staff members in September 2000- most assistance involving health NGOs stopped. Approximately 50,000 -100,000 East Timorese remain displaced in squalid IDP camps or among villagers in West Timor. Insecurity remains high due to the continued

presence of East Timorese pro-integration militias among the IDP population. The provincial government responded to humanitarian needs with some limited support, but this is inadequate to fully meet basic needs. It is recommended that once the security situation improves, ECHO assistance to West Timor continues.

Relevance

The *relevance* of ECHO to intervene in the health sector with their Partners in Timor was high due to the acute health needs. The relevance of the choice of beneficiaries was excellent as the result of the ECHO strategy - inherent to the Framework Partner Agreement - by operating through partner UN organisations, and in particular through NGOs. This facilitated a decentralised utilisation of funds, which was *the appropriate* method to target refugees, displaced or vulnerable groups.

Co-ordination, coherence and complementary

There was initially no need for ECHO to play a pro-active role in health policy *co-ordination* or geographical targeting of the efforts as this was done by UN organisations. ECHO had no permanent expert in ET during the first months of the emergency, although the Jakarta-based ECHO correspondent made brief visits to Dili. However, the absence of a permanent ECHO expert during these months negatively affected the administrative aspects such as the processing of applications of Partner Organisations. With the arrival of the ECHO field expert, co-ordination aspects at Dili level of the operation considerably improved. She has been *the right person, in the right place, although arriving late.* Once in place, there were logistical problems, and evaluation mission is of the opinion that there was a need for an additional logistical - administrative ECHO person.

Only one NGO expressed satisfaction with the administrative procedures of ECHO. All the other expressed dissatisfaction, in particular with the slow process of signing contracts and commitment of ECHO Brussels with payment procedures.

Cost-Effectiveness

The *cost-effectiveness* of the ECHO funded activities has been high as the result of the initiatives of the international NGOs. The *cost-effectiveness* of interventions by ECHO funded Partners reduced due to problems with the type of employment and the salary system of Timorese staff, whereby health workers receive fixed salaries irrespective of their output. Hard working staff receive the same salary as non-performing or absent colleagues.

Efficiency

The operational capacity of the partners was by and large good with the exception of a few of the smaller NGOs, which had problems in mobilising skilled staff, or were not aware of emergency health standards such as for example laid down in the SPHERE “Humanitarian Charter and Minimum Standards in Disaster Response”. The quality of the NGO interventions improved through good collaboration with and supervision by the ECHO correspondent, and by the establishments of Minimum Standards and Choice of health activities by the DHS.

Expatriate NGO staff carried out simple tasks, which could also have been done by Timorese health workers, if they had been in a different employment system. This problem is reflected in the relative high proportion of the ECHO budget allocated for NGO staff salaries. The ratio could reach as high as 60% of the international NGO budgets. The suitability of the NGO activities in the post-crisis environment has been the subject of debate in East Timor by the population, Timorese health workers and politicians. The reputation of the NGOs seemed to improve once more dialogue took place – and after their value became more visible.

Impact & strategic implications

The *impact* of ECHO’s contribution to the reduction of human suffering has been significant with numerous death prevented, and reduced suffering from disease. The ECHO intervention in East Timor is likely to have been one of the more successful one’s in comparison with

other ECHO interventions world-wide.

There is a large dependency of the health system on external funding in the absence of own East Timorese resources. In addition, the UNTAET authorities - apparently under political pressure from East Timorese politicians - chose for a system of providing health services free-of-charge. This will create further dependence on external aid, and reduce sustainability.

The effect of the ECHO intervention on the local economy could have been larger if the authorities would not have chosen for a centralised approach. Some NGOs spent 80% of their budget on salaries and other NGO operational costs instead of on direct investments in the health system and the local economy.

Visibility

As the result of the good quality of ECHO's intervention through its health partners, there has been high visibility in terms of outputs. This was generally appreciated by the people with whom we spoke. As far as the stickers on cars and houses are concerned, the EE Team observed that partners obeyed this instruction.

Horizontal Issues

Gender

The health care programs of the ECHO Partners focused on children and women. The positive relationship between their better health and economic, social and cultural aspects is obvious. A problem though is the dogmatic stand of the very strong Catholic Church in East Timor on family planning in particular. Some NGOs diplomatically made family planning available to couples, who were seeking those services.

LRRD/Linking relief, rehabilitation and development

The Division of Health Services will start using TFET funds to replace some of the activities currently funded by ECHO, and is as such important for the phasing out strategy of ECHO. These funds will be utilised for the contracting of the more developmental-oriented international NGOs currently working with ECHO funds. The "vision" of the health authorities for the health system seems to be one of a publicly financed - publicly provided system, at no cost to the consumer, and with a heavy emphasis on a Timorese civil service. The decision for this type of health system was mainly political.

One of the key problems in the East Timor health system is the shortage of managerial capacity. The choice for a publicly-provided health system implies that it will take at least 7-10 years before well-trained and skilled Timorese government health managers are in place. Furthermore, it will be difficult to maintain those managers for low civil service salaries. A concern of the NGOs is that they do not feel as the partners of the DHS in development, but as implementers with a marginal role in a dialogue.

The apparent choice in East Timor for freely provided health services is another reason for concern. Free health care systems tend to be unsustainable and inefficient.

Security of humanitarian staff

There were no accidents concerning ECHO financed aid workers in the health sector. NGOs are responsible for their security policy, and some NGOs are prepared to take bigger risks than others. It is a good thing that NGOs have the freedom to judge their own risks. All emergency NGOs, which came immediately after the referendum, had communication equipment required and observed security protocols. They also closely co-operated with the Security Forces. Much larger risks were endured by the NGOs in West Timor, and also those NGOs, which operated in East Timor *before* the referendum.

RECOMMENDATIONS

- The ECHO strategy of working through NGO partners has been excellent, and should

continue in a new crisis anywhere in the world.

- The EE team recommends that the qualitative statement of Article 4 of the General Conditions of the Framework Partner Agreement could be changed into a quantitative statement such as for example that the response will not delay longer than “x” working days. The number of days (“x”) could then be defined on the basis of each emergency. ECHO Brussels could then be held responsible for any undue delays by its partners, for example by paying interest over delayed payments.
- A more decentralised ECHO field-driven approach at country level would be more appropriate, and should apply for all aspects of the contacts between ECHO and its partners with a Framework Partnership Agreement.
- It would be justified to draw more attention from the public in Europe to ECHO’s intervention in East Timor. ECHO could for example commission for this purpose a film with a title such as “East Timor two years later - what did the EC’s Emergency Support achieve?”

- The effect of the NGO intervention on the local economy could have been larger if the authorities would have chosen for a more decentralised utilisation of project funds.
- A more decentralised and autonomously managed human resource market is likely to absorb more health workers in formal employment than the current system of recruiting publicly paid health workers.
- There is a need that “developmental NGOs” - in collaboration with their Timorese district counterparts - obtain more autonomy of management and executive responsibilities concerning the utilisation of resources, and human resource management.

- The ECHO external evaluation mission would like to express their concern about the above mentioned issues, and feels that ECHO’s NGO partners are put in a difficult position in their transition towards TFET funding, once ECHO withdraws. The evaluation mission doubts the wisdom for the European Commission to contribute TFET funds into health without discussing *some* of the above identified problems. Massive donor funding of the current system may mask the underlying health policy problems. It might create an unsustainable system once donor funding reduces. This could create (political) problems for the future independent government. However, if the above policy issues are addressed, the evaluation mission *endorses* the course taken by the DHS and the World Bank of the *sector wide approach*, and in particular the approach whereby Timorese and international contractors are recruited to strengthen the health system.

LESSONS LEARNED

- Lessons learned from the contracting approach world-wide suggests that it is more important to seek common ground with potential contractors, and to think in terms of partnerships and common goals than in terms of control and a juridical approach.
- The contract approach may be utilised to develop new initiatives towards more performance-based incentive systems for health staff. This may imply the recruitment of a limited number of (well-paid) civil servants, and a larger share of staff to be locally recruited by district and health facility management. The very simple basic incentive principle is that more work done of good quality should also increase the salary of a health worker.
- Double checks, for example in collaboration with the donor organisations (World Bank, European Commission) could be developed to reduce the potential for rent seeking in the contracting process at national level.
- The contract approach could be utilised to promote the development of the Timorese private sector, and to create a conducive environment of partnerships with the church-related health facilities, for-profit health organisations such as Cafe Timor, and other potential actors in the private health sector.

1 INTRODUCTION

This is the health sector and nutrition evaluation report of the ECHO Humanitarian Aid interventions for the Timorese population during the period 1999-2001. This part of the report is written by Robert Soeters, who visited East Timor from the 7th until the 23rd of March, 2001. A visit to West Timor took place in August 2000, and another visit to East Timor in November 1999. The report follows the standard ECHO evaluation format, and provides answers to the evaluation objectives specified in the Terms of Reference. The consultants met with a number of stakeholders including representatives of the Division of Health Services, WHO, World Bank, and the European Commission. Of the 13 medical NGO ECHO partners currently working in East Timor, 12 were interviewed. An electronic questionnaire was answered by 6 NGOs, which provided valuable inputs. Field work consisted of visits to a number of health facilities. We also visited the ECHO office in Jakarta. Earlier versions of this report were discussed with different stakeholders.

In addition to the evaluation of the health work funded by ECHO, considerable attention was given to LRRD aspects because most of the ECHO Partners involved had already started with developmental activities and because the EC aims to continue their funding through TFET funds with some of the same partners. On the request of ECHO, additional information about the functioning and operations of NGO has been added in section 4.4.

1.1 ACKNOWLEDGEMENTS

We would like to acknowledge the constructive discussions with the different stakeholders in the ECHO intervention, including representatives of the European Commission in East Timor (John Keating, Catrine Schulte-Hillen) and Jakarta (Josep Vargas), World Bank (Sara Cliff, Chris Smith, Janet Nassim & Francis Ghesquiere), Division of Health Services ET (Jim Tollock, Rui Paulo de Jesus, Isabel Hemming, Alvaro Alonso), WHO (Alex Andjaparidze), and the Heads of Mission and other Representatives of 13 NGOs, currently present in East Timor.

In Brussels we exchanged ideas and were supported in our mission by the ECHO Evaluation Unit (Jacqueline Coëffard, Maite Orens-Teleki), ECHO III Operational Unit (Ruth Albuquerque, Paul Koulen), AIDCO (Christopher Knaut, Markus Pirchner) and RELEX (Andreas List).

2 CONTEXT

2.1 POLITICAL AND SOCIAL-ECONOMIC SITUATION AND HUMANITARIAN NEEDS

During a three-week rampage by Indonesian supported militias, immediately after the pro-independence referendum of August 1999, East Timor's infrastructure was largely devastated. An estimated 75% of the population were displaced either to West Timor or into the interior of the island. After their return, the population found their properties and most public infrastructure destroyed. An estimated 80,000 East Timorese are still in West Timor, of whom approximately 50% are not expected to return. The exodus of the Indonesians included most people with managerial and technical skills.

The economy of East Timor collapsed after the September 1999 events. Banks, public transport systems, telephones, and hotels disappeared. Humanitarian needs for the refugees and displaced were acute in terms of shelter, food supplies, health care services, clean water and sanitation. A huge humanitarian effort started immediately after the arrival of the Australian-led Intervention Force. Most of the operational work was done by some 100 international and local NGOs, backed by massive donor funding. This historic episode was

top world news for approximately two months, and focused the attention of the world. The interim administration UNTAET under a UN mandate was put into place early 2000, and full independence of East Timor is expected by 2002.

2.2 HEALTH SECTOR EAST TIMOR

In the health sector most government health facilities were destroyed. Church-related health facilities were less affected, but still suffered considerable damage. Most of the 160 mainly Indonesian doctors left the country. The remaining East Timorese health workers are mainly nurses and support staff, and the country was left without managerial capacity to run the health services.

Outbreaks of communicable diseases such as diarrhoeal & immunisable diseases, dengue, malaria, and TB threatened under the unfavourable circumstances of lack of shelter, destroyed water and sanitary facilities, shifting populations, and the collapsed health infrastructure. Even during the pre-crisis era, East Timor had an infant mortality rate (IMR) of 70-95 per 1,000 live births, maternal mortality ratio (MMR) of 890 per 100,000 live births. Malaria was highly endemic, representing approximately 25% of all morbidity. Tuberculosis is a major health problem with an estimated 8,000 active cases nationally. HIV/AIDS is not (yet) a major health problem.

In this crisis period, both international NGOs and local church-related organisations played a crucial role. Some 20 international health NGOs spread out over the country - some on the same day as the International Forces for East Timor (INTERFET) cleared the area from militias. Besides the NGOs, OCHA, WHO and UNICEF quickly set up offices in East Timor and played an important co-ordinating role during the first months. There were regular meetings with all health NGOs; the UN compound served as a meeting place for NGOs entering the country, and was a forum for agreement on who would do what, where and when. The atmosphere during those early days was energetic, supportive, and business-like.

ECHO had no permanent expert in East Timor during those first months, although the Jakarta-based ECHO correspondent made brief visits to Dili. So ECHO partners mostly had to discuss their proposals in Jakarta with the ECHO correspondent (which was politically undesirable) or in Brussels (which was logistically cumbersome). NGO respondents specifically mentioned that operational support and co-ordination considerably improved with the arrival of the ECHO Correspondent in Dili in March 2000. This had obviously been lacking before (see also section 4.4).

The EC made eight financial decisions both for East and West Timor through which some 29 million Euro became available to combat the humanitarian crisis, of which 14 million Euro was focused on health and nutrition projects. This financial support encouraged ECHO partners to set up important relief efforts in East Timor.

2.3 HEALTH SECTOR WEST TIMOR

This section is written based on material collected during the consultant's visit to West Timor from 9 to 19th of August 2000. During this assessment mission, in preparation of a new UNHCR-funded health project the consultant visited not only the capital Kupang but also, Kefamenanu and Atambua districts which directly border East Timor. During this stay he visited two refugee camps, and several health facilities. He met the district health officers (Dinas Kasehatan) of Atambua and Kefemenanu districts and discussed the situation concerning the East Timorese refugees. In addition, discussions took place with representatives of WHO, UNHCR, ICRC, Care, MSF-Belgium and the Provincial Health Department Officer of Kanvil.

Indonesia's health infrastructure in West Timor did not suffer the damage of East Timor. The main problem was the influx of refugees, overburdening the health system. NGOs therefore intervened in the camps, a few of them getting ECHO funding, for example MSF-Belgium. Most refugees returned to East Timor during the first eight months after the crisis. In September 2000, three UN staff members were murdered in Atambua, which resulted in the UN downscaling its relief efforts and withdrawing all expatriate relief workers. The future of the remaining refugees in terms of health and other humanitarian needs is unclear, but integration in the existing health system seems the most appropriate strategy.

Problems of demand in West Timor

The refugees -and also the general population- under-utilise the existing government services due to limited opening hours and the perceived poor quality of the services. In addition, the refugee population may not feel welcome in the West Timorese health facilities. The local West Timorese population did not appreciate the often aggressive behaviour of the militias, and this negatively affected the attitude of health workers towards *all* East Timorese refugees. Many refugees expect the health services to be free-of-charge, while there were no resources to actually deliver free services. Some observers argue that a proportion of refugees are not habituated to attending modern health services and prefer traditional practitioners.

Problems of supply

The influx of refugees created an additional burden on the Indonesian regular health services. The services provided to the refugees are in theory free-of-charge. For this purpose the government provided additional funding, but this funding stopped in August 2000. This came on top of the already existing problems of the West Timor government health services such as inadequate salaries and poorly motivated health workers.

Conclusion

The assistance provided by ECHO-funded NGOs was useful. But after the murder of the three aid workers in September 2000 most assistance from health NGOs stopped. Approximately 50,000 -100,000 East Timorese remain displaced in squalid IDP camps or in villages in West Timor. Insecurity remains high due to the continued presence of East Timorese pro-integration militias among the IDP population. The provincial government responded to humanitarian needs with some limited support, but this is inadequate to meet basic needs fully. It is recommended that once the security situation improves, ECHO assistance to West Timor continues.

3 RELEVANCE

The *relevance* of ECHO to intervene in the health sector in Timor was high due to the acute health needs. The relevance of the choice of beneficiaries was excellent due to the ECHO strategy of operating through partner UN organisations, and through the INGO partners with whom ECHO has a Framework Partnership Agreement. This facilitated a highly decentralised utilisation of funds, which was *the appropriate* method to target refugees, displaced or vulnerable groups. NGOs made great efforts, sometimes at considerable personal risk, to assist remote communities. This would have been unlikely to be successful following any other strategy. The relative vague ECHO mandate of "assisting the Timorese population in the sectors of health and nutrition" was justified, because this allowed the partners to develop appropriate strategies adapted to local circumstances and needs. The system applied by ECHO of Framework Partner Agreements was appropriate under the given circumstances where the key to success was the fast response by partners with a proven ability and reputation to do the job. The capacity and willingness of the larger ECHO NGO partners to pre-finance - or finance from their own resources - has been an important additional reason for success.

Supplementary feeding programmes under the heading “nutrition” were less relevant in the East Timor situation. Only 3-4% of children aged six months to five years are acutely malnourished, while one in five is chronically malnourished. This is a relatively low percentage, also often seen in non-crisis situations, and may be caused by illness. However, “health and nutrition” was considered as one component, and the ECHO partners used available funds to choose more relevant “health” aspects. Therefore, the fact that the nutrition aspect received relatively little attention by ECHO and its Partners, was justified.

4 CO-ORDINATION AND COHERENCE

4.1 HEALTH POLICY AND GEOGRAPHICAL CO-ORDINATION

In the months before the ballot, ECHO took a proactive attitude towards the crisis by releasing funds for the East Timor population and by facilitating the initial activities of some partners (MSF-B, MDM-S/P, MEMISA/PERDHAKI, ACF-F, MDM-F). Health policy co-ordination was carried out immediately after the crisis by the ECHO UN partners WHO and UNICEF. There was at that stage no need for ECHO to play a pro-active role in health policy co-ordination. Co-ordination of the geographical targeting of NGO interventions was carried out with great enthusiasm by OCHA during the initial months. There were no clearly identified local authorities, and co-ordination was mainly through local- and Dili-based OCHA officers, a role later taken over by UNTAET. Therefore, ECHO did not play a role in geographical co-ordination during the first months, and was not required to do so. NGO representatives and the OCHA officers could probably better judge the immediate relief needs, in a situation of continuous change -new displacements, outbreaks of diseases, medical emergencies and humanitarian needs.

Once the East Timorese Interim Health Authority was put in place in February 2000, policy co-ordination improved, in the sense that minimum standards were developed that NGOs were requested to follow. These standards - for mobile clinics, level II fixed-location clinics without in-patient beds, and level III fixed-location facilities with in-patient beds - proved useful. They helped the NGOs to develop operational plans, and lead NGOs were selected to assist with the development of District Health Plans. Based on these plans, the Interim Health Authority started a dialogue with the NGOs and the District Health Officers, which resulted in changes and amendments, and in the signing of Memoranda of Understanding with most of the NGOs. ECHO continued to fund most of these District Plans, and once the ECHO correspondent arrived, she was helpful is facilitating this process by organising inter-NGO meetings, by providing advice to the NGOs, and by clarifying the role of the NGOs with representatives from DHS, UNTAET, and the World Bank.

4.2 WEST TIMOR

Among the support provided by ECHO in West Timor to the first projects, was the approval of projects aimed at providing non-food items and water and sanitation assistance to the displaced people in West Timor even before the ballot. Another NGO provided drugs, medical material and training to 21 Catholic Health Units in East Timor. This NGO found itself with most of the drugs and medical material in Kupang just when the refugees arrived from East Timor. The NGO requested an amendment of the contract in order to provide health assistance to the refugees through their local church health network, and so was one of the first international organisations to provide assistance to the refugees in West Timor.

4.3 CO-ORDINATION OF ADMINISTRATION

During the initial months of the emergency there was no ECHO expert in Dili. The Jakarta ECHO office was reinforced by an additional person, and East Timor was given high priority. The Jakarta ECHO correspondent made short visits to East Timor, and ECHO was active in

information collection concerning the situation, sharing this information with potential partners. A Dili ECHO office opened in March 2000, approximately five months after the start of the crisis. This delay contributed to lost opportunities and delays in the submission of proposals by ECHO partners (this point was brought to the evaluation team's attention by several NGOs). With the arrival of the ECHO field expert, co-ordination aspects at Dili level considerably improved. ECHO partners received support for their applications and proposals. The judgement of the expert in policy and administrative co-ordination had a positive impact on the health services in East Timor. Her approach was to support the efforts of the Interim Health Authority - later Division of Health Services (DHS) - and to identify financial gaps that occurred in the tedious process of developing long-term policies through the Trust Fund for East Timor (TFET) funding mechanism. She has been *the right person, in the right place, although arriving late.*

Once in place, there were logistical problems such as obtaining an adequate ECHO office. The office and the house of the ECHO expert were the same, and the space was insufficient. There were problems with electricity and air-conditioning, which made the work more difficult than necessary.

Although the evaluation mission is impressed by what the ECHO correspondent achieved under the circumstances, they are also of the opinion that there was a need to recruit an additional logistical/administrative ECHO person in Dili. However various other evaluation reports equally highlight similar problems of logistic administrative support for the ECHO field offices. The evaluation mission thinks it is important to stress what could be common problems in ECHO projects, and therefore presents an overview of findings and recommendations in Annex 1.

The *processing* of ECHO Partner proposals at Brussels level took more time than justified. One NGO reported that they signed a contract within eight weeks after submitting their proposal. Most others received signed contracts considerably later - on average four months - with the longest response time of seven months. The larger NGOs pre-financed their efforts while waiting for bureaucratic procedures to run their course in Brussels. The effectiveness of smaller NGOs was negatively affected by the slow responses of ECHO bureaucracy.

Article Four of the General Conditions of the Framework Partnership Agreement for the Financing of Humanitarian Operations states that ECHO will notify the humanitarian organisation "as soon as possible of the response to the proposal, taking into account the urgency of the operation". The EE mission judges that "as soon as possible" means approximately four weeks taking into account the "urgency of the operation" in East Timor. We therefore conclude that the delays were unacceptable, creating many problems for ECHO partners - delayed activities, staff contracts prematurely cancelled, and unnecessary financial pressure.

The EE team recommends that the qualitative statement of Article 4 of the General Conditions could be modified with a quantitative statement such as that the response will not delay longer than "x" working days. The number of days ("x") could then be defined on the basis of each emergency. ECHO Brussels could then be held responsible for any undue delays by its partners, for example by paying interest over delayed payments.

Another related issue delaying the process of response to the Partners is the highly centralised system of approving proposals. A more decentralised ECHO field-driven approach at country level would be more appropriate, and would apply to all aspects of the contacts between ECHO and its partners with a Framework Partnership Agreement.

4.4 INTERNATIONAL NGOS, THEIR OPERATIONS AND RELATIONSHIP WITH ECHO

4.4.1 INTRODUCTION

The evaluation team prepared an electronic questionnaire before the start of their mission to East Timor. They sent it on 28/2/01 to 13 NGOs involved with health care, the World Health Organisation and UNICEF. The questionnaire was also sent to non-health organisations such as WFP, UNHCR, OXFAM, CESVI, ACF-F and CARE.

Six out of 13 (46%) of the medical NGOs answered the questionnaire - AMI-F, Cordaid, HealthNet, MDM-P, OIKOS, World Vision. The following NGOs did NOT answer the questionnaire; MSF-B, MERLIN, MDM-F, IRCT, IMC, CIC-P and CAM-F. The following NON-MEDICAL organisations answered the questionnaire; CESVI, ACF-F, OXFAM Aus/UK.

World Health Organisation, UNICEF, UNHCR, IOM also received requests for answering the questionnaire, but did not respond. For the purpose of this health part of the report we only analyse the answers of the 6 medical NGOs which responded. We printed the questions in bold.

4.4.2 RESULTS

1. On whose initiative did you enter Timor (own initiative - requested by another organisation - ECHO)?

Four of the NGOs entered East Timor on their own initiative, Cordaid entered on request of a local partner Perdakhi and by the ECHO office in Jakarta, while HealthNet entered on request of MSF Holland.

2. How would you describe the contacts with ECHO in terms of support - facilitating project progress - flexibility in approach - leadership?

AMI-F:	Good and flexible
OIKOS:	Good due to Dili Correspondent
World Vision:	Good flexibility at Dili level.
Cordaid:	The co-operation when changing the programme objectives was good by ECHO Jakarta
HealthNet:	There was very close, fruitful co-operation with the ECHO correspondent at Dili level.
MDM -P:	No problem

3. How would you describe the administrative relationship between your organisation and ECHO?

AMI-F:	Good
OIKOS:	Slow procedures by ECHO leading to delay in signing contract - payment delayed 6 weeks, while still awaiting final payment. Payment received two months before the end of the contract period.
World Vision:	Delays in funding have been difficult for all NGOs. However, the fact that ECHO “does” fund NGOs is positive.
Cordaid:	When it comes to project design and reporting the co-operation was formal and less flexible
HealthNet:	At Brussels level there were unjustified delays. Brussels approved the last project cycle only 7 months after its commencement!!

MDM-P: The only known factor is that ECHO will sign the contract and that eventually ECHO will meet is financial obligation, but this part of the process should be much shorter.

Interviews with the other NGOs showed a similar pattern. For example AMI-P expressed that there were unclear delays in signing contracts. The situation of IMC (an American-based NGO with an office in London) has been disturbing. They waited for almost a year - unsure whether Brussels would sign their contract. They assumed that they had a contract, but in the end there was no contract.

Conclusion

Only one NGO (AMI-F) expressed satisfaction with the administrative procedures of ECHO. All the other expressed dissatisfaction, in particular with the slow process of signing contracts and commitment of ECHO Brussels with payment procedures.

4. Did your organisation during the emergency intervention develop a vision for transitional and structural development? In how far did ECHO play a role in the development of this vision?

AMI-F: Yes. AMI has always made middle-term plans and has always worked closely with IHA (Interim Health Authority) first and then, with DHS (Division of Health Services).

OIKOS: Since the beginning of the intervention OIKOS is part of a long term and sustainable development. The operation is being implemented in the framework of a continuum between the emergency phase, rehabilitation and long term development. In fact most of the support received from ECHO has been useful to re-establish the health services and for the urgent rehabilitation of health facilities. ECHO support is currently important in the implementation of "District health Plans". Those plans are in the so-called "Grey Zone". A good co-ordination with Development Instruments (and budget lines) from the European Commission will be required during this period.

WORLD VISION: ECHO has tried to ensure that there is a co-ordinated approach to NGO interventions. World Vision has implemented many transitional programs from relief to development. ECHO has been involved in the planning for a sustainable health services plan and has been completely involved in the planning. ECHO has played a key role in monitoring government officials on the role of emergency assistance and how the NGOs fit in the overall plan. In addition ECHO has been able to assist the NGOs in formulating a plan to meet the unmet needs that we have identified in the country. This involvement has been critical in linking NGOs and the emerging government.

Cordaid: No, we did not develop a structural development vision in *West Timor*. Cordaid/Memisa did assist the local partner in sending medical teams to take care of refugees. We trusted that the refugees would be able to go back to East Timor soon and that the local situation would become relatively normal again.

HealthNet: HealthNet specialises in supporting the development of sustainable health systems in situations where these have been disrupted and was therefore invited to take over from MSF Holland once the initial emergency phase was over. From the outset, we have therefore had a mandate to build capacity rather than substitute and this is in line with the District Health Plans which each NGO was invited to submit in August 2000. ECHO has been supportive of this process.

MDM-P: This is a good one. Right now, and maybe a bit late, some of the NGO are employing Heads of Mission with more development in their background.

5. Provide suggestions for the improvement of future ECHO programmes.

Three of the medical NGOs answering the questionnaire expressed worries about the transition of ECHO emergency funding towards the TFET funding through the World Bank/DHS set-up. Although (see question 3) there is criticism about the slow bureaucratic procedures in Brussels concerning signing contracts and payments - at least the NGOs are very satisfied that ECHO supports international NGOs.

OIKOS was the most specific in their response on this question, and we fully quote their comment:

- In emergency situations, ECHO needs to have administrative systems and financial instruments enabling an urgent/immediate response to the NGO requests. It is not enough to say that the NGO must have resources to advance. OIKOS has limited resources and those resources, are shared between the cash flow for ECHO projects and complementary interventions in other sectors (e.g. in East Timor for distribution of seeds and tools, that was one of the priorities identified in Same and Aileu).

- Usually is more efficient to participate in the framework of Global Plans, jointly prepared between the NGOs and ECHO, than in the framework of small and isolated projects. It's not an administrative question, is a question of impact. Those plans must have a co-ordination between sectors of intervention, including the co-ordination with other donors. Sometimes happens to have good project proposals, that could be valuable to ECHO strategy, even if ECHO has no money to fund. In those situations a co-ordination between ECHO/NGO and other Donors could be important to find resources to implement those projects.
- ECHO must have a correspondent in the beneficiary country since the beginning of the funding process, specially in situations like ET were there is problems between the beneficiary country and the Neighbour country where is an EU Delegation.

The evaluators also discussed the transition from ECHO funding to TFET funding with the NGOs during the individual interviews. It emerged that there were serious concerns about the administrative procedures and the efficiency of the new TFET mechanism.

4.4.3 NON-EUROPEAN NGOS

One American NGO carries out similar activities to European NGOs, but was to date not provided with an ECHO contract, although this, in the opinion of the NGO teamleader was more or less promised. The EE team feels that ECHO's regulation which does not permit collaboration with non-EC NGOs should be changed. This issue has also been observed as undesirable in an ECHO Analysis of ECHO Evaluations 1996-1999 (Eykenaar, J et al).

5 EFFECTIVENESS

The effectiveness of ECHO-funded activities has been high as the result of the initiatives of the international NGOs. They facilitated and carried out a large share of the health services in East Timor immediately after the referendum. In the one year from the start of the crisis NGOs carried out 620,000 external consultations. Although many NGOs had alternative sources of funding, the bulk of the financing came from ECHO. There were 133,750 suspected malaria cases, of which only 110 people died, which is a low case fatality. NGOs helped UNICEF and WHO to implement their immunisation campaign, and there were only 1,392 cases of measles in the 12 months after the crisis, which is also low given the circumstances. Maternal mortality is likely to have been reduced through a system of evacuations by NGO ambulances, in co-ordination with transport from other UN organisations and peace-keeping Forces. One District- based NGO reported facilitating 5-10 Caesarean Sections per month. This implies at least five maternal lives per month saved by that one particular intervention.

6 COST-EFFECTIVENESS

The cost-effectiveness of the ECHO-funded partners in the health sector was reduced considerably by management and motivational problems with the Timorese UNTAET-paid health staff. During the first months of the emergency, some NGOs directly paid Timorese health workers and as such created a direct managerial relationship. In early 2000, UNTAET started paying salaries, adopting a centralised approach of human resource management. Health workers received fixed salaries irrespective of their output, on which health facility managers had no longer any influence. Hard working staff received the same salaries as non-performing or absent colleagues. The resulting problem of motivating staff was observed both by NGO managers as well as Timorese District managers. Another problem that reduced the cost-effectiveness of the ECHO partners was the unrest among the Timorese UNTAET-paid health workers. This was caused by a protracted recruitment exercise whereby 1100 of the 2000 Timorese health workers were offered permanent employment. As a result, after June 2000, Timorese health workers were uncertain concerning who would be "in" or "out".

Due to the above factors several NGOs reported that staff motivation progressively worsened during the last nine months. It created a situation whereby relatively expensive NGO workers and Timorese staff in religious health facilities carried out most of the work, while several Timorese health workers in government health facilities reduced their working hours, or sometimes refused to work. Several NGO managers and staff brought this point up as an important matter for ECHO concern.

7 EFFICIENCY OF THE IMPLEMENTATION OF THE OPERATION

It was possible to plan the aid and put it into operation fast, because of the eight Decisions taken by ECHO. Some Partners were quick to respond. The operational capacity of the partners was, by and large, good, with the exception of a few of the smaller NGOs, which had problems in mobilising skilled staff, or who had staff which were not aware of emergency health standards such as those for example laid down in the SPHERE "Humanitarian Charter and Minimum Standards in Disaster Response". The quality of the NGO interventions improved through the good collaboration with and supervision by the ECHO correspondent. Another positive influence on quality was that the Division of Health Services developed a manual with Minimum Standards. These Standards describe the health activities that must take place at the different levels of the health system, and to which each NGO must adhere. Some NGOs have done excellent and innovative work. Others are more the emergency type of organisations who mainly specialise in health service substitution in acutely under-served areas. These are characterised by fast logistics, short expatriate contracts, and a relatively high dependence on volunteers who can be mobilised at short notice.

The EE team originally planned to make an efficiency study of each of the 15 ECHO-funded health NGOs in East Timor. However, time was not sufficient to carry out this task which, if implemented superficially, could have created misunderstandings and questions on methodology, instead of making a useful contribution to this report.

The policy of the Division of Health Services to reduce the number of NGOs is a good one. This may imply that only those NGOs will remain which have proven skills and capacity in management, public health, health financing, contracting issues, health-seeking behaviour analysis, public-private sector issues, human resource development based on performance-based systems, or generally innovative health sector development.

The ECHO strategy of working through NGO partners have been excellent and should continue in a new crisis anywhere in the world.

Many NGOs said that they relied more than was necessary on expatriate staff rather than on Timorese. This was caused by the decision of UNTAET authorities to use a non-performance-based incentive system for Timorese staff in which local managers had no authority over management issues. Motivation of East Timorese staff was also lowered by a lack of clarity over their positions: they did not know whether they would be employed or not in the government system. These factors also explain the relative high proportion of ECHO-funded NGO budgets allocated to expatriate staff salaries, which could be as high as 60% of the budgets. NGO overhead costs such as transport, office accommodation and communications was typically another 20%. The proportion of funds directly utilised to improve the Timorese health services such as community activities, training, equipment, and drugs, was only 20% for most NGOs. This is very low.
The consultant checked the budgets of the NGOs in Dili to substantiate the above statement. The consultant *is aware* that DHS and UNTAET planned operational costs mainly to be financed by the central authorities. However, whether this was planned or not is not the point. The point is that, sadly, centralised purchase systems are likely to be inefficient, and several NGOs indeed reported stock-outs, blockage of training activities, non-performing health centres due to lack of equipment, etc.

NGO logistics were generally good. Logistic centres were quickly set up in Darwin, Dili and the operational areas. The economy of scale here was poor because of the large number of NGOs operating in small catchment areas. This has already slightly improved after the departure of a number of emergency NGOs. A further reduction of NGOs will improve the economies of scale of the operation, which is also planned by the DHS. Ideally, one NGO could have the responsibility for approximately 100,000 people, which is roughly the number of people in a standard district, carrying out the standard package of health activities, including a referral hospital.

The suitability of NGO activities after the crisis has been the subject of much debate in East Timor. Timorese health workers sometimes had the feeling of being invaded by foreign organisations, and political leaders were sometimes rather negative concerning NGOs. The reputation of the NGOs seemed to improve when more dialogue took place, and when people started to realise that there was no immediate alternative to the NGOs' logistic, administrative and managerial capacity. However, the acceptance of the NGOs by the population, Timorese health workers and the politicians remains a point of concern.

Monitoring and evaluation systems have been greatly enhanced by the setting up of Minimum Standards, to which most partners seem to comply. Auto evaluation and the capacity to enhance a more structural type of assistance is weak with some of the more emergency type of organisations, which also depends on the quality of fast-rotating staff.

8 IMPACT OF THE OPERATION

ECHO's contribution to the reduction of human suffering by providing emergency health services throughout the East Timor crisis has been significant with numerous death prevented, and reduced suffering from disease (see also the section of effectiveness). *The ECHO intervention in East Timor is likely to have been one of the more successful one's in comparison with other ECHO interventions.*

There is a large dependency of the health system on external funding in the absence of any East Timorese resources. In addition, the UNTAET authorities -apparently under heavy political pressure from East Timorese politicians- chose a system of providing health services free-of-charge, which will create further dependence on external aid, and reduce sustainability (see also chapter 11).

The effect of the NGO assistance on the local economy has been important through their recruitment of some local staff, and by reducing morbidity so that the population lost fewer productive days as the result of disease. However, the effect of the NGO intervention could have been larger if the NGOs had been allowed to spend more of their budget on health and community activities. As a result, some NGOs spend as much as 80% of their budget on overheads instead of investing in the local economy. An approach with a more decentralised utilisation of funds at local level would have stimulated the economy better.

Negative environmental effects are not noted, and there has been awareness about the safe disposal of medical waste.

The ECHO intervention through its NGO partners had some impact on the discussion about the future of the health system. An example of this is the efforts of one NGO dealing with mental health problems. Without their perseverance and the support of ECHO this issue would have remained low on the policy agenda. Other NGOs brought in expertise concerning training methodologies, the roll-back malaria agenda, contractual approaches, and health-seeking behaviour surveys.

Local capacity-building has been important, although different NGOs applied different approaches. Some NGOs employed local staff and taught them managerial skills which may remain useful even if they do not continue working for health. However, as the result of the problems with human resource policy, the capacity building of Timorese staff has been less than optimal.

9 VISIBILITY

ECHO's intervention through its partners has been of high quality, and this has meant high visibility in terms of output. This was generally appreciated by the people with whom we spoke. As far as stickers on cars and houses are concerned, the EE Team observed that partners complied.
It would be justified if the public in Europe had their attention drawn more to ECHO's intervention in East Timor. ECHO could for example commission a film for this purpose, called "East Timor 2 years later - what did the EC's Emergency Support achieve?". This could also serve the more general goal of maintaining interest in Europe for East Timor's further development.

10 HORIZONTAL ISSUES

10.1 GENDER

The health care programs of the ECHO Partners focused on children and women. The positive relationship between their improved health and economic, social and cultural aspects is obvious. A problem though is the dogmatic stand of the very strong Catholic Church in East Timor on sexual health, and family planning in particular. Some NGOs diplomatically made family planning available to couples who were seeking it.

10.2 SECURITY OF AID WORKERS

As far as the EE team is aware, there were no security-related incidents concerning ECHO-financed aid workers in the health sector. Generally speaking each NGO is responsible for its own security policy. This results in a situation whereby some NGOs are prepared to take bigger risks than others. This independence to judge their risks is considered by the evaluation team to be positive. All emergency NGOs which came immediately after the

referendum, had the communication equipment required and observed security protocols. They also co-operated closely with the Security Forces. Larger risks were endured by the NGOs in West Timor, and also by those NGOs which operated in East Timor *before* the referendum.

11 REPLACEMENT OF HUMANITARIAN AID INTO STRUCTURAL DEVELOPMENT (LRRD)

The Division of Health Services will start using TFET funds to replace some of the activities currently funded by ECHO, and is as such important for the phasing out strategy of ECHO. Instead of the European Commission developing separate EC budget line programmes, they decided to channel their long-term support for East Timor through the DHS- and World Bank-managed TFET funds. Joint Donor Missions are joined by a European Commission representative, and an EC representative sits on the TFET Board. The World Bank provides the main technical assistance in the health sector in East Timor. This Sector-Wide Approach (SWAP) aims at improving donor co-ordination, and creating a more comprehensive policy development environment in East Timor.

HOWEVER, FIRST EXPERIENCES WITH THE SWAP APPROACH HAS ALSO BROUGHT OUT A NUMBER OF DISADVANTAGES, WHICH DEEPLY CONCERN SOME OF ECHO'S NGO PARTNERS. THE PICTURE EMERGING FROM THE INTERVIEWS IS THAT THE INTERIM HEALTH AUTHORITY AND LATER THE DIVISION OF HEALTH SERVICES INTERPRETED THEIR ROLE MORE AS A CONTROLLING ONE, RATHER THAN A FACILITATING, DEMAND-DRIVEN, AND DECENTRALISED ONE. THEIR "VISION" OF THE HEALTH SYSTEM IS OF A PUBLICLY FINANCED - PUBLICLY PROVIDED SYSTEM, FREE OF USER CHARGES, AND WITH A HEAVY EMPHASIS ON A TIMORESE CIVIL SERVICE. IT IS TRUE THAT THE DIVISION OF HEALTH SERVICES IS STILL IN A PROCESS OF POLICY-MAKING, AND THAT THEY TRY TO INVOLVE TIMORESE STAKEHOLDERS AS MUCH AS POSSIBLE IN THE PROCESS. WE APPRECIATE THIS.

However, it appears that some of the decisions, *have already been taken,* decisions for example for a centralised system of human resource management and public provision of health care. The Timorese health system is being fixed with no real influence from the policy debate. Representatives of the Division of Health Services stressed that highly placed political authorities played an important role in the decision for this type of health system and made their decisions stick. Furthermore, the DHS representatives stress that they fully commit themselves to a process of policy development whereby the Timorese play the main role, not external experts.

Given this direction being taken by East Timorese health system, some policy makers also expressed doubts about the usefulness of the international NGOs in the immediate future. WHO proposed that experts be recruited as advisors for the publicly-provided health system, who would work alongside Timorese health managers. Some Timorese politicians were openly critical about the role of the international NGOs. However - with the months passing - people started to realise that the Timorese health system would need more time to gain the capacity to replace the international NGOs. The ECHO expert in Dili played a positive role in this process by identifying problems, stimulating dialogue, and assisting with finding pragmatic solutions. Nevertheless, an optimum atmosphere of partnership and dialogue is not yet in place between the health authorities and the international NGOs. Equally there are question marks about the use of the comparative advantages of the church-related health institutions and the Timorese for-profit private health sector.

This puts the exit strategy of ECHO funding at risk. In November 2000 the Joint Donor Mission recommended that the continuation of funding for the NGOs take place through the TFET in order to empower the Division of Health Services.

The EC member of the Joint Donor Mission proposed a number of criteria for the phasing out of ECHO funding:

1. That legal-administrative mechanisms be in place (deadline 31/01/01)
2. That at the level of DHS the capacity to operate as contracting agency for the NGOs be in place.
3. That a clear policy be in place on issues of public-private mix and contracting -out of health services.
4. That funds be increased under TFET to finance the contracts (by EC Budget Lines)

We discussed the above criteria with a representative of the Division of Health Services, in the presence of the World Bank and the European Commission representatives. The DHS and the World Bank representatives assured us that the legal administrative mechanism would not pose a problem. They also thought that there would be no need for ECHO to play a funding role after September 2001. The NGOs, whose services are still required, will be offered an ECHO-style contract by DHS (TFET), without jeopardising their independent mandates. The DHS will therefore offer the NGOs first "ECHO Style" contracts, and in a later stage more developmental contracts.

The other two above-mentioned criteria concerning the DHS' contracting capacity remain worrisome. It appears that the DHS still needs to modify their approach.

If all donors put their eggs in the SWAP basket, this also creates a very strong position for the DHS to choose who is "in", or "out". This may harm a true appreciation of the forces in civil society. In the absence of different donor organisations developing different approaches and relationships with their East Timorese partners, the SWAP approach requires additional checks and balances. This requires the political and health authorities adopting an open approach to health policy alternatives, and facilitating decentralised developments in which there is a place for different actors in the health sector.

11.1 MANAGERIAL CAPACITY

One of the key problems in East Timor is the shortage of managerial capacity in the East Timor health system. The apparent choice of a publicly-provided health system means that it will be at least seven to ten years before well-trained and skilled Timorese government health managers are in place. It will take time before the current Timorese District Health Officers have adequate knowledge and skills to effectively run the districts. Furthermore, once these managers have the right skills it may be difficult to keep them at a salary of approximately $240 per month. In the competitive human resource market in East Timor and neighbouring countries they are likely to accept better paid jobs in the private sector.

This may lead to a situation whereby an elite group of civil servants with relatively low salaries will have a monopoly in the absence of a well-regulated private health market. Evidence from countries as different as Armenia, India, Cambodia, and Indonesia show that under such circumstances, government health workers may start carrying out informal private practice, to compensate for what they consider low salaries. The first informal medical and pharmaceutical activities have already started in East Timor, and this development is likely to accelerate during the coming period. If the East Timorese authorities aim to forbid such informal activities they are unlikely to be successful. All this calls for clear vision from the East Timorese authorities. The vision should include answers as to how to regulate the private sector, how to contract skilled district and health facility management, and how to create performance-based incentive systems for health workers.

There is a large amount of literature about the performance of public institutions. We recommend Marc Wuyt's 1992 book for a general discussion, and the World Development Report of 1993 for a more health-related discussion.

11.2 PARTNERSHIP NOT CONTROL

Another concern of the NGOs is that they do not feel like partners of the DHS in development, but like implementers with a marginal role in discussion. This is unfortunate. Their comparative advantage lies in knowing the local conditions and adopting flexible strategies to achieve the overall health policy goals laid down in standards, indicators, etc. It is true that the more emergency NGOs are probably unsuited for this role, which in any case is not their mandate, nor are they wishing to become developmental NGOs. Other NGOs may simply lack the skills and knowledge successfully to participate in policy dialogue. However, the developmental NGOs could make a valuable contribution.

This would require the developmental NGOs, *in collaboration with* their Timorese district counterparts, to have more autonomy of management and executive responsibilities concerning the utilisation of resources, and human resource management. Some issues can better be left to local judgement, instead of to centralised planning, for example which clinics to open where, and how much local staff to recruit. There could also be more autonomy in hiring and firing health staff, or giving health facilities with good output results more funds to increase staff levels. This would create a more efficient human resource market, which is likely to *absorb more health workers in formal health care facilities* than the current system of recruiting a publicly-paid health worker's elite.

11.3 CONTRACT APPROACH (LESSONS LEARNED)

The Division of Health Services is in the process of developing contractual arrangements with NGOs. Lessons learned from the contracting approach worldwide suggests that it is more important to seek common ground with potential contractors. It is also better to think more in terms of partnerships and common goals than in terms of control and a juridical approach (Perrot, 2000). The emphasis on "best practice" analysis for the contracting agent (in this case the DHS) is on regulating and financing, and much less on the operational and strategic details at district or health facility level. This is where the contractors provide their knowledge of the local situation, experience and innovative ideas. The contracting agent sets the indicators, standards and quality assurance mechanisms, and facilitates demand-driven approaches, and innovation.
The tendering process must be competitive - and if contractors do not achieve their targets they may lose the contract.

The contract approach may also help to make health workers and managers more efficient. It may lead to the recruitment of fewer civil servants, and a larger share of locally recruited health staff without civil service status by district and health facility management. Salaries instead of being fixed may depend on output, including the number of patients treated. Quality of work and staff discipline may also influence the salary of staff. The basic idea is that *more and good-quality work increases the salary of a health worker.* This comes from the hard lessons learned in many developing countries. Failure to do so may create an elite system of civil servants, who instead of serving public goals may become involved in money-seeking activities. District and health facility managers could recruit most health workers locally - and should preferably have the right to hire and fire. A very limited number of very well paid and specialised civil servants would be responsible for the contracting process. It is also important to create administrative double-checks to reduce the potential for money-seeking during the contracting process; this could be done for example through collaboration with the donor organisations (World Bank, European Commission).

The contract approach can also be helpful for the development of the Timorese private sector. It may create a conducive environment for partnerships with the church-related health facilities, for-profit health care providers such as Cafe Timor, and other potential private sector actors.

11.4 "FREE" HEALTH CARE, AND SUSTAINABILITY

Health care systems without patient user fees or pre-payment have a poor reputation. The main criticisms concern their sustainability and efficiency. It tends to create a system of *free health care for the well connected, and no health care for the poor*. It also tends to nurture money-seeking by health workers (World Bank 1987, World Bank 1993). The apparent choice in East Timor for a free service is another reason for concern, even if only meant as a temporary measure. A system of nominal fees might have been more appropriate so that at least the population starts to value health services. In a health care system without user charges the population is unaware about the costs of the health services. This tends to nurture large inefficiencies, because a consumer cannot complain about a service for which he or she does *not* pay. The current health system is therefore expensive and inefficient. A better public-private mix health system with performance-based incentives for health staff *with nominal fees* would have made the system more competitive and efficient and thereby more sustainable.

11.5 CONCLUSIONS LINKING RELIEF, REHABILITATION AND DEVELOPMENT

The ECHO external evaluation mission would like to express their concern about the above mentioned issues, and feels that ECHO's NGO partners are put in a difficult position in their transition towards TFET funding, once ECHO withdraws. The evaluation mission doubts the wisdom of the European Commission contributing TFET funds to health without discussing *some* of the above identified problems. Massive donor funding of the current system may mask the underlying health policy problems and might create an unsustainable system once donor funding reduces. This could create (political) problems for the future independent government.

The evaluation mission is of the opinion that the criteria formulated by the EC Joint Donor Mission in November 2000 concerning contracting capacity and public-private mix issues are only partially met. Our role in this process was to express reservations, but we recognise that the responsibility on the follow up lies with the EC to respond as they see fit. However, *if the above policy issues are settled,* the evaluation mission endorses the course taken by the DHS and the World Bank towards a sector-wide approach, and in particular the approach whereby Timorese and international contractors are recruited to strengthen the health system.

12 RECOMMENDATIONS

- The ECHO strategy of working through NGO partners has been excellent, and should continue in a new crisis anywhere in the world.
- Only one NGO expressed satisfaction with the administrative procedures of ECHO. All the other expressed dissatisfaction, in particular with the slow process of signing contracts and commitment of ECHO Brussels with payment procedures. The EE team recommends that the qualitative statement of Article 4 of the General Conditions of the Framework Partner Agreement could be changed into a quantitative statement such as for example that the response will not delay longer than "x" working days. The number of days ("x") could then be defined on the basis of each emergency. ECHO Brussels could then be held responsible for any undue delays by its partners, for example by paying interest over delayed payments.
- A more decentralised ECHO field-driven approach at country level would be more appropriate than the current centralised system. This could reduce the response time after ECHO Partners submit their proposals.
- It would be justified to draw more attention from the public in Europe to ECHO's intervention in East Timor. ECHO could for example commission for this purpose a film with a title such as "East Timor 2 years later - what did the EC's Emergency Support achieve?"

- The effect of the NGO intervention on the local economy could have been larger if the authorities would have chosen for a more decentralised utilisation of funds.
- A decentralised and autonomously managed human resource policy is likely to absorb more health workers in formal employment than the current system of recruiting publicly paid health workers.
  There is a need for efficiency reasons that “developmental NGOs” - in collaboration with their Timorese district counterparts - obtain more autonomy of management and executive responsibilities concerning the utilisation of resources, and human resource management.

- The ECHO external evaluation mission is concerned about the issues mentioned above - and under the section LRRD - and doubts the wisdom for the European Commission to contribute funds into TFET for health as long as these issues are not fully discussed. However, if the above policy issues are addressed, the evaluation mission *fully endorses* the course taken by the DHS and the World Bank of the *sector wide approach*, and in particular the approach whereby Timorese and international contractors are recruited to strengthen the health system.

13 LESSONS LEARNED

- Lessons learned from the contracting approach world-wide suggests that it is more important to seek common ground with potential contractors, and to think in terms of partnerships and common goals than in terms of control and a juridical approach.
- The contract approach may be utilised to develop approaches towards more performance-based incentive systems of health staff. This may imply the recruitment of a limited number of civil servants, and a larger share of locally recruited health staff (without a civil service status) by district and health facility management. It may imply systems whereby salaries are based on output such as punctuality, number of patients treated, immunisation coverage, quality of work. The very simple basic principle is that *more work done of good quality also increases the salary of a health worker.*
- Double checks, for example in collaboration with the donor organisations (World Bank, European Commission) could be developed to reduce the potential for rent seeking in the contracting process at national level.
- The contract approach could also be utilised to promote the development of the Timorese private sector, and to create a conducive environment of partnerships with the church-related health facilities, for-profit private health organisations such as Cafe Timor, and other potential actors in the private health sector.