

# The La'o Hamutuk Bulletin

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## Building a National Health System for East Timor

The health of the East Timorese people depends to a significant degree on the implementation of an effective and reliable national health care service accessible to the entire population. Given the massive destruction of September 1999, the poor health system inherited from Indonesia, and the long-term effects of Indonesia's war and occupation on the physical and psychological state of the East Timorese, the health needs in East Timor are great.

The Indonesian military and its militia forces damaged 77 percent of the health posts following the 30 August 1999 vote for independence, totally destroying or severely damaging about 35 percent. In addition, they looted or destroyed 67 percent of East

Timor's medical equipment. At the same time, Indonesian doctors and nurses fled the territory. While many East Timorese nurses were trained under the Portuguese and the Indonesians, the number of doctors was small. Today, the doctor-patient ratio (not including internationals) in East Timor is about 3 doctors to 100,000 people, while in Indonesia it is 12 per 100,000, and in Australia it is about 240 per 100,000.

In the aftermath of the Indonesian military's post-referendum campaign of terror, international and local NGOs filled the vacuum created by the destruction of the previous health infrastructure. Currently, there are 23 East Timorese medical doctors and one surgeon in the entire territory. As such, the existing system is heavily reliant on international assistance. Non-governmental organizations, funded by a number of donors and coordinated by the Division of Health Services (DHS), are the main providers of health services. Specialist services are sometimes available, but only in Baucau and Dili.

The emergency phase of health provision is now considered over. East Timor's health sector is now in a transitional phase, one of long-term development. The establishment of the Interim Health Authority (IHA) in late February was an important step in this development process. In early August, the IHA changed its name to the Division of Health Services.

(continued on page 3)

### *The Bulletin is Back . . .*

The *La'o Hamutuk Bulletin* has returned. Since our last issue, *La'o Hamutuk* has undergone organizational and personnel changes. Now that these changes are complete, we expect to publish the *Bulletin* on a regular basis. As always, we invite our readers' comments, ideas, and contributions.

This issue of the *Bulletin* focuses on East Timor's evolving health system. It provides an overview of the major components of the national health system emerging under the auspices of the Division of Health Services (DHS) and explains how the funding of the DHS works. It also contains analysis and suggestions from three local health workers—Maria Dias, Natércia Godinho-Adams, and Dan Murphy. The views in these articles, as well as other bylined articles in the *Bulletin*, are the authors', and not necessarily those of *La'o Hamutuk*.

This issue also includes an analysis of the health situation in post-war Mozambique and its implications for East Timor, as well as a summary of a recent report from the World Health Organization on the health situation in the territory. Finally, there is a brief update on the situation in Oecussi, and an editorial that discusses the current negotiations over oil rights in the Timor Gap and their implications for the future of East Timor's health system and other social services.

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# FUNDING THE NEW HEALTH SECTOR

*The Division of Health Services (DHS) will spend an estimated US\$70 million over three years (from 1 October 2000 to 30 September 2003) to reconstruct and improve East Timor's health infrastructure, and build a viable national health system. The \$70 million will come from four main sources, each contributing to specific aspects of the national health strategy that the DHS will implement.*

## **The World Bank-Managed Trust Fund for East Timor (TFET)**

These are funds that donors to East Timor have entrusted to the World Bank to administer on their behalf. They take the form of the Health Sector Rehabilitation and Development Project, signed by the World Bank and UNTAET on 7 June 2000. The three-year project is worth an estimated US\$38.2 million. About US\$28 million of the project's funding comes from the TFET, the rest from bilateral donors (foreign governments).

*Value of contribution: \$28 million*

## **United Nations Agencies**

A variety of United Nations agencies such as the World Health Organization and the United Nations Children's Fund will provide services and material donations.

*Value of contribution: US\$7.5 million  
(at least US\$2.5 million/year)*

## **The East Timor Consolidated Budget (ETCB)**

These are the funds for the East Timor Administration—the embryonic government of an independent East Timor that the East Timor Transitional Administration (ETTA) is constructing with its local counterparts. The ETCB pays the salaries of East Timorese civil servants (such as those working for international NGOs in the health sector), and funds specific activities carried out within the Interim Health Authority. The funds of the ETCB come from the ETTA/UNTAET Trust Fund and from bilateral donors.

ETCB funding for DHS activities:

2000-2001: US\$6.9 million  
2001-2002: US\$7.6 million  
2002-2003: US\$7.7 million

*Value of contribution: US\$22.2 million*

## **Bilateral Funding for the Health Sector Rehabilitation and Development Program**

Bilateral funds come from donor governments through their particular aid agencies such as the Australian Agency for International Development (AusAID) and the Japan International Cooperation Agency (JICA). Bilateral assistance goes directly from one government to another. In this case, the recipient government is the ETTA to provide the additional needed funds to complete the funding of the Health Sector Rehabilitation and Development Program.

*Value of contribution: US\$10 million*

## **Other Humanitarian Assistance**

The US\$70 million does not take into consideration funds that support non-DHS activities. These include health facilities run by local NGOs, those run by the Catholic and Protestant churches, the clinics of Timor Coffee Cooperative, and those of INGOs operating district-level health systems. It also includes a small grant program administered and implemented by AusAID. AusAID will make US\$750,000 available (with a limit of US\$5,000 per grant) to local health NGOs and associations (such as organizations of midwives) to support training programs and equipment purchases needed to improve organizational capacity.

## **Funding Concerns**

Many international NGOs and others have expressed concern that East Timor's national-level health needs are far greater than those included in the DHS budget, and that, as a result, there will be unmet needs. The DHS budget, for example, does not yet include the US\$6.4 million needed to rebuild five regional hospitals (*see page 3*), and for equipment and training for the national health information system. In addition, there are strong concerns about the insufficient amount of resources to provide healthcare to rural, relatively isolated communities.

INGOs fear that ETTA and the World Bank erroneously expect that INGOs have large amounts of funds, or that they will be able to find funding, to fulfill these unmet needs. INGOs do not receive funding from the ETTA Trust Fund or the World Bank Trust Fund. While money from the East Timor Consolidated Budget pays the salaries of their East Timorese employees (national civil servants), the INGOs are dependent upon external funding to pay the salaries of their foreign staff members and for their operating costs such as transportation, logistics, and administration of their district-level activities. Fortunately, the European Community Humanitarian Office (ECHO) has committed almost US\$5 million to help fund, among other things, district health plans through June 2001. But funding is not certain after that point. If the INGOs do not soon receive confirmation of such funding, some of them might have to leave East Timor in mid-2001. This would seriously disrupt health care services in particular districts.

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*(Building a Health System continued from page 1)*

### **From the Interim Health Authority to the Division of Health Services**

The IHA grew out of the efforts of the East Timorese Health Professionals Working Group, which held its first workshop in December and decided to undertake a review of the territory's health infrastructure. They initiated a Joint Working Group on Health Services, including representatives from UNTAET, international NGOs, the World Health Organization, UNICEF and the United Nations Population Fund. The Working Group identified the most pressing needs in healthcare service provision, the measures that would rapidly address them, and the minimum short-term requirements for the fulfillment of these needs. A second workshop in February discussed the findings and agreed on a minimum set of standards for establishing an organization to coordinate East Timor's health system. After this meeting, UNTAET established the IHA as a joint international-East Timorese body, and as the embryonic "Ministry of Health" for East Timor.

The DHS consists of 16 East Timorese health professionals, along with seven international staff from the UNTAET Office of Health. Dr. Sergio Lobo and Dr. Jim Tulloch head the organization. The main short-term goals of the Division, in collaboration with various UN agencies, health NGOs, and the World Bank are:

- 1) To provide basic health services; and
- 2) To design the health system most suitable to East Timor's needs.

Activities toward the first goal include: the re-building and rehabilitation of healthcare facilities; the re-establishment of basic health services; ensuring the supply of essential drugs and immunization services; the training and support of local health workers; and the maintenance of the communicable disease surveillance system instituted by the World Health Organization in Sept. 1999, along with the improvement of disease prevention and control.

The DHS is also responsible for helping to develop national health policies, systems, legislation, and regulations, and to determine mechanisms to ensure adequate funding mechanisms for the health system. At this point, the health sector receives most of its funding from international donors—a significant portion of which the World Bank administers (*see page 2*).

In addition to a few local health NGOs and associations, there are many other health-related activities taking place outside of the DHS. Most important are the health posts of the Catholic and Protestant churches. The Catholic Church alone has 23 clinics and health centers throughout the territory. As well, the Timor

Coffee Cooperative (CCT) presently has three clinics, and aims to establish 14, which will be located throughout the four coffee-growing districts. The CCT eventually expects to employ 100 health workers, all East Timorese, with two doctors in each of the four districts. The CCT clinics will service the 17,000 members of the cooperative and their families (bringing the total number of people covered to more than 70,000). Finally, different contingents of the United Nations-led peacekeeping force also provide medical care.

The IHA/DHS will spend approximately US\$70 million over the next three years in carrying out its various functions, and will employ 1,087 health sector workers in 2001 (the vast majority of whom will be nurses—a category that includes midwives). (During Indonesia's occupation, there were 1,887 registered East Timorese nurses.) The reduction in the number of health sector employees was a deliberate decision by the United Nations, the World Bank, and the CNRT. They feared that a larger number of employees would prove unsustainable once East Timor becomes independent, given the assumption that the country will have very limited financial resources. Some are concerned that there will not be enough employees to meet the East Timorese population's health needs—despite the presence of health providers outside the DHS structure.

Dr. Sergio Lobo acknowledges the shortage of medical personnel, especially doctors, in East Timor, but he is confident that the DHS will have the capacity to serve the population adequately when UNTAET leaves. Dr. Lobo contends that most diseases in East Timor do not need the care of a doctor, that trained nurses and local health workers can treat many of these illnesses by drawing on already existing resources. In this regard, he foresees increased opportunities for community participation, with a local health committee in every sub-district, and a much greater role for women in health care provision and education. At the same time, Lobo states that—in order to minimize conflicts—such a social transformation must arise from prevailing, indigenous social values, rather than from good, but "imported", ideas.

In terms of actual health facilities in the territory, the current plan foresees the following:

- 1) 5 hospitals (the main one will be in Dili; the others will be in Ainaro, Baucau, Maliana, and Oecusse);
- 2) a small number of "level three" clinics in some of the remaining districts, with each clinic having 6 to 10 beds;
- 3) 63 health posts (both with and without beds), with one in each sub-district; and

4) 85 health posts and 116 mobile clinics based in each sub-district to cover outlying villages.

The DHS intends to construct 25 new clinics in the most needy sub-districts by the end of 2001. After their completion, the DHS and the World Bank will assess the situation and decide how many other health posts to build in 2002 and 2003, and will determine where to locate them. During this time, they will also build or rehabilitate of the four hospitals outside of Dili.

### **The Role of International NGOs**

The major responsibility of the DHS is to support the health policy development process and the design of a health system suited to the needs of East Timor, and to design and oversee the implementation of a national health strategy. It is beyond the DHS' current capacity to provide health services. For this reason, the DHS has to rely—at least temporarily—on the work of various international NGOs (INGOs) to fulfill district-level health needs.

The DHS thus designated responsibility for implementing district health systems to different INGOs on the basis of district-level processes involving NGOs working within the district, local health authorities, and the Catholic Church. These lead INGOs are charged with planning, organizing, and managing the provision of health services in each district. All other health organizations working in the districts will have to work with and coordinate their activities with the lead INGOs. The DHS has also appointed temporary (East Timorese) district-level health officers who will work closely with the District Administrators, serve as the link between the DHS and the lead health agency in each district, and oversee local health education. In addition, the DHS will assign an assistant to each district officer to focus on preventative public health issues. The DHS may also encourage the use of volunteer community workers at the sub-district level.

There is a good deal of diversity among the various district-level plans. This diversity is important because it demonstrates a recognition on the part of the DHS that needs vary between districts. It will also allow the DHS to evaluate the strengths and weaknesses of the various plans over a one-year period, and to come up with a strong, standard model for the future for all districts. At the same time, East Timorese health professionals will use the time to research models of health systems from other parts of the world (although it is not clear how the DHS will facilitate this research process). Future district-level health systems will possibly be a mixture of services from the government, NGOs, churches, and local cooperatives.

### **Concerns and Criticisms**

Various “stakeholders” in the evolving health system have voiced criticisms regarding its development. The most common one relates to a perceived insufficient amount of consultation with the local population, and with international NGOs and local partners involved in the health sector. At the same time, many worry that funding is inadequate to ensure minimum health standards and long-term sustainability in terms of health service provision. Along the same lines, there are concerns that not enough technical, on-the-job training is taking place.

#### ***Marginalization of the local population***

The construction of health facilities is an area in which local companies could potentially participate. But because the World Bank and the DHS are requiring very high standards of all contractors and may only accept contract bids for clusters of 5 clinics, it is doubtful that East Timorese businesses (or local or international NGOs) will receive any contracts. (To undertake such a project requires high amounts of capital and capacity.) As a result, millions of dollars will probably go to foreign businesses, rather than stay within East Timor and help to strengthen the local economy. It is possible, however, for foreign businesses that win the contracts to sub-contract all or part of the work to East Timorese businesses. This will inevitably happen to a certain degree, thus ensuring some economic benefit to the local economy.

Critics of the DHS argue that this is not enough. Furthermore, they fear that having foreign companies responsible for the construction of the health centers will undermine the long-term maintenance of these facilities as local people will be less familiar with their construction. In addition, they contend that foreign businesses are unfamiliar with the difficult conditions—especially in the sub-districts—present in East Timor. Local businesses, and even INGOs somewhat, on the other hand, are already accustomed to the conditions, and are, thus, better-equipped to carry out the construction.

Some argue that the lack of significant inclusion of local businesses and organizations in the construction of health centers is a manifestation of a larger problem: the marginalization of local interests in the development of the national health sector. Many local health NGOs and associations, for example, do not participate in the DHS structure. This is a result of a deliberate decision by the DHS due to the concern of many East Timorese health professionals that the excluded local entities have insufficient skill levels and capacity.

As such, these local NGOs and associations do not receive direct funding through the DHS structure (see page 2). At the same time, local health associations have not played a significant role in the design of the current health system. It is for this reason, some contend, that local people have a very low-level of understanding of what is actually taking place in the health sector.

### ***Insufficient Involvement of International NGOs in the Design of the National Health Sector***

While lead INGOs in the districts will have considerable space to operate as they think best, the autonomy is not as great as it might seem. INGOs have to work under DHS and UNTAET restrictions regarding the number of local employees and the salaries received by local staff.

Many INGOs working in the health sector have called attention to what they see as an inadequate level of consultation with both the World Bank and the East Timor Transitional Administration (ETTA)—the two principal architects of the new health system. According to a number of INGO personnel, the World Bank and UNTAET are very eager to receive information from them, but do not consider their views about the shape of the new health system. In part, this may be because the INGOs are only here on a temporary basis. These same INGOs, however, are directly providing health care and also have to address the local consequences of the policies developed by the DHS and the World Bank.

INGOs, for example, carried out district-level assessments under the misapprehension that there were adequate funds in the trust funds for all district-level health needs. The INGOs had this false idea because of insufficient communication between the DHS and the World Bank (and, subsequently, the INGOs). Only later, when the World Bank presented its budget for the health rehabilitation project, did the INGOs learn that funding would not cover all needs, and that many local health workers would lose their jobs. The INGOs were left to deal with the consequences from the unfulfilled expectations among local people and many of their staff, thus damaging their relationships with the local population.

INGOs continue to be critical because the World Bank/DHS Health Sector Rehabilitation and Development Program did not provide any direct funding for INGO activities, yet assumed INGOs would continue to provide hospital, community and outreach services. From the World Bank's perspective, such funding makes no sense given the limited funds available to build the health sector and given the fact that INGOs are only in East Timor for the short-term. INGOs respond, however, that one of their principal responsibilities is to build capacity among East Timor's health workers and

that their work and indeed very presence have very important long-term implications. That said, without adequate funding, INGOs cannot fulfill their mission.

Ideally, all health projects involving internationals should have a strong training component. For example, consultations should be the primary responsibility of East Timorese nurses, with expatriates on hand to act as observers and/or consultants when necessary. The need for such a heavy emphasis on skills transfer is all-the-more important given the small number of local health workers that exist. For such reasons, INGOs must put a heavy emphasis on the skills of expatriates as teachers, not simply as health providers.

### ***Sustainability and the Maintenance of a Strong, Public Health Sector***

Because of an assumption that the government of an independent East Timor will have very limited resources, UNTAET, the World Bank, and the CNRT have all agreed to limit the size of the country's civil service. The goal of this policy is to ensure that an independent East Timorese government will be able to afford to pay the salaries of its civil servants. While fiscally sound, the wisdom of the policy is questionable if the goal is to ensure the servicing of the health needs of the East Timorese population—especially those that live in rural areas and sub-district towns. In addition, given the small size of the civil service and what is perceived to be the insufficient funds for training, there are serious questions about the ability of the future Ministry of Health that will evolve out of the DHS to maintain the organizational and physical infrastructure that UNTAET is constructing.

Given the poverty of financial resources, there are fears of the privatization of health care, in the form of for-profit services. According to a World Bank representative in Dili, there is strong agreement between all the "stakeholders" that basic necessities—such as immunization of children, maternal and infant care, and anti-malaria and anti-tuberculosis treatment—should be free. Given the limited resources of East Timor, however, privatized, or profit-driven health care is a definite possibility for particular services. (See articles on pages 9 & 12.)

### ***Insufficient Emphasis on Environmental Health***

Many INGOs would like to see the DHS place a much greater emphasis on environmental health, hygiene promotion initiatives, and sanitation. As of yet, there has been hardly any coordination between the DHS and relevant ETTA departments such as the Environmental Protection Unit, Water and Sanitation, and Agriculture.

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## Lessons from the Indonesian Health System and Future Health Priorities

*By Maria Dias*

The many shortcomings of the Indonesian health system should serve as a lesson to us all. In order that our people become healthy and prosperous, indigenous and international health practitioners must try hard to identify, and then put an end to, the poor health practices introduced to us by the Indonesian system—many of which still continue today.

During the occupation, the Indonesian authorities tried to win us over with humanitarian assistance like rice, maize, milk, and medicines. They even built a new general hospital in Dili, opened health clinics in remote areas and a nursing school, and increased the number of local nurses.

But the brutality of Indonesia's colonial project and the endemic corruption in "New Order" Indonesia undermined any attempt to do good, including in the health sector. The Indonesian doctors who came here were almost always more interested in their own financial gain than in improvements in the health of the people. They began by opening their own private practices and pharmacies. They then persuaded patients to visit these practices for treatment. Finally they would give out prescriptions that the patients would have to purchase at their pharmacies.

The more we study the health system during Indonesian times the more we can see that the health of the rich and the well-connected was, in practice, more important than that of the poor. The Dili General Hospital (Rumah Sakit Umum or RSUD), for example, had four classes of rooms for patients to stay in (VIP and classes 1–3). For this reason, the quality of the service you received depended on the class that you could afford. Patients had to pay for everything—from simple plaster and medicines to operations. This system was so unfair, especially as the health service had a sizeable budget, and caused our

people much suffering.

Throughout the transitional period, health services are available free of charge, but, as health workers, we still must be very careful to construct a system that empowers the most marginalized people within the community. We must avoid duplicating the Indonesian system which only allowed the rich and politically well-connected to receive adequate treatment. And there are concrete reasons why I fear this might already be happening in some ways.

Our clinic in Dili recently took in two East Timorese refugee returnees, for example. They had both just given birth in a local health facility under the IHA/DHS where they had spent four days. Nevertheless, the women were still full of blood from their deliveries. No one had bothered to check or clean the women at the previous facility. This reminded me of when I would visit patients at the hospital during the Indonesian occupation, patients for whom I would have to provide care because the hospital staff had abandoned them.

Perhaps the two women had not received adequate treatment because they had just returned from nearly a year away, living as refugees in West Timor with many pro-integration supporters. In other words, perhaps they were victims of politically-based discrimination. I know such cases occur. It is for such reasons that we health workers must be totally neutral and work to ensure that discriminatory practices in health facilities do not occur, no matter what anyone feels about the patient's political, social or economic background.

International non-government organizations (INGOs) can help us by leading us by the hand and together form a framework which will allow the Timorese people to move towards their independence—in the full sense of the word. When the transitional period is through, the people should be able to stand on their own two feet

and should not be dependent on other countries. For this reason, there must be more comprehensive training for indigenous health practitioners. We need the help of the internationals for this. We are very grateful for the INGOs coming to help us, but we must have the opportunity to improve our skills so that we are not constantly dependent on the international community. We must work together—whether we are service providers under the DHS structure or private clinics or local NGOs—with the international community leading the way.

For this reason I request that all the international doctors and staff, who have come to serve in our land, do so with just one common purpose: to help empower the community. They can do this by much more emphasis on:

- 1) providing training for indigenous doctors and nurses (including health education); and
- 2) providing education about important health issues at the grassroots level of the community.

Health practitioners must make an extra effort to provide preventative health education at the grassroots level. In general, the people are still blind when it comes to understanding preventative health concepts. Health education should be all-inclusive and not just focus on illness and disease. Our organization, PAS, for example, has incorporated the building of toilets and animal shelters, along with environmental education and first aid training into our program on Atauro island. Such activities will help decrease the number of visitors to the clinic. Indeed there is just as much work to do outside of the clinic as there is inside.

We also need to make greater efforts to help the most vulnerable people whose marginalization is often increased by their inaccessibility to health facilities or food distribution points. Such people are also more

vulnerable to the political ambitions of others. The hamlet or *suco* where a chief lives, for example, usually receives its share of emergency food distributions whereas those who live in other hamlets of that village often miss out. This has happened in the area where we recently set up a clinic on Atauro island.

Finally, women must play a lead-

ing role in the day-to-day running of the health service, at the administrative, managerial and service levels. There are currently no East Timorese women involved in the central body of the Interim Health Authority, for example. As women are the primary caregivers in our society, and well over 50 percent of the population, such a situation is unacceptable.

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## **A Vision for a People-Centered Health System in East Timor**

*By Dr. Dan Murphy*

East Timor has suffered as much or more than any other country in modern times. We can attribute this to the inadequacies and designs of the Western world powers, as well as to Indonesia. East Timor is poor because for 500 years they have had a boot on their neck. Nothing can truly compensate the people for the tremendous loss of life and state of collapse in which East Timor finds itself. At the very least, however, these same world powers owe East Timor a huge debt.

A glaring problem facing this new country is the poor health of a population long neglected. The infrastructure is destroyed, qualified medical personnel are non-existent, resources scant. People have lost everything including housing, possessions, even clothing.

An overview of health reveals grinding poverty with all the attendant conditions, including infectious diseases worsened by complications of pregnancy and delivery, frequently resulting in the death of mother or child or both. Many villages have no access to any health care.

Tuberculosis (TB) is a particular example of the kind of challenge faced by East Timor. Prior to last September, TB was already infecting people frequently. After the post-referendum turmoil, however, it is even worse. As a result, TB is now at an all-time-high and is killing people at an alarming rate. Like so many of the other health problems, TB is at least as much a socio-economic problem as it is a physical infection.

The Bairo Pite Clinic where I work has been operational since September 1999. In that short period of time we have seen 100,000 patients. Maternity is very active and, as of yet we have not had a mother die in our care. We average 15-20 in-patients with conditions ranging from malaria, pneumonia, and diarrhea to yaws, encephalitis, and leprosy. Visiting specialists are very helpful; a recent U.S. Naval eye team saw, in two weeks time, over 3000 patients. We have an extensive pharmacy, and an excellent laboratory. Kitchen facilities, laundry, and a new maternity ward will soon be operational. Ten East Timorese medical students help and learn at our facility.

Yet this is not at the heart of what must be done to

improve the health of the country. Our patients may be well today only to return tomorrow with the same conditions. The only way to prevent this is to change village-level dynamics. For this reason, our next program will include going to the countryside to listen to the people, to learn what they see as their health problems. We will then discuss how the people can address these problems using local resources as much as possible.

We see ourselves as facilitators of this process, our clinic a referral source and training site for the village health worker. Preventative, rather than curative, strategies are at the center. Local involvement and empowerment is the key. Village women are the number one health resource of East Timor. They, more than anyone, exhibit concern for health in the community.

Through this process, a national network of local health advocates could emerge. People would choose and support their own local health representative, who would then learn and become the link to the system. The same principles could apply in the cities. Neighbourhood groups could organize around health care issues, choose a worker, and join the network.

Imagine what will happen to health when each community has a representative actively working through a national program. I envision computer links to most places making communication much easier. East Timor has less than one million people and under 500 villages; these things are possible.

Of course curative medicine is still needed. Small clinics could treat several villages. Then larger polyclinics would be needed for the sub-district level, and hospitals with more surgical and specialty capabilities for each district. Dili has the national referral hospital. Links to foreign countries are needed for special cases such as open-heart surgery.

Training for Timorese doctors should take place locally. Again, computers could play a large role, supplemented by practical training at local hospitals and clinics as well as short courses by visiting doctors.

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*Dan Murphy is the head of Dili's Bairo Pite Clinic.*

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## Mental Health and Psycho-Social Recovery in East Timor

By Natércia Godinho-Adams

Professional mental health services in East Timor are almost non-existent. Such a deficiency would be problematic in any society. In a society whose members have experienced massacres, systematic rape, and various forms of torture, however, the absence of an adequate mental health system severely undermines efforts aimed at reconstruction and reconciliation.

The first National Mental Health and Psychosocial Recovery Consultation (June 20-25) in Dili marks the beginning of serious efforts to redress this gaping hole in the emerging health system. UNTAET and PRADET (Psychosocial Recovery and Development in East Timor)—a new organization that involves local and international NGOs and health professionals—sponsored the event. NGOs, UNTAET representatives, and guest speakers from Australia and the US attended.

The lack of any professional mental health program is, to a certain degree, a reflection of the more general health crisis faced by East Timor following last year's referendum. Before September 1999, for example, there were 134 doctors in the territory. Now there are only 33. This clearly limits the ability of medical professionals to recognize and diagnose those who suffer from mental illness. As interim measures, participants suggested possibly upgrading the skill levels of nurses, as well as importing nurses from other countries. The Health Minister of New South Wales, Australia, announced that his government will assign a psychiatrist to spend one week out of every month in East Timor.

Even before September 1999, the mental health system in East Timor was woefully inadequate. During the Indonesian occupation, for example, the authorities reportedly often sent those who 'suffered' from mental illness to an institution in Jakarta; some sent there are reported to be missing. Within East Timorese culture, many regard the mentally ill as '*bulak*' (or "crazy"), people who have usually received treatment from *curandeiros* and *feiticeiros* using traditional medicines.

Post-traumatic stress disorder, domestic violence, public violence, grief and depression are various forms of mental illness. Conference participants learned of current programs and projects to address these phenomena in East Timor. Local and international NGOs are doing most of the training and outreach. The International Rehabilitation Council for Torture Victims, for example, has carried out a psychosocial rehabilitation survey of counseling needs in East Timor. ETWAVE and FOKUPERS, two local NGOs, are providing counseling services for victims of political and domestic violence as well as sexual assault. Caritas offers counseling to trauma victims through a system of two-way radios. And Timor Aid has carried out a three-week training on trauma and psychosocial counseling of children.

The first National Mental Health and Psychosocial Recovery Consultation was a positive and historic event. Out of it emerged an appreciation for greater interagency collaboration, awareness of the need to incorporate care for the mentally ill in the emerging health system, and plans for regular meetings between members of PRADET and the IHA/DHS, and other NGOs.

An important challenge for mental health workers in East Timor is to bridge the conceptual gap between the emerging medical system—one based largely on Western notions and practices—and local customs and traditions, and to avoid imposing Western ideologies that may not have a place in the future well-being of this society. At the same time, the mental health system must incorporate an appreciation for East Timor's history, one marked by centuries of colonization and, more recently, horrific levels of political violence. Unfortunately, this discussion was largely absent during the recent consultation, as was dialogue on the need to extend services to rural areas.

The tone of the meeting seemed to have favored a Western medical model approach to mental illness, one that falls short of initiating what is needed most in East Timor: a huge campaign of information to raise public awareness of the causes and manifestations of mental illness, as well as knowledge on appropriate responses, and; two, a national survey to provide benchmarks and direction for national mental health policies. Education is important to help "normalize" mental illness so that members of the public seek treatment for psychological disorders as easily as they do for physical illnesses. A national survey will help ensure that the supply of mental health workers meet the anticipated increased demand for services.

In any society, mental health issues are very complex to address, given the taboos attached to mental illness. But in light of recent political rhetoric on reconstruction and reconciliation, it is paramount that mental health services receive adequate funding and attention. We can not place mental health problems on the back burner in the hope that they will sort themselves out. Research indicates that trauma and exposure to traumatic events can be transgenerational—in other words, that parents can pass on such mental health problems to their children. Thus, if mental health services continue to be deficient, almost non-existent, there is potentially a great threat to the well-being of future generations. With this in mind, UNTAET, NGOs, and the DHS have a very delicate task on their hands. Surveys to assess immediate needs, huge educational campaigns over the radio, as well as fora and public debates can help bring about a new discourse on mental health services, while at the same time demystifying the meaning of '*bulak*.'

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*Natércia Godinho-Adams is an East Timor-born psychologist who recently worked with Timor Aid.*

## **Health Care and Privatization: Lessons for East Timor from Mozambique**

*By James Pfeiffer*

As a poor nation seeking to rebuild from a devastating conflict, East Timor is not unique. A number of other developing countries, especially in Africa, have recently confronted similar challenges. Their experiences are instructive for those East Timorese and foreign supporters concerned with promoting social justice during this reconstruction period. Mozambique, a former Portuguese colony in southern Africa, provides a valuable case study.

Mozambique, like East Timor, suffers from what foreign consultants often call “resource constraints.” According to the recent WHO report on East Timor (*see page 12*), there is a consensus that health services should be free, but “economic constraints”—present and future—make it very difficult to realize this ideal. For this reason, patient co-payments, private health care and private insurance are options under consideration. At the same time, this scarcity of resources has resulted in insufficient staffing for the emerging health department. As a result, international NGOs are under pressure to fill the gaps in services that the “constrained” health system cannot handle.

The Mozambique experience over the last eight years demonstrates that the promotion of private health care and the channeling aid NGOs have a negative impact on society in two key areas. First, such practices drain resources away from the public sector; and, second, they fragment the programs of the national health system.

### **Assuming Resource Constraints**

The notion that national governments cannot offer free universal health care coverage in developing countries due to insufficient resources has dominated health policy making for the last two decades. But this is a very problematic assumption. Mozambique is one of the poorest countries in the world, so clearly there are real limits to how much the government can spend on programs. The question is, however, how should a country deal with such limits?

After independence in 1975, the Mozambican government established a national primary health care system to reach its poor rural populations. The system was so successful that the World Health Organization cited it as a model for developing countries. A war of destabilization financed by neighboring South Africa, initiated in the early 1980s, however, targeted the health system and its workers. The system continued to function remarkably well under the extreme conditions, but Mozambique had to rely increasingly on external assistance to recover from the economic catastrophe and destruction caused largely by the war. As a result, Mozambique turned to the World Bank and the International

Monetary Fund (IMF) to gain access to financing for development projects and to obtain relief from an enormous international debt burden.

As a condition for funding, the World Bank and IMF compelled Mozambique to limit total spending in specific sectors beginning in 1987. They even restricted how much the government could pay its health workers. The government has also had to pay up to US\$1 million per day to service its debt to international lenders, thus diverting scarce resources it could have spent on health and education.

The World Bank, the United States Agency for International Development (USAID), and others have cited the intensifying “resource constraints”—creations, in part, of the conditions imposed by the agencies themselves on government spending—as justification for the need for a larger private health sector. These agencies have also channeled funding through international NGOs (construed as private sector charities) to serve populations made vulnerable by reduced government spending, rather than using the funds to strengthen public sector health care. As a consequence of this approach, Mozambique’s post-war health sector reconstruction has witnessed the emergence of a for-profit health sector in large towns and cities, and the proliferation of hundreds of poorly coordinated foreign agency health projects scattered throughout the country.

### **Effects of Privatization**

In Mozambique, the emergence of a private health sector has had a negative impact on the public system that serves the poor. As a result of the free market policies that international financial institutions and some bilateral (government to government) donors have pressured Mozambique to adopt, social and economic inequality has dramatically increased. A two-tiered health system has emerged in which poor people continue to seek treatment in the under-funded, understaffed, demoralized state sector while the small group of largely urban, rich elites receive services from increasingly well-endowed private clinics that have emerged in most major cities.

Public system workers become further demoralized when they see how much their private sector colleagues earn. Many poorly-paid government system workers now have to work second jobs in the private sector or treat people in their own homes to survive. Medicines and equipment frequently disappear from the public warehouses and pharmacies, then reappear in private clinics and local markets where they are sold for a profit. Some health workers, including doctors, have abandoned the public sector entirely and work full-time in private clinics. The overall effect has been the continued deteriora-

tion in the quality of public sector services and the accumulation of resources in private clinics. The private sector has thus intensified the resource constraints faced by the public system.

At the same time, the initiation of fee payments for many basic services (a practice encouraged by the World Bank and the IMF) within the public sector has produced the predictable decline in the number of people using these services. Research throughout Africa has increasingly shown that experiments in user fees, even with minimal payments, for primary health care services often lead to declining utilization. Thus, the combined emergence of private clinics and fee-for-service in the public services has deepened the marginalization experienced by many of the poor.

### **Effects of funding through NGOs**

Major agencies such as the World Bank and USAID argued that international NGOs could provide many of the community-based health services and education that the government could no longer afford. In addition to substituting for under-funded public services, NGOs, they argued, could often reach poor communities more effectively, compassionately and efficiently than public services. As a result, many bilateral donors channeled much of their health assistance through international NGOs, some of whom implemented projects outside of the national health system. Other donors provided project-specific support to the health service, but under the control of foreign coordinators. By 1995, there were nearly 100 different NGOs and foreign agencies in-country conducting 405 such projects in the health service, nearly all with expensive expatriate staffs and independent administrative systems. The proliferation of projects led to increasing fragmentation of primary health care programs, and loss of Mozambican control over the health sector.

Coordination problems were common in most of Mozambique's provinces. As a result, conflict between international NGOs was frequent and there was often wasteful spending of resources for big projects that were unsustainable once the NGOs left. In one province, three foreign agencies working in the health sector had annual budgets of over US\$1 million while the public health system had US\$750,000 to cover a population of 1 million. Huge proportions of the foreign agency budgets went to administrative costs, salaries, international staff benefits, and the construction of compounds.

So many problems resulted that all the major health sector donors signed a "Code of Conduct" in 2000 in Maputo. The code emphasizes that donors should channel most aid through the national health service and

allocate it in accordance with the national plan. Perhaps this is a recognition of a valuable lesson: a well-funded, centrally-planned national health system, can provide services more efficiently and cost effectively than an uncoordinated mixture of private sector actors.

There are important differences between what emerged in Mozambique in the late 1980s, and what exists currently in East Timor. Already, under the Interim Health Authority, there is a high level of coordination with international NGOs. But constant vigilance is necessary to ensure that this continues.

### **Learning from Mozambique**

There is much for East Timor to learn from Mozambique's experience. First and foremost, East Timor should insist that it will not compromise a vision of free health care for all. Capitulating to the private health care argument will ultimately lead to an impoverished public sector, greater social inequity, and betrayal of the principles of social justice that so many died to achieve.

International NGOs, of course, have a crucial role to play during this period. East Timor desperately needs outside support to construct and maintain the health system that the population deserves. The training needs are huge and NGOs can provide a wide range of technical support to build East Timor's human resources. NGOs can bring dynamic new ideas to primary health care provision that can be integrated into the health system in a systematic and coordinated way. But the Mozambique case demonstrates that using NGOs as substitutes for government services as part of a privatization package will lead to a fragmentation of health programs and diversion of funds from a sustainable national health system. Privatization in the end will benefit a few, while diverting resources from the poor majority. Resisting privatization of health care begins by challenging the assumption that "resource constraints" are a given.

It is unlikely that East Timor will be able to sustain any of its social programs on its own for many years to come, and will have to rely on foreign aid. The major question is whether that aid will be used to eliminate resource constraints in order to build a free, strong, universal health care system, or will it be diverted to a plethora of foreign agencies and privatization schemes?

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## Unfulfilled Promises Prolong Hardships for the People of Oe-cusse

On 18 and 19 September, almost 150 people demonstrated in front of the UNTAET District Office in Oe-cusse, demanding a permanent, reliable, and safe means of transportation between the enclave and the rest of East Timor. Despite promises by both the CNRT and UNTAET to address the problem, the authorities have failed to provide adequate transportation for the district's inhabitants in the more than three months since the *Bulletin* first reported on the situation in July.

UNTAET in Dili responded to the September demonstrations by announcing that there would be an operating ferry between Oe-cusse and Dili by early October. On 27 September, the East Timor Transitional Cabinet agreed to the operation of a passenger ferry service between Oe-cusse and Dili and to provide a subsidy for the service. As of 8 November, however, there is no officially sanctioned or subsidized passenger ferry service between Oe-cusse and Dili.

There is presently a private barge run by an Australian company, East Timor Shipping and Supply (ETSS), that travels between Oe-cusse and Dili once a week. UNTAET's District Affairs official, Gerry Fox, described the barge, designed only to carry humanitarian goods, as an "informal and extremely temporary solution that is not altogether safe."

The barge carries a maximum of 50 people on its weekly journey, but there are hundreds of people hoping to make the trip every week. While UNTAET does not yet officially support the running of the barge, they explained that they have provided chairs, life-jackets, and some life-rafts.

Ana Paula, National Council Representative for Oe-cusse, explained that "people can travel on this cargo barge because we, people from Oe-cusse, went to ETSS directly and asked for their assistance. We have received no assistance from the CNRT or UNTAET. UNTAET has enough money to send their international staff to Bali on weekend holidays and we don't accept that they don't have money for the people of Oe-cusse."

Although the East Timor Cabinet allocated funds for the service in late September, UNTAET has not yet begun subsidizing the service as they are still negotiating the memorandum of understanding with ETSS. Meybel Villavicencio of UNTAET's Office of the Deputy Transitional Administrator says that there

are presently not sufficient funds in the "Marine Ports" budget for the project. Her office will therefore need to take funds from another budget, which will require even more negotiation and time.

Even when UNTAET signs the memorandum and pays the subsidies, however, the barge transportation will be inadequate. The barge, for example, does not have sufficient safety equipment for all passengers, and the anticipated agreement between UNTAET and ETSS will only run for three months in the hope that a better option will arise after that time.

In response to concerns about the lack of safety, the small number of people served by the boat, and its temporary nature, Maybel Villavicencio of UNTAET told *La'o Hamutuk*, "Well, it is a free service, a kind of charity." In response, Ana Paula stated that "the people of Oe-cusse are ready and willing to pay a fair price for the service. The service, however, must be safe, reliable and accessible to everyone."

The isolation of Oe-cusse, a district of 42,000 inhabitants, has profound implications for its residents, contributing to ongoing shortages of food and other materials, extremely substandard health services, and a serious lack of information about the reconstruction process. And there is virtually no access to UNTAET radio and television. Due to the lack of transport, students from Oe-cusse have not been able to register themselves at East Timor's only university in Dili for the new period of study. And district residents who have been able to find their way to Dili for business or family matters have found themselves without any means to return to their homes in Oe-cusse.

Despite a formal agreement between UNTAET and the Indonesian Government providing for "unimpeded access" of goods and people on a special transit corridor between the enclave and the rest of East Timor, militia threats and violence completely hinder safe land travel. Although there are UN flights which regularly travel between Oe-cusse and Dili, these are primarily for international staff. UN staff—including peacekeepers—receive first priority for the flights; international NGO staff get second priority, and local NGOs and CNRT representatives receive third. For the vast majority of the people of Oe-cusse, these flights are completely inaccessible.

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## *The World Health Organization Releases Report Analyzing National Health Situation for the First Half of the Year*

On August 18, the World Health Organization (WHO), a United Nations agency, released its "East Timor Health Sector Situation Report" for January-June 2000. While providing an overview of the health situation in post-referendum East Timor, the report also discusses the international organization's activities in East Timor and its ideas for the future direction of the territory's emerging national health system.

The WHO supports the work of the IHA/DHS—the embryonic "Ministry of Health" which has the principle responsibility for defining health policy, as well as for planning, implementing, and coordinating health services on the national level. Until the IHA's establishment in February, the WHO performed these functions.

Still today, the WHO participates in the formulation of national health policy, and works to strengthen national capacity in the areas of public health and curative medicine. It also plays "a technical coordination role" in the provision of health services and sustainable public health development. In this regard, the WHO helped to set up a communicable (contagious) disease surveillance system to track reported and/or suspected cases of specific diseases (such as diarrhea, cholera, and malaria) and to help coordinate and guide the work of non-governmental organizations in the field. According to the WHO, the system helped to identify the presence of Japanese Encephalitis, and thus prevent a major outbreak of the disease. Other current activities of the organization include helping to establish a national child immunization program and a strategy to reduce the incidences of malaria.

According to the WHO, East

Timor is no longer in an emergency phase, but is now in a transitional/developmental phase—a sign that the danger of a major health catastrophe has passed. Nevertheless, the collective state of the East Timorese people's health is frighteningly low.

While past estimates suggest that 450-500 women per 100,000 die in childbirth, for example, the WHO fears that the figure could be as high as 850 deaths per 100,000 births. The WHO also reports that about 20 percent of children suffer from chronic malnutrition, and that an estimated 80 percent have intestinal parasitic infections. There are about 8,000 active cases of tuberculosis, directly affecting more than one percent of the country's population. Overall, communicable diseases account for about 60 percent of all deaths in East Timor. In relation to such statistics, the report states that the public's knowledge about health-related matters is poor and, thus, the WHO has identified health promotion as "a key component of the basic package of health services to be introduced."

Malaria control is one of the WHO's major concerns in terms of public health. Malaria is a serious problem in East Timor, with over 61,000 reported cases during the six months covered by the report. The WHO works in partnership with two international NGOs (MERLIN and the IRC), to implement malaria control programs. As such, the WHO has supplied the NGOs with various medical supplies and 175,000 treated mosquito nets.

Dili is one of the areas of the country most prone to malaria. To help make Dili mosquito-free, the WHO recommends redesigning the water drainage systems that feed into the Comoro and the Santana rivers.

In addition, it calls for stopping the practice of growing *kang kung* (a green, leafy vegetable) in Dili's swamps and major drainage canals. [Of course, such a measure could have a negative impact on the nutritional levels of Dili's residents.] The report also recommends that all development projects undergo an environmental health impact evaluation to be better able to anticipate negative health impacts and to include mitigating measures at the design and planning stages.

Regarding mental health, the WHO states that a large number of national and international organizations have come to East Timor with offers to help with post-conflict emotional and psychological trauma. The international health body argues, however, that East Timor's health priorities and health workforce constraints limit the ability to accept such offers of assistance. Current plans are prioritizing community-based mental health programs. The Department of Mental Health at the WHO's headquarters in Geneva, Switzerland is assisting the IHA/DHS with efforts to establish a National Basic Mental Health System.

The report also identifies some important areas of need in East Timorese public health. Currently, for example, there has been no progress made in developing programs to control intestinal parasitic infections and iodine deficiency anemia in women and children—common public health problems. In addition, there is no leprosy control program.

From a political-economic perspective, the report's most significant section is where it states that there is a consensus that health services "be free at the point of deliv-

ery.” It contends, however, that “economic constraints”—present and future—make it difficult to realize this ideal. Policymakers are thus beginning to consider other forms of health care, including private health insurance and patient co-payments (by which patients must pay a certain amount of money for services). In other words, profit-oriented health care is possible.

The perceived potential need for the involvement of profit-driven actors in the health field is a reflection of East Timor’s material poverty. At the same time, there is a shortage of trained health workers in the country. While there were

3,500 health workers under the Indonesian system, there are now only about 2,000 health workers. Nevertheless, many of these workers cannot find employment in the health sector given the lack of sufficient resources. While UNTAET has proposed 1,480 staff, the National Council has proposed only 1,087 due to worries about the post-independence government’s ability to support a larger civil service.

But as the WHO admits, “[t]here is concern as to the difficulties of sustaining a health service with such a small workforce.” As a result of the reduced workforce and a shortage of doctors, all health care work-

ers will have to assume extra responsibilities—both clinical and administrative. And for this reason, the World Bank and UNTAET trust funds will fund a national training program to increase the skills of health workers.

In terms of other future activities, the WHO will work closely with the DHS within the framework of the World Bank-funded Health Sector Rehabilitation and Development Project. (*See article on page 2.*) It will also continue its technical advisory and support roles to U.N. agencies, national and international NGOs, and other organizations involved in health matters. □

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(*Oil and Health, continued from p. 14*) within 400 nautical miles of each other divide the seabed at the midpoint. Given that the oil and natural gas deposits lie on East Timor’s side of the midpoint, Australia should forfeit all rights to the deposits.

But according to the 30 October 2000 issue of *Business Week*, the Australian government does not want international law to govern the negotiations. Instead, Canberra is apparently employing the same blatant self-interest that informed its support for Indonesia’s crimes from 1975 to 1999, refusing to give up its claim to the oil and natural gas. And it is backing up its claim with threats.

According to a Western diplomat quoted by *Business Week*, Canberra is threatening to cut its four-year, \$75 million aid program unless East Timor honors the old treaty. A spokesman for the Foreign Ministry in Canberra basically confirmed the report.

The Australian government has spent a lot of money providing security and humanitarian assistance to East Timor since September 1999. But this is a very small—and insufficient—price to pay given its complicity in Indonesia’s crimes. As the Australia-based Action in Solidarity with Indonesia and East Timor argued in a recent press release, “Australian military intervention in East Timor was only ever necessary because of the 25 years of unqualified support for Suharto’s invasion of East Timor. A consistent policy of refusing military, political and diplomatic support for Suharto’s policy during this period combined with a principled stand in support of the right of self-determination would have

helped end the suffering of the East Timorese people years ago.”

It is for such reasons that *La’o Hamutuk* calls upon the Australian government to cease its demand for any rights to the oil and natural gas in the Timor Gap. Regardless of the legal merits of East Timor’s claim (which are very strong), basic justice requires that Canberra recognize and apologize for its shameful past. A concrete manifestation of such an act would be to allow East Timor to enjoy without sanction the full benefits of the oil and natural gas deposits in the Timor Sea.

Such a gesture would be good for Australia’s political health. It would also provide East Timor with desperately-needed financial resources to ensure that all East Timorese have adequate access to free and high-quality health care, and to build the type of socio-economic infrastructure necessary to reduce the profound poverty that underlies most of the illnesses people experience.

Advances in a society’s healthcare are not simply a matter of wealth. Countries of relatively modest means can also achieve great progress. Cuba, for example, despite being a “Third World” country, has made amazing advances in the delivery of health services.

But adequate resources clearly matter. At the very least, there must be enough to satisfy basic needs, along with the political will to distribute those resources in an equitable fashion.

In this regard, tuberculosis—a common killer in East Timor—is intimately linked to oil and justice.

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## Health, Wealth, Apologies and Oil: The East Timor-Australia Connection

Many diseases experienced by East Timor's population are, first and foremost, the results of poverty—not simply the lack of proper medicines, technology, and trained medical personnel.

Tuberculosis, for instance, used to be a common affliction in Western countries. Today, it is rare. Here in East Timor, however, tuberculosis is widespread. More than anything, distinct levels of nutrition and public sanitation—and, thus, different amounts of resources—explain this dramatic discrepancy.

International analysts often present the lack of sufficient resources, or poverty—such as that experienced by East Timor—and the associated health problems as unavoidable, or as natural, and thus unchangeable. But as the current negotiations over ownership rights of the oil and natural gas deposits in the Timor Gap demonstrate, there is nothing inevitable about poverty. Rather, it is the material expression of unequal power relations.

East Timor suffered tremendously as a result of such unequal power relations. Numerous wealthy and powerful countries shamelessly supported Indonesia's invasion and occupation of East Timor simply because of the desire to maintain good relations with resource-rich Indonesia. One such country was Australia.

Recent disclosures prove that Australia's government was well aware in 1974-1975 of Indonesia's plans of aggression against East Timor. Officially, Canberra expressed support for self-determination. In reality, however, the Australian government effectively encouraged Indonesia's action by consulting with Jakarta about its criminal plans for East Timor, and by saying and doing nothing to indicate any serious opposition to Indonesia's planned takeover of the former Portuguese colony. In fact, Australian officials often expressed their preference for an Indonesian-controlled East Timor, rather than an independent one.

Throughout Indonesia's illegal occupation, Canberra provided significant military training and weaponry, regularly exchanged intelligence information, and engaged in joint military maneuvers with Jakarta. And perhaps no Western country worked as hard as Australia did to provide diplomatic cover for Indonesia's atrocities in East Timor. Australia even went so far as to extend *de jure* recognition of Indonesia's brutal annexation of East Timor—a necessary step to enter into negotiations over the Timor Gap.

Almost 11 years after the December 1989 signing of the resulting treaty, Australia's role in East Timor's suffering and the Timor Gap are again at the center of East Timorese politics.

On August 31, students gathered at the University of East Timor to confront Australian Foreign Minister Alexander Downer and demand an apology for Canberra's complicity in Indonesia's invasion and occupation of their country. But, unfortunately, a promised question-and-answer session with Downer never happened.

Currently, the East Timor Transitional Administration is negotiating a new treaty with Australia. Under the 1989 agreement, Canberra and Jakarta divided the Timor Gap roughly in half. The East Timorese and local United Nations leadership wants to redraw the boundary line so that the seabed boundaries are consistent with international law. Under the 1982 United Nations Convention on the Law of the Sea, countries  
(continued on page 13)

### What is La'o Hamutuk?

*La'o Hamutuk* (Tetun for *Walking Together*) is a joint East Timorese-international organization that seeks to monitor, to analyze, and to report on the activities of the principal international institutions present in Timor Lorosa'e as they relate to the physical and social reconstruction of the country. *La'o Hamutuk* believes that the people of East Timor must be the ultimate decision-makers in the reconstruction process and that the process should be as democratic and transparent as possible. *La'o Hamutuk* is a non-partisan organization that seeks to facilitate greater levels of effective East Timorese participation in the reconstruction and development of the country. In addition, *La'o Hamutuk* works to improve communication between international institutions and organizations and the various sectors of East Timorese society. Finally, *La'o Hamutuk* serves as a resource center, providing literature on different development models, experiences, and practices, as well as facilitating contacts between East Timorese groups, and specialists and practitioners involved in matters relating to development in various parts of the world.

*In the spirit of promoting greater levels of transparency, La'o Hamutuk invites individuals to contact us if they have documents and/or information relating to the reconstruction that may be of interest to the East Timorese people, and members of the international community.*