Political Economy of Healthcare in Post-conflict Timor-Leste: Contestation and Ownership in Policy-Making

POLITICAL ECONOMY OF HEALTHCARE IN POST-CONFLICT TIMOR-LESTE: CONTESTATION AND OWNERSHIP IN POLICY-MAKING

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Abstract

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Keywords: Political economy, Healthcare, Post-conflict, Timor-Leste, Contestation, Ownership, Policy-making

This thesis examines the political economy of national ownership in situations of aid-dependent and oil-dependent, with particular reference to the case of the reconstruction of the healthcare system in Timor-Leste. The study demonstrates that, in a range of areas, the FRETILIN government (2002-2007) was able to exercise some autonomous decision-making even though it was heavily aid dependent. Conversely, under CNRT government (2007-2017), elites were empowered by oil resources and consequently they had greater control over development. The study identifies three main approaches used in development policy-making: patronage-based, populist and rationalist, and argues that, from 2002 onwards, the Timorese government generally used patronage-based strategies that benefitted elite political networks, increasing corruption. However, the creation of a 'modern' healthcare system that would benefit future Timorese generations was central to elites' political ideology and consequently healthcare became subject to populist rather than patronage-based politics.

Analysis of four key health programmes, funded separately by the World Bank, the Cuban government, WHO, and USAID, shows that ownership in the field of healthcare has become concentrated among powerful groups (donors, elites, MoH, and the Church). Meanwhile, health professionals, who advocate a liberal approach, lack a political voice. These case studies indicate that the Paris Declaration's focus on country ownership to ensure better aid delivery was unrealistic because, in reality, 'ownership' becomes subject to contestation among powerful actors with different power resources. Findings on the analysis of the four programmes also suggest that Timorese elites did not worry much about healthcare, rather than it being 'central' to their ideology.

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Table of Contents

List of Figures

Abbreviations

AAA	Accra Agenda for Action
ACFOA	Australian Council for Overseas Aid
AIDS	Acquired Immune Deficiency Syndrome
ANP	National Petroleum Authority
AusAID	Australian Agency for International Development
CAC	Commission Anti-Corruption
CAVR	Commission for Reception, Truth and Reconciliation
CBTL	Central Bank of Timor-Leste
CEP	Community Empowerment and Local Governance Programme
CNRT	National Congress for Timorese Reconstruction
DAC	Development Assistance Committee
DFAT	The Australian Department of Foreign Affairs and Trade
DFID	Department for International Development United Kingdom
DHS	Division of Health Services
ESI	Estimated Sustainable Income
ETTA	East Timor Transitional Administration
FALINTIL	The Armed Forces for the National Liberation of East Timor
FRELIMO	Mozambique Liberation Front
FRETILIN	Revolutionary Front for an Independent East Timor
GDP	Gross Domestic Product
HIV	Human immunodeficiency virus
HNGV	National Hospital Guido Valadares
HSRDP I	Health Sector Rehabilitation and Development Programme I
HSRDP II	Health Sector Rehabilitation and Development Programme II
HSSPS	Health Sector Strategic Plan Support
IAB	Investment Advisory Board
ICRC	International Red Cross Committee
IHA	Interim Health Authority
IMF	International Monetary Fund
INS	National Health Institute Timor-Leste
ISPA	Infection of Respiratory Tract
JPDA	Joint Petroleum Development Area

MDG	Millennium Development Goal
MoF	Ministry of Finance
MoH	Ministry of Health
MoHI	Ministry of Health Indonesia
MTP	Malaria Treatment Protocol
NAM	Non-Aligned Movement
NDP	National Development Plan
NGO	Non-governmental organisation
NHSSP	National Health Sector Strategic Plan
NRHS	National Reproductive Health Strategy
NSDP	National Strategic Development Plan
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OPMT	Popular Organisation of East Timorese Women
RACS	Royal Australasian College of Surgeons
RDTL	Democratic Republic of Timor-Leste
SAP	Structural Adjustments Programme
SDG	Sustainable Development Goals
SISCa	Integrated Community Health Services
SSC	South-South Cooperation
SWAp	Sector Wide Approach
SWF	Sovereign Wealth Fund
TB	Tuberculosis
TFET	Trust Fund for East Timor
UDT	Timorese Democratic Union
UNFPA	United Nations Population Fund
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNTAET	United Nations Transitional Administration in East Timor
USAID	United States Agency for International Development
WDR	World Development Report
WHO	World Health Organization

WHO-SEARO	World Health Organization for the Southeast Asia Region
ZEESM	Authority of the Special Administrative Region of Oecusse

Chapter 1: Introduction

The 2005 Paris Declaration on Aid Effectiveness asserted the centrality of ownership in developmental discourses. However, this has raised certain debates among political analysts about the utility and appropriateness of this term. Supporters of the ownership agenda see it as an effort to create new relations of equality among donors and recipient countries that allow local leadership to lead development programmes and their implementations (Buffardi 2013; Hasselskog et al. 2017). Meanwhile, critics assert the opposite, that ownership is not achievable due to contending interests among development actors (within which aid functions as a tool of donor[1] strategy to gain more control over the development agenda and limit policy choices on the part of recipient governments) (Castel-Branco 2008; Hutchison et al. 2014). In the context of fragile and conflict-affected states, in particular, there is a particularly deep, intrinsic challenge for the 'local ownership agenda' arising from internal divisions and governance challenges which imply contested local agendas and interests. As a result, it is not possible for a national ownership to emerge.

Using the political economy approach developed by Hughes and Hutchison (2012); Hutchison et al. (2014); Hout (2015), this thesis presents empirically-based research to examine these critiques in the context of healthcare development in the post-conflict country of Timor-Leste. It examines the conflicting 'ownership' positions of different political actors within the national political economy and demonstrates that, consequently, development policy will be 'owned' by dominant groups (who have power and resources) at the expense of subordinate groups who enjoy unequal access to state resources.

The focus of this introductory chapter is to present the main aims and themes of the research and outline the political economy framework used to analyse the politics and political economy of healthcare in Timor-Leste post-independence. In particular, it relates these to two variables: the changes in leadership and the shift from aid-dependence to oil-dependence, with special attention being given to the effects of these variables on the power relations

[1]The use of the term donor is an inexact term used throughout this thesis to refer to external parties who allocate aid money.

between aid agencies and local actors. This outlines the specific contribution of the research regarding the context of international intervention and the aid effectiveness agenda that are intended to ensure local ownership in fragile states.

The chapter is divided into seven sections. The first discusses the background of the case study and the significance of the research. The second provides a theoretical context to understand the politics of aid delivery and explains the rationale for using a political economy approach as a basis for understanding the politics of healthcare in Timor-Leste. Sections C and D introduce the politics of donors and elites, respectively, and argues that political factors make it difficult for the aid effectiveness agenda to achieve national ownership. Based on these arguments, the next section specifies the key questions that form the focus of this research investigation. Following this, Section F outlines critical realism, the overall approach of the research, which complements political economy theory while Section G presents the relevant issues that were considered salient to the methodology. Lastly, Section H gives a brief outline of the main aims and scope of the seven chapters.

A. Background

This section discusses the re-building of the healthcare system as one of main agendas of the Timorese government after the conflict that followed the East Timor Special Autonomy Referendum in 1999. This redevelopment process was made possible by two factors. Firstly, during the early period of independence (1999-2006), international agencies provided aid support in various forms. Secondly, since 2007, oil money from exploration in the Timor Gap started to become available to the development budget. The main focus is on the inadequacy of knowledge regarding the politics of healthcare and local ownership, considering how the different leaderships and development funding sources affect power relationships among development actors, which in turn affect national ownership of healthcare.

Timor-Leste is a country located in Southeast Asia with a population of around one million people and rich oil reserves. It was invaded by Indonesia in December 1975, an act condemned by the United Nations (UN) but tolerated by the Western powers, which led to a 24-year independence struggle on the part of the Timorese. The fall of the Suharto regime in Indonesia in 1998 resulted in

a UN organised referendum on independence within Timor-Leste. The results indicated that 78.5 percent of the Timorese people favoured full independence. Following this, a wave of violence, including attacks on civilians and looting and arson on a massive scale, devastated the country. The country was then governed by a UN transitional authority until 2002. Since then, Timor-Leste has been an independent country with the official name, the Democratic Republic of Timor-Leste (RDTL).

Timor-Leste faced serious problems delivering healthcare services post-independence due to the collapse of the healthcare system during the post-referendum conflict. This happened in two ways: first, medical services were interrupted by the conflict which targeted government buildings, including health facilities, destroying up to 70 percent of public infrastructures in towns and villages throughout the country – with any remaining medical equipment and supplies being stolen or destroyed (Martins et al. 2006). Secondly, the health situation deteriorated further because many of the country's health professionals, including doctors and senior health administrators, had departed in 1999. Subsequently, only 25 Timorese doctors and one specialist remained (Tulloch et al. 2003), compared to 160 doctors providing health services when Timor-Leste was part of Indonesia (Rosser and Bremner 2015b).

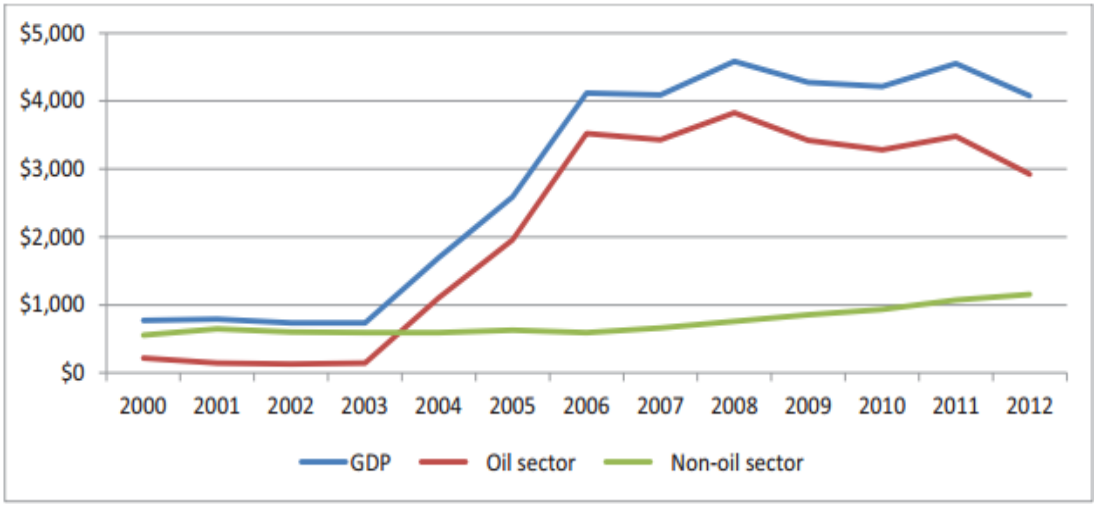
The consequent limited healthcare facilities and services post-independence caused the health status of Timorese to decline. For instance, research indicated that only 24 percent of women in cities could access skilled medical personnel when giving birth, while in rural areas this statistic dropped to 12 percent; thus, maternal mortality rates reached 800 per 100,000 births. Meanwhile, over 40 percent of the population existed below the poverty line, and women were particularly affected with 28 percent suffering from malnutrition and 7 percent of these needed treatment (Asian Development Bank 2005). In response, the new Timorese government put forward a programme to establish a healthcare system, with improved healthcare access and quality as the main agenda; however, before access to oil money, it had few financial resources to fund this.

The future development of Timor-Leste became an immediate concern for the international community and external donors held a meeting in Tokyo, in December 1999, where they agreed to allocate aid to fund development projects in the country. Following this, numerous bilateral and multilateral

agencies poured into the country to run projects. According to Lao Hamutuk, a local non-governmental organisation (NGO) which has published very insightful analyses on development issues in Timor, aid donors contributed approximately US$ 5,200 million into Timor-Leste from 1999 to 2009 (Lao Hamutuk 2009). This huge amount of money shows the serious commitment of international actors to ensuring a better future for the Timorese people, including improving the health sector (Clinton 1999). This amount of funds will possibly increase since there are some projects that are still on-going or have not yet been implemented. The situation also meant that the first Timorese government, under the leadership of FRETILIN (the Revolutionary Front for an Independent East Timor), was dependent on aid money as the main resource for development.

At the end of the FRETILIN term in office (2007), the Government started to receive large amounts of income from petroleum revenues which constituted around 80 percent of Timor-Leste's Gross Domestic Product (GDP) (see Figure 1.1). This oil money was allocated to the development budget to fund programmes to develop public services post-independence, including essential areas, like healthcare access and facilities. However, although the existence of oil money reduced the amount of aid to support development programme, international contributions are still significant for achieving the health plan priorities of the country.

Figure 1.1: Oil and Non-Oil Sectors' Share of Total GDP (US$ million)



Source: (MoF Timor-Leste 2014)

Some existing studies concerning Timorese healthcare discuss the power struggle between MoH (Ministry of Health) and donors – for instance, Wild et al. (2015) and Martins et al. (2013). But these do not further analyse how the politics of elites affects the direction of health development. This present research project addresses this gap, and is also different because it examines the political economy in health development in Timor-Leste over the past 25 years and relates this to significant changes that have occurred in the country; namely, changes of government (Indonesian to UNTAET (the United Nations Transitional Administration in East Timor) to FRETILIN to CNRT (the National Congress for Timorese Reconstruction)) and the shift in development finance from aid-dependence to oil-dependence.

B. Summary of Contemporary Debates about Aid for Development

In its simplest meaning, international aid is defined as the transfer of resources (money, goods, and services) between governments (or international and local NGOs); this has to include an element of grant of at least 25 percent (Lancaster 2000; Lancaster 2008). The purpose is to meet at least one of four economic and development objectives: (1) stimulating economic growth through building infrastructure, supporting productive sectors such as agriculture, or bringing new ideas and technologies, (2) strengthening education, health, environmental, or political systems, (3) supporting subsistence consumption of food and other commodities, especially during relief operations or humanitarian crises, or (4) helping stabilize an economy following economic shocks (Radelet 2006).

The terms “development aid” and “humanitarian aid” became a topic of discussion following the end of World War II. This warfare had involved more powerful weapons than previously used, and these not only engulfed public facilities but also caused great suffering to civilian populations. Many of the survivors faced starvation as jobs and food were scarce. The consequent human issues (hunger, poverty and desperation) became a special concern for the United States in the context of the threat of communism in Europe and the onset of the Cold War. Therefore, under the Marshall Plan, the White House allocated US$ 18 billion to support European stabilisation and reconstruction post-war (Prentzas 2011). This effort marked a new era of international cooperation through foreign aid.

From the outset, there has been debate over the purpose and effectiveness of international aid, particularly when allotted to postcolonial countries in the Global South (Kapoor 2008; Tandon 2008). In the existing literature, there are three main camps that may be identified as the development aid community, sceptics, and radicals. These will be discussed in detail in Chapter 2 but here a brief overview of the key points of the debate is provided. Some from the development aid community, such as Sachs (2005) and Stiglitz (2002), argue that, although there are some challenges to delivery, aid is still useful in poverty alleviation and fostering development in developing countries. Therefore, according to this group, efforts to improve aid delivery should always be promoted so that aid quality can be improved. This idea then encouraged the recent series international forums on aid effectiveness held since 2002.

Meanwhile, both sceptics and radicals argue that aid is not really useful for development. According to the sceptics, including such scholars as William Easterly and Dambisa Moyo, international aid has not worked overall. This is because aid conditions were too soft, making it easy for rulers to abuse it for their political ends. The solution put forward by the sceptics is that the world's poor should stop relying on Western aid and start to find alternative sources of development funding which would encourage greater discipline and efficiency (Easterly 2006; Moyo 2009; Easterly 2013).

The last group, the radicals, takes a critical perspective on the implementation of neoliberal development in developing countries. This camp is subdivided into Foucauldian and political economists. According to Foucauldian view, aid is a form of 'liberal governmentality' practice which makes countries in the South adopt the West's reform agenda as their own agenda (Mosse and Lewis 2005; Duffield 2007; Li 2007). Political economists differ in key ways from Foucauldian critics of neoliberal development; while also critiquing neoliberal practices of aid, they take a different approach for understanding development. In its critical perspective, political economists argue that development policies are a product of competition amongst elite groups, and these will use their power to secure their interests from other actors (Hughes and Hutchison 2012; Hutchison et al. 2014; Hout 2015; Hameiri et al. 2017).

For political economists, donors are not all powerful as Foucauldians suggest. As well as the challenges of aid distribution, aid agencies face local

actors who are interested in influencing the outcomes of governance, and for whom aid is a source of power. Some case studies are provided by Hope (1996), Farah (2009) and Rodan et al. (1997). Even small and poor countries like Timor-Leste have powerful elites with interests in influencing aid programmes. This point suggests that, in reality, it is not easy for donors to fully achieve their reform targets since they have to deal with different interest groups in the local country. As a result, development policies will reflect the interaction of power between all these actors.

The political economy approach to understanding the politics of development are equally applicable in sectors like healthcare. Neoliberals frame health as a resource for assisting development by raising the pool of productive workers and increasing the productivity of each worker in that pool (Simon-Kumar 2007; Rosser 2009). In contrast, structuralists argue that the health sector represents a contested site in which different groups, including businesses, government agencies and civil associations, compete for the maximum influence over the health policy and implementation (Hutchison et al. 2014; Mcloughlin 2014).

By using a framework based on political economy, this research will examine the politics of healthcare in Timor-Leste and discuss key actors (international, national and sub-national), their interests, and how relationships among them shape development policies in Timor-Leste. It will also explore further significant issues that will be introduced in the next section, based on the following question: What has been the impact of the local dynamics involved in healthcare policy on donors' neoliberal practices?

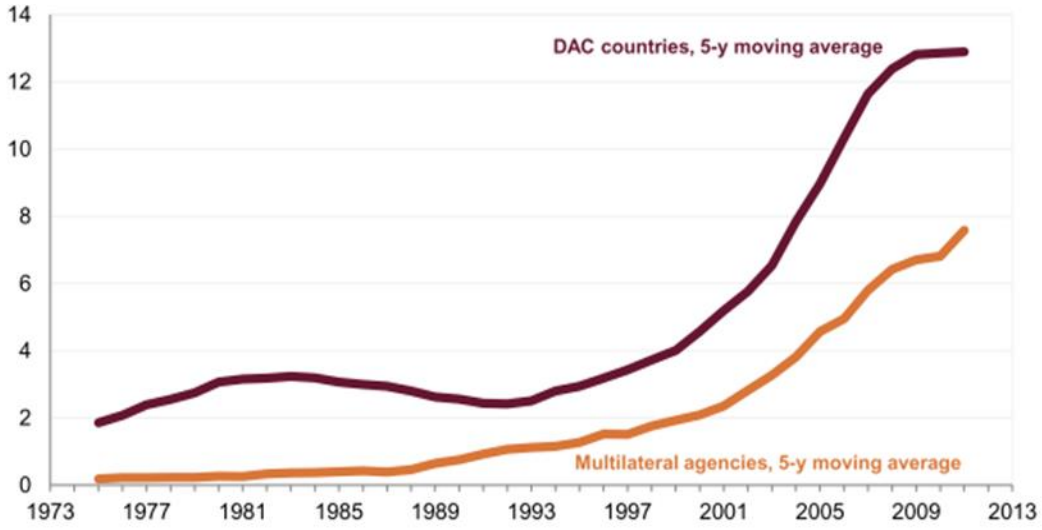
C. The Politics of Aid Delivery and Ownership of Healthcare

Although some argue that promoting local ownership leads to a more effective aid programme, political economists tend to believe that, because each actor has different interests, it is impossible to achieve national ownership of development without significant advances in our understanding of the dynamics involved. These mean that 'ownership' is continually contested and shared among particular groups of people.

In the 1980s, health was not a priority for neoliberal donors, who saw public provision of health services as an intervention in the market that caused misallocation of resources and undermined economic growth (see Chapter 2 for

further discussion). However, the shift to the post-Washington Consensus that occurred in the 1990s, following evidence of the success of state-led development in East Asia and Latin America and the disastrous consequences of structured adjustment in sub-Saharan Africa, meant that health became a new priority (Birdsall et al. 1993; World Bank 1993). The health sector was now viewed as a significant factor that can improve human capital – and the improvement of human capital would lead to the increase of productivity and finally create economic development (World Bank 1997).

Figure 1.2: Aid to Health 1973-2013 (US$ billion)



Source: (DAC 2015a)

Since then donors started to use aid as a strategy to sustain human development (specifically in combating disease and hunger) in low and middle income countries. To ensure significant results in health gains, donors committed to scale up the amount of aid. While in 1993 total commitments for health from bilateral and multilateral donors were approximately at US$ 3.2 billion, twenty years later (in 2013) it increased dramatically to about US$ 20.8 billion, as shown in Figure 1.2, above.

Despite some significant contributions to health gains (WHO et al. 2008), some challenges still remained many of which occurred due to three political factors in aid practices; namely, commitments and practice were not well connected, harmonisation between donors was poor, and donor practice did not align with local priorities and systems (OECD 2012a). This is because local priorities and systems are a contested space and fluctuate over time; therefore, making it difficult for donors to align with them. Although some international

forums on aid effectiveness had successfully produced initiatives to improve quality of aid delivery, only a few commitments were successfully carried out (Wallace 2009; Chandy 2011). Regarding this, Espey et al. (2011) argue that there is an urgent need to reform the health aid sector.

The Paris Declaration, 2005, proposed a national ownership[2] principle as a central way to improve aid effectiveness. Through this, both donors and countries were encouraged to let local leadership take the lead in development practices, while donors provide supports to strengthen their capacity to manage development (DAC 2008b). Arguably, aid would then have a more sustainable and greater impact.

However, political economists argue that this was too optimistic in assuming that development actors share the same priorities of development and that national ownership consensus can be achieved nationally. Although the Paris Declaration also recognises complexity, fragility and contestation in aid operations, its tendency to focus more on promoting ownership as one of the pillars of aid effectiveness is considered unrealistic. In fact, political interests remained a dominant factor in aid relationships in which donors have the main control (de Renzio et al. 2008; Van de Walle 2014). Based on the political economy perspective, the overall rationale of this study is that the donor reform agenda faces the existence of contesting local powers that are capable of influencing development policy to suit their own agenda. Thus, this makes policy ownership the subject of contestation and consequently it will be shared among powerful actors, rather than reflecting a national democratic vision of development. Although in some areas, local actors can exercise priorities on policy-making, this is largely a political decision based on calculations aimed at maintaining and sustaining power, rather than using a liberal-technocratic approach that relies on expert knowledge to guide actions intended to address important issues that affect society.

D. Elites and the Politics of Development in Timor-Leste

Having outlined the importance of understanding political contestation in the aid delivery process, this section discusses the formation of elites, post-independence, the politics of elites in the development of healthcare. It also

[2]The terms ‘country ownership’, ‘local ownership’ and ‘national ownership’ are used interchangeably used in this thesis.

indicates the current Timorese leadership perspective on the concept of ownership and its leading role in the G7+ forum[3] which demands that the concept of national ownership is revisited and strengthened with full commitment from development agencies to make it more effective in the process of aid delivery.

The nature of leadership during the struggle for independence divided Timor's elites into two groups: the home grown and the international diaspora (Guterres 2006; Hughes 2009). The home-based group consisted of former soldiers from FALINTIL (The Armed Forces for the National Liberation of East Timor), who were involved in the struggle for independence through guerrilla war against the Indonesian military. Xanana Gusmao became the leading figure of this group. The other group, from the international diaspora, consisted of those Timorese individuals who left Timor for Portugal or other Portuguese-speaking countries during struggle for independence while promoting FRETILIN's diplomatic interests. One of the important figures in this group is Mari Alkatiri. During the post-independence era, elites from these two groups played important roles in Timor's democratic state by occupying positions in institutions and political parties.

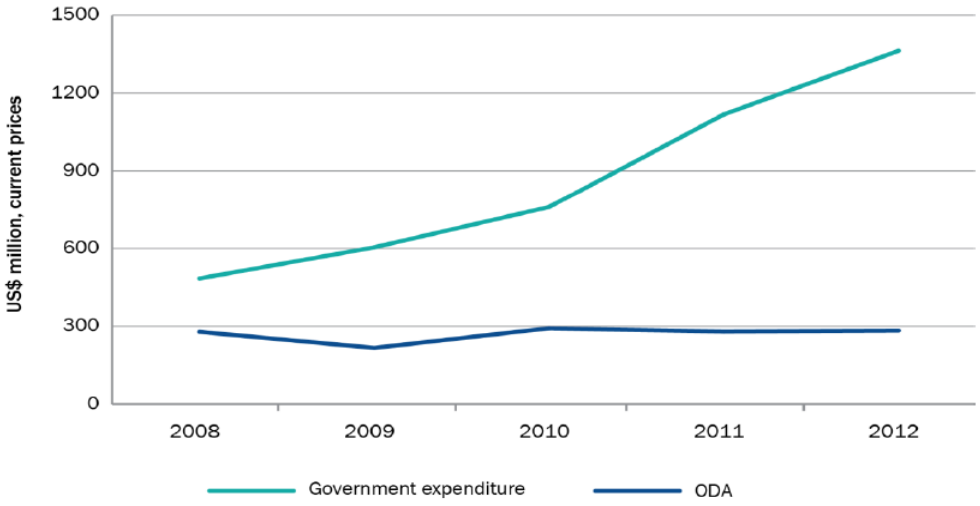
During Alkatiri's term of government, 2002-2007, aid became an important source of development. It contributed approximately 60 percent of the country's state budget and meant that the country was heavily dependent on external support (World Bank 2003a). The main reason for this was the Timorese economy's sudden freedom from the Indonesian economy. In fact, during this time, Timor-Leste was one of the poorest provinces in Indonesia in which its economy relied very much on the Central Government subsidies (Habibie 2006).

Although dependent on aid money, Alkatiri's leadership was able to conduct some decision-making. Consequently, some argue that this meant that government resources were allocated through patronage politics, benefiting the interests of particular groups who supported elites. For instance, when FRETILIN government was in power, some of their key supports were appointed in public service positions both in the capital and districts (Hughes 2009; Nuttall 2017).

[3]This is a voluntary association of conflict affected countries that are now in transition to a new stage of development.

Under the CNRT government (2007-2012, 2012-2017) the revenues from oil began to flow into the country. This significantly reduced the level of aid-dependency and development became heavily dependent on oil income. However, fear of the resource curse, which commonly affects weak states rich with oil resources, encouraged the Timorese leadership to set up the Timor Petroleum Fund, as a form of sovereign fund, so that oil money could benefit future Timorese generations. For political economists, policies like establishing sovereign fund is good as an idea but it would not able to prevent elite political dominations who are interested in the allocation of oil resources for their interests.

Figure 1.3: Timor-Leste Government Expenditure and International Aid, 2008–2012



Source: (Office of Development Effectiveness 2014)

Figure 1.4: Donor's Actual Disbursements to Timor-Leste

Year	Actual Disbursements (US$ million)
2005	11.31
2006	18.52
2007	50.77
2008	47.21
2009	132.92

2010	244.46
2011	289.89
2012	326.42
2013	300.52
2014	286.57
Total costs	**1.804.61**

Source: (Data collated from the Timor-Leste Ministry of Finance (MoF) Transparency Portal, July 2015)

Until recently, aid remained a source of development for Timor-Leste although it only contributed approximately 18.7 percent from the overall government expenditure in 2012 (see Figure 1.3 above), but the role is significant and is directed to fund development in strategic sectors like public services. As in other countries, aid in Timor-Leste involves bilateral (Australia, France, Japan, the Netherlands, United States) and multilateral donors (such as the European Commission, Asian Development Bank, UN, World Bank). As can be seen from Figure 1.4, above, from 2005-2014, aid partners have dispersed more than US$ 1.8 billion in actual commitments. This amount of money has been directed to fund 919 development projects across the country (Data collated from the Timor-Leste Transparency Portal of the MoF, July 2015).

Since 2010, Timor-Leste has been a member of the G7+ forum, which aims to reshape the terms by which aid operators used. Based on lesson-learned in fragile states, this group believes that aid has made beneficial contributions to development and, consequently, it seeks to develop a new paradigm for this form of engagement that can improve the effectiveness of aid. In particular, it proposed that further dialogue is needed to improve the quality of aid in developing countries. In response, the Busan High Level Forum on Aid Effectiveness was held in 2011 and resulted in an agreement on a New Deal for Engagement in Fragile States. The New Deal emphasizes the ‘aspirations’ of aid recipient countries regrading better commitment of development agencies to the realization of country-owned strategy for improve aid effectiveness. This has become the ‘language’ used by Timorese leaders when negotiating with donors (Da Costa 2012). The emergence of the G7+ and the New Deal reflect new power dynamics between donors and recipients in a changing aid landscape

post-2015. A further question arises: Is there a gap between existing ideas and the reality? The answer to this question will constitute an interesting contribution of this research.

E. Research Questions

This research is intended to answer the primary question: What is the interrelationship between domestic politics, donor assistance and funding constraints on the development of healthcare policies and programme in Timor-Leste since 2002?

To do so, it considers the following secondary questions:

a. Who are the key actors in the health sector, what are their interests and how have power relations between these actors shaped health policy in Timor?
b. What has been the impact of this on relations with donors?
c. To what extent can we say there is national ownership of health policy in Timor-Leste?

F. Information Sources and Generation

This research is based on a qualitative case study which used a political economy approach to identify the key actors in healthcare policy, their interests, and how the relationships between these actors have shaped health policy and implementation. It considers the kinds of strategies used by these political actors to secure national ownership of development and how these affected external donors' neoliberal agendas. Through these considerations, the study aims to contribute to the more general debate on politics of ownership in aid implementation, as well as show that 'ownership' in fact means a contested politics of unstable agendas incorporating patronage and populism as well as bureaucratic rationalities.

The main objectives of the field research were as follows:

a. to map policy processes in health sector development in Timor;
b. to identify particular points in the policy process that are contested between local and international actors;

c. to examine the strategies pursued by these actors in seeking to promote their interests.

In addition to a wide range of secondary sources, the study generated primary research information. This involved 45 participants (19 female and 26 male) (see Appendix) with a balance of non-Timorese (15 respondents) and Timorese participants (30 respondents). Participants were employees at MoH (7 respondents) and national (2 respondents) and international NGOs (non-governmental organizations) (13 respondents), and included healthcare professionals (doctors and nurses, 8 and 6 respondents each. Some additional interviews were conducted with other key actors in healthcare development such as a senior member of an anti-corruption agency, a senior lecturer at the Faculty of Health Science, University of Timor-Leste, a member of professional healthcare association, a member of the National Parliament, a senior foreign healthcare professional who has been working in Timor since the territory was under Indonesian rule, and the former Indonesian healthcare officials who were working in Timor-Timur Province (3 respondents).. I also spoke informally with healthcare service users including lecturers, taxi drivers, and housewives as part of the field observation.

Such primary data included collection from in-depth interviews. Face to face interviews were used because, according to Opdenakker (2006), these have several strengths compared to other interview methods (e.g., email or telephone), two of which were considered particularly useful to this research: 1) they give social cues (voice, intonation, body language, etc.) which can provide extra information; 2) the researcher is able to create a good atmosphere for conversation.

To ensure the coverage of the evaluation questions, an interview guide was provided and a semi-structured approach was used. This approach gives the researcher the ability to investigate issues deeply as well as allowing the participants “to express themselves openly and freely and to define the world from their own perspectives, not solely from the perspective of the researcher” (Hancock and Algozzine 2006: p.40). The researcher can also develop the conversation and explore new areas for discussion (Hesse-Biber and Leavy 2011). The interviews also followed Patton’s suggestion (2002) that questions in qualitative research should be open-ended, neutral, singular and clear since this

allows participants to answer the question according to their personal views and thoughts. Because of the level of aid fragmentation, it was expected that policy processes will be poorly developed and highly skewed towards donors' projects. Therefore in interviews, particular attention was paid to the complexity of interactions between states agencies and different donor entities.

Key informants were classified in three categories: aid workers; MoH employees; and healthcare professionals. Aid workers are defined as personnel who work for governmental and non-governmental organizations (both national and international NGOs), and provide services related materials and technical. The MoH employees are staff members tasked with formulating and implementing policies to achieve specific goals in the health sector. Finally, healthcare professionals are individuals responsible for giving health services in the community.

Since this research involves human data, an ethical review process is needed to ensure both researcher and participants' dignity, rights, safety and human well-being are protected before data collection begin. Therefore, before undertaking the research, the researcher conducted two series of ethical process: Firstly, the project was approved by the Chair of the Research Ethics Panel of the University of Bradford. Secondly, when I arrived in the field, this research plan was presented in National Health Institute Timor-Leste (INS), which is responsible for evaluating health-related research, where it was reviewed by seven committee members and received an approval for data collection.

This primary data is combined with extensive use of secondary sources, including document reviews and observation to supplement the interviews. The form of documents used were in the form of public records (both printed and electronic); for instance, annual publications, written reports, strategic plans, policy manuals, newspaper editorials, agendas, handbooks, books, brochures etc. These documents are important because they provide written records which have meaning (Corbin and Strauss 2008). Some of official publications from the MoH Timor-Leste are available online and are downloadable. Copies of printed versions of particular publications were also accessed by asking interviewees who were employees in relevant institutions, including the MoH.

However, because they are produced for a purpose other than the research agenda, documents were unlikely to give sufficiently detailed

information to answer the research questions; therefore, direct natural observation was also used. This was made more effective because, while interviewing some respondents during data collection, the researcher received invitations from local healthcare professionals to observe healthcare delivery programmes in the National Hospital that were assisted by international doctors. However, this only became a minor source of information, providing additional background only or material to illustrate points made by the interviewee who had extended the invitation. During these visits, I clearly identified myself as a visiting researcher to all relevant persons and had extra copies of information about the research available to give to anyone who expressed an interest on such occasions. No ad hoc interviews were conducted on such visits.

Some argue that direct observation involves the risk of affecting the workers behaviour or causing the researcher to become biased: the observer bias effect (Wallen and Fraenkel 2011). To minimise shortcomings of the three methods, triangulation of data between observation, interviews and documentary analysis was used. For instance, during interviews, some Timorese doctors argued that the role of international doctors was significant in healthcare delivery. In order to validate this, I made a field visit to the National Hospital to verify whether or not had international health workers providing medical care and training for Timorese. An exhaustive review of relevant project documents, evaluation reports and policy analyses by agencies (including World Bank, USAID, and WHO) was made through a process of online searching; this was confirmed and strengthened the viewpoint from interviews and observations. Although these documents were not produced to address my research questions I found them useful for understanding the relationship between the presents of foreign doctors and quality of healthcare in Timor. Thus, through these process of rechecking information from one source with other information sources, the researcher was able to come to the conclusion that International doctors did play an important role in the implementation of Timor's healthcare system.

Three research processes were undertaken after gaining approval from the ethical committees of the University of Bradford and the INS: listing and contacting some eligible respondents, interviewing respondents, and using interview materials for analysing research topic. Preparations for data collection involved two stages. First, some potential respondents and institutions to be

contacted were listed and invited to participate in this research. Information about these respondents (who were managers or supervisors of relevant projects) was available in the public domain, or clearly specified in project documents held by ministries and donors. I also contacted senior staff members who were decision-makers on these projects and approached them directly by email or letter, followed up by a phone call to their secretary and set up set an interview appointment. This aimed to ensure that no individual felt pressured into taking part in the research. In any case, the interviewees were busy people with a high degree of power and control over their working day and schedule of appointments, and they would not agree to be interviewed unless they were very interested. Another alternative source of interviewees came from former senior officials and NGOs that had been involved in these projects the past (in decision-making or implementation). I felt confident that this was not an intrusion on their privacy as the contact details for such individuals are publicly available and it is their job to field enquiries about projects and policies. It should be emphasised that only respondents involved in the programmes investigated were interviewed and thus they understood the context – junior staff who had been allocated to talk to me by their employers and did not know much about the topic of this research were not interviewed.

Secondly, before the interview process started, a copy of a consent form, which had been approved by both ethical committees and contained relevant information about the research, was given to participants. As well as this information, the form made clear the rights of respondents (i.e., to withdraw from participation, to refuse to answer any question or to allow the interview to be recorded), the way interview material would be handled, and researcher contact information. The consent form was written in Indonesian, English and Tetum – as an important way to establish and maintain mutual trust and understanding between researcher and participants. The interviewee was given the opportunity to read the form and make a decision as to whether to agree to participate in the research or not. If a participant felt he/she had already been involved in the same studies, they could decide to not participate.

Since the research used a snowball sampling method, each respondent was asked to refer the author to a colleague (for instance, someone in the same office), who was knowledgeable on healthcare policy-making. During data collection, for instance, I was homed in on family planning programme. I went

about finding interviewees that related to them. The snowball sampling strategy was extremely helpful to access technical respondents the researcher would have had otherwise difficulties to access. Those who agreed were provided with a hard copy of the consent form on the spot and given a day to consider it and decide whether he/she would like to participate in the research. Some chose to participate on the day they were contacted, while others preferred to be interviewed on an arranged day according their available time. These interviews took place in their work places – in development agencies' and government offices and in the National Hospital in Dili, the capital city of Timor-Leste.

It is important to bear in mind that for the kinds of informants interviewed – government officials and aid officials – dissemination of information about policies and project evaluations is part of their job description. Therefore, they valued the opportunity to discuss their projects with an academic researcher, since this could also provide them with feedback and new ideas about how to evaluate their work. Furthermore, although any challenges or difficulties in working relationships between development partners were raised during the interview, these issues are well-recognised in the aid and development industry and were not likely to cause embarrassment. The aim was not to elicit whistleblowing but rather their thoughts on the process of relationship building and partnership management, as well as the implications of different agendas for development outcomes; and the questions were worded with this in mind. As this is an important aspect of the relationship between academics and development practitioners, concerns about over-exposure are less applicable in these circumstances. Moreover, this particular proposal took an original approach to an under-researched case study and consequently it was likely to be of interest to respondents.

Thirdly, to ensure confidentiality and anonymity, each recording and interview transcript was assigned a code, and the name of the individual was recorded. Meanwhile in Timor-Leste, the research materials were kept locked in the researcher's accommodation. The original recording materials were saved on a laptop and secured with a password. An interpreter was not used during interviews because all respondents preferred to speak in English or Bahasa Indonesian. As they had already been informed in the consent form, each participant had the right to access the interview documents and was given a copy of the information if requested. They also had the opportunity to raise any

concerns when consent was sought through contacting researcher by email or phone – these details were also given in the consent form.

After finishing the data collection and travelling back to the United Kingdom (UK), the author backed up the interview recordings on a pen drive which was kept in a locked safe. Written notes were kept in a hard-backed notebook with numbered pages, and these were photocopied at regular intervals to provide a back-up copy. All the materials of the research were placed in a secure box in the Student Research Centre at the University of Bradford, which was then locked. Only the author/researcher was able to access the box. When using interview materials for data analysis, care was taken to ensure that interviewees cannot be identified from quotations used from their interviews.

The only significant constraint of this research came from limited funds to undertake the field work. The limited budget meant that the author was unable to go to districts and subdistricts outside Dili to get more comprehensive field data about the dynamics of healthcare service delivery. However, this did not undermine the research radically for two reasons: most key informants were knowledgeable about healthcare development in the country because they made regular visits to areas outside Dili and secondary sources, like local government officials, donors, and other researchers, were very helpful for the research analysis.

G. Thesis Structure

In order to discuss the dynamics of power relationships among actors in healthcare policy and implementation in Timor-Leste, this thesis is divided into seven chapters. The second and third chapters discuss the theoretical framework of the research based on the research questions established above. The focus of Chapter 2 is on the theoretical approaches to understanding the politics of aid as a source of development. The discussion presents the debates about aid for development with emphasis on the political economy approach to understanding the politics of ownership among actors. This perspective forms the central framework of this research to discuss the politics of healthcare policy-making post-independence in Timor-Leste.

Chapter 3 builds on this theoretical framework, in particular the implications of patronage and populism for local ownership, to understand the

effect that the influx of oil money can have on the ability of elite actors to decide development policies. Here, the debates between liberal institutionalists and political economists about the role of powerful elites and institutions in service delivery policy-making are introduced, as well as the dominant political economy perspective used to understand elites and their policies in the post-conflict context. The chapter then examines the ways and extent to which the oil money allocated to the state budget affects opportunities for elites in decision-making, which means that state resources are partially allocating through patronage politics that benefits certain power bases.

Chapter 4 examines the politics of healthcare in Timor-Leste since the country was under colonial power up to the present day, indicating who the contemporary actors are and the context and development of their ideas. The chapter examines the extent to which development of healthcare has become the tool of elites to maintain their power and interests through patronage and populism, even when the liberal-technocratic approach was used in healthcare decision-making. The purpose is to develop an understanding of why only privileged groups have access to good quality healthcare, while the majority of Timorese could only access poor healthcare facilities, which has made them continuously rely on traditional medicine because this is more accessible for them.

Chapter 5 and Chapter 6 use the framework developed in previous chapters to examine the politics of ownership in healthcare decision-making among development actors in Timor-Leste. Chapter 5 examines the ways and extent to which development aid flows were used by FRETILIN elites as a means to maintain their political agendas and, under the CNRT government, elites controlled of oil as a source of development finance to expand opportunities to shape development policies according to their needs. In this context, issues and characteristics of local or national ownership are examined, across a range of types of decision-making.

Chapter 6 examines these issues in detail in relation to four key externally-supported healthcare programmes: the World Bank health programme, the Cuban medical programme, the WHO health programme, and the USAID (United States Agency for International Development) family planning programme. It also discusses how government relations with donors reflect the changing attitudes to ownership of healthcare policy. In each case, the author

examine how the relationship between political elites, the MoH, healthcare professionals and key constituencies, such as veterans and the Church, affect donor-government relationships and how these have influenced the conception of ‘ownership’ that the MoH attempts to promote.

Chapter 7 presents the main findings and conclusions from this research, explores their implications, and recommends some areas for future research.

Chapter 2: Literature review: Approaches to understanding Aid Finance for Development

This chapter reviews the literature on political factors in development practice and how these relate to aid effectiveness agendas, in particular, considering the implications of these for the concept of 'country-owned'. It develops a theoretical framework based on a structuralist political economy approach to enable better understanding of the dynamics of healthcare development in fragile contexts. Using this framework, the chapter explores how the nature of donor-recipient relationships – which involve power and ulterior interests – shapes and limits the process of establishing a common development 'commitment'. This discussion provides a basis from which to critique the principle of country ownership. From a political economy perspective, ownership is understood as a product of political contests and so reflects a continual struggle among development actors to serve their own interests through 'ownership' of development agendas. As a consequence, it is questionable that, even when a country has some level of ownership, development directions will be 'owned' by the whole population. Moreover, contestation between the diverse groups involved has implications for donors' ability to achieve their purposes because they must contend with local power and resources which challenge external development aid agendas.

The chapter is divided into six sections: the first discusses some theoretical approaches to aid for development, and argues that political economy is central to understanding donors' approaches, local ownership politics and development agendas. The theoretical framework is further developed in the second section, which reviews evidence regarding how the nature of political relationships among development actors has limited efforts to improve aid delivery. After reviewing the achievements of the international aid effectiveness forums in Section C, the fourth section examines the neoliberal motives involved in aid delivery programmes promoted by international donors, which have to contend with local powers that are also interested in aid resources and so make donors' aims difficult to achieve. The fifth section focuses on the Paris Agenda on Aid Effectiveness, which identified ownership as a key to achieving better outcomes on aid delivery. The discussion explores why ownership, as a result of political processes, is a problematic concept that

makes it difficult to achieve development targets because each actor is interested in promoting their own 'ownership' of development and sustaining their political interests. Finally, the last section relates this discussion to ownership and the implementation of aid in Timor-Leste.

A. Problems of Aid Legitimacy

This section examines political economy approaches to critically assessing international interventions and local politics. Firstly, it presents three different schools of thought in the aid and development debate and, then, focusses specifically on the political economy approach as a powerful paradigm through which to examine aid implementation, the contest of power among development actors, and how power relationships among these actors affect development policies in recipient countries.

The concept of international aid was introduced following the end of World War II, with the United States support provided for the reconstruction of Europe. While there are various definitions (see Lancaster 2000; Riddell 2007; Lancaster 2008), perhaps the most widely recognised comes from the Development Assistance Committee (DAC), an international committee with a mandate to discuss aid programmes and policies in developing countries on behalf of the Organisation for Economic Co-operation and Development (OECD).[4] DAC defines Official Development Assistance (ODA) as:

> those flows to countries and territories on the DAC List of ODA Recipients and to multilateral institutions which are:
>
> i. provided by official agencies, including state and local governments, or by their executive agencies; and

[4]DAC was established in 1960. The members are bilateral and multilateral actors and its works are largely dominated by the United States and other Western powers (including France, Britain, Germany, IMF (the International Monetary Fund), World Bank etc.). The United States dominance in the organization has backed up the two Bretton Woods institutions (IMF and World Bank) running a programme of development which focuses on human security and good governance as well as increasing the power of the Washington Consensus and influencing the ideas and policies of the DAC (Gibbon 1993; Carbonnier 2012; Dreher and Sturm 2012). Therefore, although members in the DAC have their own aid programmes, "they would all look to the IMF and World Bank to ensure recipient compliance with that core set of policies" (Woods 2008: p.1216). This, in turn, makes both institutions more powerful in the UN system – even up to the present day.

ii. each transaction of which: a) is administered with the promotion of the economic development and welfare of developing countries as its main objective; and b) is concessional in character and conveys a grant element of at least 25 per cent (calculated at a rate of discount of 10 per cent) (DAC 2015b).

There is a debate in the literature concerning the implications of aid: whether it is flawed but potentially useful in spurring development in the Global South, and whether it represents continuities with colonialism or even has the purpose of continuing Western domination over the countries in the Global South (Kapoor 2008; Tandon 2008). Regarding this debate, scholars can be divided into three main groups, each with characteristic approaches and strands of thought: the mainstream development aid community, sceptics and radicals.

The first of these, which includes Sachs (2005) and Stiglitz (2002), argues that aid can contribute to the effort to end poverty; but only if steps are taken to improve its effectiveness. The implementation of international aid meetings, which is discussed in the next section, reflects the continuous efforts of the development aid community to improve the quality of aid delivery. These can be divided into different approaches which include neoliberals and neo-Weberians. From the neoliberal perspective, the key to economic growth is participation in the free market and, to support this, state intervention has to be limited. This will encourage entrepreneurship and efficient allocation of resources. Neoliberals claim that development aid has a role to promote neoliberal development by assisting in economic policy-making. Therefore, intervening in situations of market failure became the focus of the post-Washington Consensus. As consequence, its critics argue that, rather than bringing genuine development, neoliberal programmes continuously serve Western ideas rather than addressing the needs of people in developing countries – this will then serve to further reproduce inequalities and subordinations. In relation to this, Fine and Escobar (and other advocates of the “post-development” movement) argue that structural adjustment was part of the neoliberal project to roll back the post-colonial state in the Global South in the interest of global capital and at the expense of human development (Fine 1999; Escobar 2010).

Neo-Weberians, on the other hand, believe that the state has the necessary power and resources to drive successful industrialization and

economic growth. Therefore, according to this group, the role of the state is significant in achieving development efforts (Sachs 2005; Maathai 2010; Booth 2012). States in East Asia have widely been used as examples of successful application of the state-led development approach. For instance, in Japan, China, Singapore, Taiwan and South Korea, the state directed development by formulating strategic policies to maintain the market. This situation contrasts to what happened in Africa after the implementation of the Structural Adjustments Programmes (SAPs), which represented a challenge to the Washington Consensus.[5] Mosse (2005: p.4) called these years the decade of challenge to the "neoliberal vision". Supporting the neo-Weberian approach, a report entitled *The East Asian Miracle* (1993) produced by the World Bank, admitted that the key to successful development in East Asia countries was state intervention. This report was significantly influenced by the Japanese government and led to the emergence of "turn to institutions" within the World Bank (Wade 1997). Even though there is theoretical diversity between neoliberals and neo-Weberian in terms of the key to successful economic development, in practice most of the aid community would fall somewhere between the two, focusing on free market economic activity well regulated by institutions of good governance.

After the success of state-led development in tackling the massive widespread poverty in Southern countries in East Asia, both the neoliberals in the World Bank and their critics agreed on the importance of institutions to secure more effective development (World Bank 1997), known as the post-Washington Consensus. The key distinction of the shift in approach is that from the early 1990s, the World Bank began to accept two premises: a) that markets do not work perfectly at low levels of development, and therefore state investment in human/social capital is necessary; and b) that well-functioning state institutions are necessary to regulate the market. This was particularly apparent in James Wolfensohn's anti-corruption-agenda (see Wolfensohn 1998; 2005). This new thinking was based on the Weberian belief that states should

[5] The Washington Consensus was first introduced in 1989 and referred to ten specific economic policy prescriptions which had become the orthodox prescription for assisting countries in Latin America out of the economic and financial crises of the 1980s (Williamson 2009). John Williamson (an English economist and a former World Bank manager) was the person who coined the name and formulated the approach through his work (Williamson 1990; 1993; 1997). Since the 1980s, this idea was propagated by the IMF and World Bank as the approach of neoliberal development to developing countries through SAPs. One of the policies included imposing conditionality on new loans, thus making developing countries adapt to market oriented development.

have the power to satisfy and control their populations and sustain them in adequate circumstances while, as markets can also make positive contributions to the lives of the poor, these need to be placed at the centre of the poverty reduction agendas (World Bank 2001b). For Stiglitz (2002), it is important that this effort is backed up by sound institutions. In response to this, the Bank promises to assist countries to build these institutions under the condition they reduce their intervention in their economy.

Some authors have pointed out that the state should not be the focus of development; rather, it should be targeted at the people because such a shift towards human development will affect the wealth of the nation (UNDP 1990). This idea is supported by Jeffrey Sachs who asserts that development should not only be about economic growth but should also focus on improving the standard of living (Sachs 2005). This point emphasizes human beings as the central target of development because their role determines the success of growth. This is reflected in a report published in 1994, where the United Nations Development Programme (UNDP) linked human development to security issues. This means any issue which relates to human beings will have an impact on security (UNDP 1994). This, in turn, affects development – therefore, human security needs to be a central focus of attention for development interventions.

Since then, good governance and human security became the main new development agendas with the focus of interventions being on improving health delivery systems (Radelet 2006). This approach has been widely adopted by many development agencies, both international (multilateral) and national (bilateral), into their 'reform' projects in developing countries. To express the approach as a specific policy in the international arena, a forum called the Millennium Summit was organized in 2000, and resulted in a commitment known as the Millennium Development Goals (MDGs). The MDGs consist of eight goals and a set of measurable time bound targets that aimed to lift the world's most destitute people out of development challenges by 2015.

However, consideration of their content indicates that there is an imbalance in responsibility between recipient and donor countries. Recipient countries had to address the issue of extreme poverty and hunger, universal primary education, gender equality, child mortality, maternal health, HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency

Syndrome), malaria, and other diseases and environmental sustainability. Meanwhile, donor countries were only required to provide aid to support the effort. Moreover, the first seven goals did not relate to contemporary conditions and have been identified as the product of historical processes rooted in the global economic structures and systems (Bendana 2004). Some authors believe that the MDGs were just an instrument of the DAC members (the majority of which are Western countries) to achieve their international political economy agendas (imposing the international financial ideology in the developing countries) (Bond 2006) and to strengthen their international hegemony over the South (Lake 1993). This can be inferred from targets 8A and 8B of the MDGs, which state the need to develop a more open, rule-based and predictable trading and financial system. Although some argue the shift from MDGs to the Sustainable Development Goals (SDGs) promises a more transformative agenda because it addresses the key shortcomings of the MDGs and also has a vision to structurally reform the global economy (Fukuda-Parr 2016), critics have demonstrated that SDGs have become another form of neoliberal agenda. Thus, they assert that they promote the principles of free market and open competition with limited state intervention and concern for welfare. For instance, goal 2b of SDGs points out: "correct and prevent trade restrictions and distortions in world agricultural markets including by the parallel elimination of all forms of agricultural export subsidies and all export measures with equivalent effect, in accordance with the mandate of the Doha Development Round" (UN 2018). These points clearly reflect the neoliberal goals prescribed by the IMF and the World Bank, as well as the continuous efforts of Western countries to sustain their 'reform' practices.[6]

The international development aid communities, which broadly follow a liberal-technocratic[7] approach and understanding of aid and development has critics both from neoliberal sceptics and from more radical directions. The sceptics argue that aid tends to damage developing countries by empowering the state at the expense of the entrepreneurial poor. Moyo (2009) provides the example of aid flows in Africa. In the last several decades, Africa has received

[6]However, it is important to note that MDGs were not simply the product of OECD DAC because they had been long negotiated in the UN, in which the G77 (an organization in the UN which consists of developing countries and focuses on promoting development interests of the countries in the South) had great diplomatic weight. Indeed, the OECD DAC failed to obtain substantial parts of what it wanted in the MDGs.

[7]This is further explained in Chapter 3.

more than US$ 1 trillion of international aid, and there is debate over the overall impact of this. Levy (1988) and Gomanee et al. (2005) argue that aid has made positive contributions to the development of the continent, but there are many studies suggesting the opposite (e.g., Goldsmith (2001). In some cases, it is argued, aid makes the situation worse by fostering corruption, creating dependency, and causing social unrest and even civil war (Moss et al. 2006; Moyo 2009; Phillips 2013). According to this school of thought, international aid which comes in the form of goods and finance is typically handed to national and/or local authorities. Many of these political leaders view aid money as free cash and use it to reward key supporters and stay in power. Meanwhile, some other public officials think of aid as permanent income and thus, they are unwilling to optimize domestic revenues to support development, preferring continued aid-dependence, a phenomenon referred to as “rentierism” (Yates 1996).

Some sceptics also argue that the presence of aid has prompted a number of conflicts in Africa. These are mainly triggered by competitions to get access to resources between villagers and the government. Therefore, to solve the problem of aid delivery, Easterly and Moyo argue that the world’s poor do not need to borrow money from the World Bank and IMF – since the conditionality has been too soft – nor do they need to keep depending on Western aid. Rather, they suggest an extreme neoliberal approach to development as a way to gain private capital to finance development which is conducted through trade, direct foreign investment, capital markets, remittances, micro-finance and savings. This approach will impose greater discipline and force state agencies to be more efficient (Moyo 2009; Easterly 2013).

The second criticism comes from the radicals (Mosse 2005; Duffield 2007; Li 2007). This group believes relationships between countries in the Global North and Global South are exploitative rather than cooperative. According to this radical perspective, aid projects are part of neoliberal agendas that aim to facilitate capital flows to developing countries in the interests of exploiting Southern resources largely for the benefit of corporations based in the Global North. To successfully achieve these agenda, the West uses practices of domination that have been variously analysed according to two main approaches: the Foucauldian and the political economy perspectives. The first

of these provides an understanding of how aid is used to perpetuate dominating practices while the second focuses more on how power is contested. It is this latter approach – in particular, structuralist political economy – that forms the theoretical framework of this thesis.

1. The Foucauldian Position

This perspective argues that aid is the practice of liberal governmentality, and constitutes a technique to make countries in the Global South accept the West's reform agendas as their own agenda (Anders 2005; Duffield 2007; Li 2007). As its name implies, this perspective uses the work of Michael Foucault on governmentality which he presented at the Collège de France in the 1970s to explain the power relations in existing societies. In this, he defines govermentality as "the conduct of conduct" (Lemke 2002: p.50), meaning an effort to shape, guide or affect the conduct of a particular community by using a set of practices and calculated strategies. This can be done through several ways, including educating the people and configuring their habits and beliefs so that they will comply with the desired agenda of development (McKee 2009). In the context of international development, scholars have used an understanding of governmentality to explain how dominant states attempt to exercise power over the Global South. It is largely exercised through neoliberal reform programmes by the powerful states, such as the United States, and international organizations, such as the World Bank.

There are various forms of donor governmentality practices in the literature. Of particular relevance to this thesis is a study conducted by Lie (2015a; 2015b) in Uganda, donor could use 'prior actions' strategies (as their 'developmentality' agenda) in shaping the conduct of aid recipient in development programming. According to this, when an aid agency assists local leaders in formulating their 'development strategic plan', it also requires them to fulfil some prior conditions which should be implemented before aid is given. This latter process involves donor-government in closed 'policy dialogue', which then results in the government agreeing to implement certain 'measures' as part of its own development strategy. Overall, this practice, means that local governments formally implement development projects in accordance with donors' policies.

Li (2007) and Boas and McNeill (2004) also found that, to ensure programmes achieve the desired 'change', international actors may apply two key strategies. The first is problematization, which means identification of problems that need to be addressed. A good example of this is the idea of 'good governance', promoted by the World Bank. This idea led to a range of policies which have become an arena for multilateral donors to include or exclude ineffective states. Some applying the Foucauldian approach argue that the promotion of 'good governance' represents the exercise of power by the North to reconfigure the South according to Northern regimes of knowledge (Taylor 2004).

The second is rendering technical, a symbolic form of practice which represents "the domain to be governed as an intelligible field with specifiable limits and particular characteristics…defining boundaries, rendering that within them visible, assembling information about that which is included, and devising techniques to mobilize the forces and entities thus revealed" (Rose 1999: p.33). In this, trained experts are involved and act as trustees with the power to frame problems and to give diagnoses and prescriptions according to the intended reform. Experts' work focuses only on the capacities of people and institutions and does not address the political economic framework in which their diagnoses and prescriptions intervene. This is termed by James Ferguson as an "anti-politics machine", or a way of working that avoids framing political economy issues as a central question in development practices (Ferguson 1994).

In her book, *The Will to Improve: Governmentality, Development, and the Practice of Politics* (2007), Li provides an example of governmentality programmes carried out by donors through implementation of integrated conservation and development projects in villages around Lore Lindu National Park in Indonesia (Li 2007).[8] Under the programme, these agencies identified some key problems that cause poverty and injustice and then proposed 'expert' technical interventions as a way to address it without an understanding of local political context. However, since the project used the intervener's prescription rather than being based on local problems and so failed to bring development benefits to the population excluded from the Park, it created a critical

[8]Donors included Asian Development Bank, USAID and the United Nations Educational, Scientific and Cultural Organization (UNESCO), as well as several international NGOs.

community; the highlanders became radicalized and wary of interventions that failed to deliver promised improvements.

Thus, Foucault's understanding of governmentality provides insight into how donor practices ultimately serve donor interests in line with a neoliberal agenda, by defining the problem and proposing solutions based on 'superior' knowhow. However, it falls short of understanding local political practices and how development becomes the site of contestation between a variety of international and local development actors. The absence of understanding of these political processes often means that donors' governmentality projects are only partially able to reach their neoliberal targets.

2. Political Economy Position

As suggested above, there is a strong argument to suggest that development operations can be better understood using political economy analysis. In the literature, there are several traditions in political economy approaches. In this section, firstly, two key approaches are discussed – namely the public choice model of political economy and structuralist political economy – and then the later political economy analysis that is used to discuss the context of healthcare delivery.

Political economy analysis uses public choice theory as its basis. This argues that key actors in development are individuals (politicians and bureaucrats) who are self-interested actors and use their position to allocate state resources for securing their vested interests rather than to serve public concerns (Mueller 1976).These approaches pay little attention to the issue of political values or ideas because it believes economic interests to be the motive of political interactions among agents (Hudson and Leftwich 2014). Therefore, according to the public choice model of political economy analysis, the market is considered a natural phenomenon and the process is influenced by the rent-seeking activities of individuals (with various ways for achieving this goal), a perspective that has been widely associated with the World Bank.

An alternative strand of political economy, which draws upon Gramscian state theory, especially as developed by Poulantzas (1978) and Jessop (2008), takes as its starting point the view that development is a site of contestation between competing groups (with different power, resources and political

opportunity structures) that have different interests and who engage in struggle over distributions of resources and the ideologies that legitimise these – development outcomes thus reflect the result of this contestation (Hughes and Hutchison 2012; Hutchison et al. 2014; Hout 2015; Hameiri et al. 2017). From this perspective, aid flows are not simply a matter of improving standards of living. Along with the distribution of resources, they constitute never-ending social and political contestations (developed from historical political economy processes and continually changing) between different groups which compete over control of development resources producing structurally unequal societies where power and wealth are unevenly allocated. In this view, aid programming is an intervention in this process in which it encourages local actors to struggle to influence the new form of governance which tries to build its power base through aid programmes. The final policies then reflect the balance of power between these development actors. It is this approach that underpins the theoretical understanding of power used in this thesis.

Donors have applied political economy analysis to 'intervene' in development more effectively. Some examples of political economy approaches adopted by donors include the World Bank's approach to policy reform and its problem-driven governance and political economy analysis, presented in 2008-2009, and the Drivers of Change approach developed by the UK's Department for International Development (DFID) in the early 2000s. The difference between these two approaches lies in the understanding of economic policy. The World Bank's neoliberal approach understands the market as an outcome of rent-seeking activities of individuals. Meanwhile, DFID and other structuralist approaches see the market itself as the result of power interactions between different social forces (including the World Bank itself as a tool of international capital) which structure economic activity in a manner to benefit the elites. The limitation to DFID's approach to political economy is in its understanding of development in that it argues that a project is to be 'delivered' within settled political frameworks rather than constructed through further political struggle. Thus, according to structuralist political economists, DFID fails to see the achievement of policies as an expression of ongoing struggles over the distribution of power (Hughes and Hutchison 2012).

Structuralist political economists regard development aid as reflecting Western interests and as an instrument to impose economic policy which leads

to capital accumulation. Ünay and Cammack argue that neoliberal international aid has facilitated states' exploitation of subordinate states and forums, at international, regional and inter-regional levels, have also been used as tools to serve the interest of major states – despite the rhetoric of reducing poverty and creating good governance (Cammack 2003; 2004; Ünay 2010). For example, even though the World Bank has an autonomous role, its policies are dominated by the United States influence (Hentz 2004). This situation makes the Bank's operations largely serve economic, social and political paradigms of the United States which aims to secure an international hierarchy of powers.

So far, this section has explained that the presence of donors in destination countries is accompanied by the resources which are attached to their reform agenda. Similarly, a variety of local development actors also see aid as a source of power for securing their political agendas. To ensure the maximum impact of the intended reform, when operating in developing countries, aid agencies need to form domestic alliances or coalitions – otherwise it might be difficult for them to influence the direction of any reform process (Hout 2015). Donors are also able to build broader political alliances with wider actors (like business groups, politicians and even military rulers) as long as it can advance or secure the reform agenda.

It is important to note that political alliances require both aid agencies and local elites to share the same vision of development (Hameiri et al. 2017). In situations where powerful elites realise that the reform agenda does not coincide with their own interests, political alliances will be suspended or even cancelled. This point then counters the Foucauldian argument that regards development agencies as having extensive power to control international programmes (see Gould 2005). Li's research on donor projects in Indonesia (Li 2007) provides further evidence that understanding politics on the ground is significant to the success of reform targets – a failure to do so will affect the programme implementation. Political economists argue that donors cannot easily dictate, even to a very small and weak state like Timor-Leste, with respect to a particular development goal. Thus, if the Timorese government wishes to, it can resist donor agendas. Once again, this argument shows that understanding political dynamics on the ground is important for donors to achieve their development agendas.

Neoliberal theory frames health as a resource to assist development by raising the pool of productive workers and increasing the productivity of each worker in that pool. From a structuralist perspective, health policy is determined by competition between stakeholders to achieve maximum influence over health policy and implementation. Each group will use their political position to drive any potential health reform in the country for securing their economic interests (Hart 2004; Hsiao 2007). Forsberg provides an example from the adoption of the new market economy after the *Doi Moi* reform in Vietnam 1986. Following the policy change, the health sector has been marketized. Economic and social policies were designed to benefit state-owned enterprises and their beneficiaries (so-called 'red capitalists'). As a result, the health system was transformed "from a highly equitable system with strong networks of primary care at grassroots level to a segmented system focusing on curative care and commercialization of services aiming at the high and middle income classes" (Forsberg 2011: p.31). Thus, this example explains how changing patterns of political power prompted by major economic change can produce dramatic shifts in the nature of service delivery.

The key ideas of structuralist political economy have been presented above, some of which are based on a Gramscian perspective, arguing that development is a product of historically specific struggles and is continuously contested among different groups. Thus, the continuation of power relationships among these groups shapes development policy outcomes and the allocation of resources. This approach forms the basis of the analytical framework through which this thesis analyses health development in Timor-Leste. In the aftermath of the conflict in 1999, the health sector became one the major areas regarded as requiring improvement. Consequently, bilateral and multilateral aid flowed into the country to assist health development. The political economy approach suggests that the impact of aid on any particular development issue depends on the range of political actors who are contesting resources in the relevant area. Thus, explaining the impact of international aid on health sector development in Timor-Leste requires examining which actors play which roles and what kind of resources they have.

B. What Kind of Power Do Donors Have?

This section further develops the conceptual framework based on the structuralist political economy approach as a means to support the analysis of the kind of power donors actually have, and to understand their domination practices and the contestations between stakeholders involved in aid implementation. In his essay, *The Subject and Power*, Foucault provides a definition of power as "a set of actions upon the action of others" (Foucault 1982: p.790). Previous to this, in a commonly cited definition, Dahl explained that the practice of power "refers to sub-sets of relations among social units in such a way that the behaviours of one or more units depend in some circumstances on the behaviour of other units" (Dahl 1968: p.407). These definitions indicate two important elements of power that are especially relevant to this thesis. First, power only exists when there is a relationship, notably a social relation. Second, a relationship of power requires actors. These actors are not always individuals. They may also involve other forms of human aggregation, such as organizations and governments. For Blau (1964), power relies on capabilities that enable people or groups to impose their interests on others. Westwood and Nye also agree that power is present because of 'ability', that is, capacities that can support the achievement of purposes (Westwood 2002; Nye 2004). There are many types of such abilities. They can take the form of capital (money and technology), knowledge, politics, culture, language, etc. In this section, it is hypothesized that in development practice, donors use these abilities as sources of power over government and civil society in target countries. However, according to a political economy perspective, local actors also have relevant 'abilities' that allow them to successfully resist, negotiate, subvert or co-opt the agendas of donors.

In his book, *Power: a Radical View* (originally published in 1974, revised in 2005), Lukes offers three levels at which donors might exercise power, which he terms 'faces of power'. The first, visible power, "involves a focus on behaviour in the making of decisions on issues over which there is an observable conflict of (subjective) interests, seen as express policy preferences, revealed by political participation" (Lukes 2005: p.19). The argument refers to the classical liberal pluralist approach to power published by Dahl. An example in the context of development is the effort to promote neoliberal reform in developing countries by donors who use power to impose conditions with the

purpose of changing the behaviour of the recipient governments and challenging their decisions regarding which programmes should be prioritised.

The second face of power – invisible power – is understood as "the ways in which decisions are prevented from being taken on potential issues over which there is an observable conflict of (subjective) interests, seen as embodied in express policy preferences and sub-political grievances" (Lukes 2005: p.25). From this argument, Bachrach and Baratz go further by providing the following example:

> [O]f course, power is exercised when A participates in making decisions that affect B. Power is also exercised when A devotes his energies to creating or reinforcing social and political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A. To the extent to that A succeeds in doing this, B is prevented, for all practical purposes, from bringing to the fore any issues which might in their resolution be seriously detrimental to A's set of preferences (Bachrach and Baratz 1970: p.7).

If applied to the development situation, this practice is reflected in the agenda-setting of donors and their programmes and project initiatives which make local countries align with donors' existing agendas and deny their national priorities.

The third face of power – hidden power – is the power used to manipulate others to make them believe that something is in their interests when it is not (Lukes 2005). This is also known as social conditioning, a strategy that makes "conflict … more invisible, through internalisation of powerlessness, or through dominating ideologies, values and forms of behaviour" (Gaventa 2006: p.29). The implementation of this practice might include giving training, capacity building and the control of the language of development.

Digeser argues that there is also a fourth face of power, namely, governmentality. As described above, the concept of governmentality derives from the work of Michel Foucault and deals with the production of knowledge and the process of socialising subjects into the power-holder norms (Digeser 1992). It is implemented similarly to the third face of power, with capacity building and training being some of the practices often used as technologies of governmentality. Some authors believe that the practice of governmentality has

been successful in internalising self-governmental disciplines in some aid recipient countries (see Mosse and Lewis 2005). However, this claim is rejected by political economists. For them, donors' power is best understood through the concept of hegemony.

Hegemony theorists argue that, under certain conditions, subordinate actors do become aware of their 'real interests' and therefore their behaviours can be inconsistent and resistance sometimes emerges. Moreover, from a political economy perspective, local governments do not only exist in a world of donor power but also in a world of rentier elites, political marketplaces (de Waal 2014), and clientelism (Lemarchand and Legg 1972). Thus, the project of donor 'reform' is only partially internalised. Consequently, when donors exercise power over local actors, it does not mean they will easily achieve the intended outcomes. In his paper, *Power and Resistance* (1985), Barbalet claims that there is always a chance for resistance to power. Thus, in this, he agrees with Weber who believed power can only be obtained if resistance is overcome (see Weber 1978c). This is due to the understanding that "the higher or more widespread the resistance, the lower the probability of realizing one's will, and the less one's power" (Barbalet 1985: p.534). According to the political economy point of view, donors will use several coalition strategies to overcome resistance, not only to secure their 'feature of power' but also to give them the opportunity to exercise more power over recipients for securing their development targets (Hutchison et al. 2014; Hout 2015).

This understanding of power is used as a framework to investigate what kind of power donors have and how they exercise power in the context of health programmes in Timor-Leste, as well as how that power is contested. It is also useful to examine the international discussions about development financing in health, and how this is best operationalised, because different approaches to giving aid empower different international and local actors in different ways.

C. The Aid Effectiveness Agenda and the Politics of Aid Delivery

The previous section explained that a realistic understanding of the complex nature of politics in aid delivery is important to increase the effectiveness of international interventions. In this section, the framework developed above is used to evaluate the efforts of the aid community to improve the quality of aid delivery through international forums on aid effectiveness. These aimed to meet

the demands of donors and recipient countries while producing some key agreements on aid implementation. This discussion seeks to show that these agreements did not really achieve their targets since they continuously failed to address political factors behind aid operations.

The concept of aid effectiveness has been negotiated and developed in international forums since the 1990s. During this period, the international political atmosphere shifted towards greater focus on human security and human development concerns (Woods 2005). The fall of the Soviet Union and changes in aid policy have influenced the changing pattern of civil wars. In Africa, Western humanitarian intervention has caused new conflicts in the form of so called "new wars" (Reno 1997; Kaldor 1999).[9] Later on, these conflicts have become a major source of poverty and food insecurity in the continent (White et al. 2001; Karanja 2010).

The crisis in development experienced by countries in Africa in the 1980s (also known as the tragedy of "the lost decade") after the implementation of SAPs has also contributed to the collapse in the economy of the territory and increased poverty. This prompted a new wave of criticism of the free market fundamentalist approach. Stiglitz's criticisms of his former employer, the World Bank, illustrate the extent of disillusionment in neoliberal approaches (Stiglitz 2002).

Subsequently, critics began to point out that aid projects are often wasteful and inefficient in implementation and therefore some strategies should be applied so that aid delivery quality could be improved – this has become a key agenda for those in the 'aid community' camp. Furthermore, a study conducted by Burnside and Dollar, which supports the aid community argument, shows that aid contribution on development would depend on the institutional conditions in recipient countries. Through careful examination of recent experiences of aid implementation they concluded that aid had only made a small contribution to growth. They argued that growth only occurs if the aid recipient country has good quality state institutions and policies (Burnside and Dollar 2000; Burnside and Dollar 2004). In other cases, some countries were continually trapped in conflict because of the state's failure to achieve economic development (Collier et al. 2003). Therefore, to prevent conflict re-occurring,

[9]Such conflicts are also described as internal wars and include ethnic mobilisation, resource extraction and state failure.

many in the OECD DAC development aid community argued that these countries were – and are – particularly in need of international aid to assist development (Sachs 2005). However, as explained below, the ramifications of more aid were not altogether positive.

Thus, in order to meet the challenge presented by the sceptics, the DAC umbrella grouping of OECD donors decided to promote an 'aid effectiveness' agenda which was largely focused on increasing the quality of aid delivery in developing countries. To do this, it decided to facilitate international meetings bringing together donors and their partners. These forums are regarded as important since they addressed aid actors' differences and efforts and aims to produce specific policies for the full effectiveness of international aid in the future.

Six months before the first of these forums, the world had been shocked by the attack on the twin towers of the World Trade Centre in New York on 11 September 2001. The tragedy created fears about instability in certain states and regions and encouraged the emergence of a so-called "security-development nexus" (the United States National Security Strategy and of the UN High Level Panel on Threats, Challenges and Change documents). Therefore, donor governments (lead by the United States) had committed themselves to increase the volumes of aid and to make poverty history (Murray and Overton 2011). The situation enhanced collaboration among all aid stakeholders from the donor community (mainly Western countries) in financing development in the poor countries (Woods 2005; Njeru 2009).

The first of the aid effectiveness forums held on 21-22 March 2002 in Monterrey, Mexico, was the Conference on Financing for Development and was attended by more than 50 Heads of State and Government. This was a response to the financial crises of the 1990s in Latin America and Asia, which slowed down and undermined the sustainability of development programmes and so contributed to the increase in poverty in affected countries – a situation that made it difficult to achieve MDGs targets. As a result, at the Monterrey conference, donors committed to allocated 0.7 percent of their Gross National Income to support poor countries to reduce poverty and achieve the targets of the MDGs.

Despite these commitments, according to a UN evaluation, while there have been some successes across the globe after the implementation of the

MDG agendas, aid interventions still failed to significantly improve living conditions (UN 2015). This has been demonstrated to be specifically due to MDGs having been used as a tool of global power to serve donor interests rather than truly focusing on eradicating poverty in developing countries (Amin 2006; Bond 2006). As a result, the dominant political motives that lay behind the implementation of development agendas meant that the efforts towards fulfilling the MDGs had limited success.

To reaffirm the commitment to improving aid effectiveness, a High Level Forum on Aid Effectiveness was held in Rome 2003. It was attended by leaders from the major multilateral banks, bilateral and international organizations and donor and recipient country representatives. The result of the forum was the Rome Declaration on Harmonization. The Declaration emphasizes the commitment to enhance the quality of aid delivery by strengthening the principles of harmonization. In Rome, the delegation committed "to harmonize the operational policies, procedures, and practices of our institutions with those of partner country systems to improve the effectiveness of development assistance" (OECD 2003). This approach has had to be adapted since it has proved ineffective because most of the international efforts in developing countries have become fragmented rather than harmonised (Annen and Moers 2012; OECD 2012b; Phillips 2013). Donors do not coordinate their aid projects and ignore requests to align aid efforts with the local country priorities. As a result, aid programmes were duplicated and did not really make a significant contribution to development of the population (OECD 2005). Therefore, it became important to coordinate aid projects by using a common system so that aid quality can be scaled up to support the achievement targets of MDGs.

In response to the Rome Declaration, new aid modalities were introduced in the form of budget support and the Sector Wide Approach (SWAp), replacing traditional project funding and aiming to reduce transaction costs (e.g., limiting the number of individual projects) and enhance local leadership (Andersen and Therkildsen 2007). Koeberle and Stavreski define budget support as "financial assistance that supports a medium-term program and is provided directly to a recipient country's budget on a regular basis, using the country's own financial management systems and budget procedures" (Koeberle and Stavreski 2006: p.5). In this context, aid is provided as financial support to a country's budget and directed to fund development projects that align with national priorities

rather than specific project activities (sector budget support) (Koeberle and Stavreski 2006; Riddell 2007). Rather than being an aid delivery instrument, SWAp is “a coordinated strategy in which donors and host governments agree on a single sector wide policy and expenditure program” (Development Information Services 2006: p.106). After discussing priorities, objectives, and the expenditure framework, donors and the recipient government create a joint implementation strategy and joint monitoring and evaluation methods for aligning donors’ operations and practices with local priorities (Siphana 2008).

Budget support and SWAp became popular as a new partnership-based approach to enhance the quality of aid and support sectors like health. However, the literature is divided regarding their impact. Some claim that there are correlations between their application and improvements in the health status of the poor (OECD 2012a; Rosser and Bremner 2015a). However, others argue that these two ‘improvement’ approaches were not significantly effective (Jones 2000; Devarajan and Shah 2006; Dodd 2011; Lucas 2013). This, they argue, depended on the political commitment between donor and domestic elites. Donor countries often pursue their self-interests through budget support and SWAp mechanisms (Canadian Council for International Co-operation 2005; Riddell 2007; Dann and Hammel 2013; Swedlund 2013; Cheng and Chan 2015; International Fund for Agricultural Development 2015). Thus, aid programmes largely continue to serve the goals and objectives of donors rather than local priorities. Meanwhile, in recipient countries, interest groups with political motives struggle to influence implementation of the two methods (Andersen and Therkildsen 2007; Cruz and McPake 2011; Tilley 2014). These conditions suggest that the problem of improving the aid quality was never primarily a technical one but was basically political in nature.

The Paris High-Level Forum on Aid Effectiveness, held in March 2005, aimed to strengthen commitments to improve the quality of aid which had been made in Monterrey and Rome. The forum itself was regarded as a breakthrough in international development since it involved a wide range of voices (35 donor countries, 26 multilateral donor organisations, 56 developing countries and 14 civil society observers) (see Mawdsley et al. 2014). The forum resulted in the Paris Declaration on Aid Effectiveness which focused on two elements: First, donor countries were encouraged to give greater local ownership in aid implementation. Second, donors and partner countries committed to be more

transparent in the aid efforts aiming to create mutual accountability at international and country level (Wood et al. 2011). In the forum, the word "partnership" became a major discourse among participants; and the phrase "inclusive partnership" is now commonly used to refer to the participation of all stakeholders including parliamentarians, foundations, the private sector and civil society (Bissio 2007).

According to some evaluations, there has been poor progress on achieving the Paris commitment targets for improving the quality of aid delivery in many aid partner countries. Arguably, this is because power and interests still dominate relationships among donors and local leaders (Mahmud 2008; World Bank 2008a; Roberts 2009; Chandy 2011; Sjöstedt 2013; Brown 2016). Even when national governments were able to establish strategic plans, the decision to do so was decided unilaterally by a particular group of people, including local elites and donor agents, as a way to sustain their own development agendas, at the expense of public priorities (Brown 2016).

The third High Level Forum on the aid effectiveness agenda took place in Accra, Ghana in September 2008 and was attended by 1,200 delegations from 100 countries and intergovernmental organisations. The focus of the meeting was to evaluate, strengthen and deepen the Paris Declaration principles and commitments. This meeting took place at a time when the global context was changing significantly – in the same month that the Global Financial Crisis reached its height. Some worried that this situation might cause a drop in the amount of Western aid to developing countries. Meanwhile, at the same time the world economy was entering a commodities boom resulting from the huge increase in the power of China and the massive competition for primary commodities that this engendered. Strengthening South-South Cooperation (SSC)[10] in the development agenda became one of the most highlighted points at the forum. Reflecting this, the Accra Agenda for Action (AAA) states: "The AAA recognises the value of co-operation that reaches beyond traditional aid arrangements, such among developing and middle income countries". This is

[10]SSC refers to an alternative form of development cooperation in the context of middle income countries. In fact, the idea is not new - it was first introduced through a meeting called the Asian–African Conference which was held in Bandung 1955 (also known as the Bandung Conference). The Bandung conference met representatives from 29 independent nations and resulted in the creation of the Non-Alignment Movement (NAM). NAM aimed to work against the domination of the West (United States and its allies) and the East (the Soviet Union and other communist states) and to create and support SSC. At Accra, the idea of SSC was harnessed to the goal of greater aid effectiveness.

an idea which revolutionised traditional thinking about aid, as flows from rich countries to poor countries. As the Agenda states, “the AAA redefines the relationship between donors, developing countries and their citizens” (DAC 2008a).

SSC has been regarded by some as an alternative option in international cooperation that can fulfil recipient countries development needs. However, the matter is not altogether simple. In political economy terms, the idea of ‘South-South’ is a rhetorical device designed to invoke ideas of equality and solidarity, arising from a common colonial experience. However, analysis of the relationship between the BRICS[11] powers and the countries to which they have given development assistance shows that the promise of equality is misleading. For example, Michael Sata, the fifth President of Zambia, likened Chinese aid and investments to Trojan horses, exploiting local resources without contributing significantly to the development of African economies or society (Brautigam 2009). Different collaborations involve different issues. For instance, Cuba has a different model of aid delivery that emphasises cooperation as a matter of “investing in people” (rather than financial flows) and of developing “a public service ethos in its health workers” (Anderson 2010: p.79). Therefore, Cuba supports health programmes in host countries by sending medical workers, providing training to local health professionals and giving students full scholarships to study medicine in Cuba, but without fully supporting local reform priorities, as discussed in later chapters. Thus, SSC still involves politics and interests. Indeed, political economists see SSC as a new form of power relation between actors who identify as ‘South’ (Morvaridi and Hughes 2018). For instance, although China and Zambia are both ‘South’, their relationship is characterised by power, not only between the two countries, but also between elites and non-elites within those countries. The ‘South-South’ rhetoric disguises power differentials between and within countries of the Global South, and makes it more difficult to identify exactly which groups are benefitting the most, or least.

Three years after Accra, in 2011, the fourth High Level Forum, entitled Partnership on Development Cooperation, was held in Busan, South Korea. It was initiated by the G7+, a group of twenty fragile and conflict-affected states attempting to reshape the terms by which aid operators work. The result of the

[11]These are Brazil, Russia, India, China and South Africa.

meeting was called a New Deal for Engagement in Fragile States (OECD 2012c). The principles in the New Deal agreement showed the wish for better achievement of aid efforts in the future particularly after “lessons-learned” in the previous implementation of aid which still did not make beneficial contributions to recipient countries (Da Costa 2012). In the meantime, the emergence of the G7+ and the New Deal also reflects new power dynamics between donors and recipients in a changing aid landscape.

The Busan New Deal agreement also demonstrated another struggle for influence by local actors over the direction of social, economic and political development in aid recipient countries. This is reflected in the principle of ownership which states that “partnerships for development can only succeed if they are led by developing countries, implementing approaches that are tailored to country-specific situations and needs” (OECD 2011: p.3). It was expected, by using local actor priorities, the full interests of many elites in the country can be easily achieved. This was, in part, because it was assumed that the involvement of civil societies in development can ensure that aid efforts work in the interests of citizens. However, they have to face donors and elites who are powerful and have interests in influencing development policy (Beausang 2012; Hughes et al. 2014; Paffenholz 2015). For instance, the New Deal process in Mogadishu was dominated by elites and international actors (Paffenholz 2015). Also, implementing the principles of country ownership and alignment does not mean the end of donor power. Donors are still able to retain their power through capacity building, training, technical assistance, reform etc.

However, some scholars also argue that civil society itself is often a form of elite group which has political purposes – mainly in relation to securing their self-existence and image – and is able to challenge the hegemonic power over development policies (Lewis and Kanji 2009). For example, Bebbington discusses a project for women’s empowerment in Bangladesh which he argues has given more benefit to NGOs than to the intended beneficiaries. Initially, NGOs formed some women’s groups to participate in a World Bank funded project involving silk production. Later, the NGOs bought the silk products at mutually favourable prices and then sold it at a higher price in the market, thus benefitting from the profit (Bebbington et al. 2007).

To this extent, it can be argued that civil societies do not always become the extensions of the aid industry. They are a form of elite that has a point of

view based in neoliberal development and actively engaged with different powers. Indeed, NGO staffs are often societally different from the people they wish to help since they are educated, often middle-class by background, and engaged in fairly comfortable white-collar work in an air-conditioned office. Thus, this influences their motives in development practices (Hillhorst 2003). Therefore, it is difficult for civil societies to go beyond the notion of always being positive in terms of delivering change to the lives and livelihoods of the beneficiaries because they are part of development actors who have interests and the ability to achieve this in political ways.

From the above discussion, it can be seen that aid can indeed be politically profitable to certain stakeholders. Both donors and local leaders have their own interests in the aid flow. On the donor side, aid can be used as a tool for achieving their reform agenda. Therefore, to ensure the maximum gain of their reform targets they may use various methods including privileging their own aid system standards and trespassing on local institutions' systems (Bergamaschi 2009; Paul 2013; Hudson 2015).

Meanwhile from the recipients' perspective, aid inflows are also a source of power. Rather than using aid for the purpose of improving the living conditions of the poor, power-holders tend to be more interested in implementing the aid effectively for their private interests (Dietrich 2011).

Looking at the above facts, it is understandable why many authors argue that the problem of power and interests has meant that the principles produced by various international forums on aid effectiveness have led to the achievement of relatively few of their agreed goals (Chuhan and Bhargava 2006; Brown and Morton 2008; Wallace 2009; Chandy 2011; Dabelstein and Patton 2013; Paffenholz 2015). This understanding was expressed by Ban Ki-moon, UN Secretary General (2007-2016): "all too often, aid is driven more by politics than by need, undermining its effectiveness" (quoted in Herfkens and Bains 2015: p.57). This has meant that efforts to allocate resources to those who need it most have been continually unable to achieve this. The above evidence also clearly suggests that although it is relatively easy for aid actors to produce agreements, there are other factors beyond aid that prevent them from following the agreed principles and which they continually failed to address, namely, political interests (see also Carothers and De Gramont 2013).

D. Aid and the Governance of Service Delivery

Having examined how political will became a central issue which meant that the international forums on aid effectiveness were not really successful in their aims, this section discusses the neoliberal motive of donor intervention. This purposes to assist changes in policy and practices that can bring more effective use of resources and it underlies the World Bank's strategy for development, particularly for improving service delivery. However, this effort has met with varied success since, as political economists argue, local dynamics have meant that donors have to deal with the interests of powerful local groups (elites and non-elites).

A lot of the debates on aid effectiveness focus on how to deliver aid, rather than how services should be operated. This is because service delivery has largely been framed within a neoliberal agenda. For neoliberals, health is a pillar of economic growth. For instance, when a family is healthy, both parents can earn wages and use these to buy food and commodities, and to send their children to school. Children who are healthy will perform well in school, making them better able to secure their future income. However, if the focus is shifted to operationalisation, this means the Bank has to consider inequalities to ensure that healthcare is accessible for the whole population. Although this involves a deeper commitment to egalitarian healthcare, at the same time, providing technical assistance and capacity-building programmes for this can be a means of propagating ideas, as discussed in the next section. Thus, despite the importance of health to the neoliberal agenda, the biggest challenge faced by societies has been the failure of the government to provide adequate healthcare services and the impact of this is poor health in the population (World Bank 2003c; Fukuyama 2014). According to data provided by the World Health Organization (WHO), poor health is concentrated in Africa. Figure 2.1 (below) shows that, in 1990, the region has the highest adult mortality rate: 721 per 1,000 people for both sexes together. Meanwhile, the second largest is that of countries in South-East Asia, with 502 per 1,000 people for both sexes. Twenty-two years later, this had not changed much. Africa still had the highest adult mortality rate, more than three times that of the Western Pacific region. This means African people face the biggest risk of dying during their productive age. In a neoliberal analysis, improving the quality of healthcare services is important

to save and improve lives so that they can be active in economic development, rather than to reduce inequalities.

Figure 2.1: Adult Mortality Rate (probability of dying between 15 and 60 years of age per 1,000 population)

Male		Female		
1990	2012	1990	2012	
395	343	326	298	African Region
205	161	115	89	Region of the Americas
276	222	226	149	South-East Asia Region
216	179	96	80	European Region
239	194	196	139	Eastern Mediterranean Region
174	116	119	78	Western Pacific Region

Source: (WHO 2014)

According to the World Bank, there are four factors that make governments unable to give good quality healthcare services to citizens. First, although governments are allocated large portions of the states' budget to the heath sector, most of the money is not spent on the improvement of healthcare services. Second, even when the money is spent on improving some health facilities, largely it does not reach the frontline service provider. Third, even if the payment received by the healthcare professionals is increased, there are few incentives to develop effective service delivery; moreover, wages may not be paid. Consequently political patronage and corruption become a way of life. Furthermore, many highly trained healthcare professionals prefer to stay in the city rather than in villages which means there is a limited number of health service providers in remote rural areas. In addition, since there is little monitoring in these areas, few health workers are penalised for not showing up further undermining the quality of service (World Bank 2003c). Lastly, health services have not yet been used optimally by poor people. Even if services are free of charge, many people who live in very rural areas are not able to access it due to the distances involved. Cultural factors may also prevent people from using healthcare services. For instance, some families prefer to go to traditional midwives for deliveries rather than clinics (World Bank 2003c).

In the 2004 World Development Report (WDR) entitled *Making Services Work for Poor People*, the World Bank proposed the marketization model as a way to address the problems on healthcare service delivery. For the Bank, healthcare services could be improved through strengthening consumers' approach to service delivery by encouraging direct transaction between citizens and healthcare service providers. This will create a competitive environment among service providers, as well as allowing patients to choose which type of services suits their needs and expectations for fees charged (World Bank 2003c). The Bank put forward this approach rather than a primarily democratic model involving the state because it believed it would improve professionality and quality of healthcare services as well as sustain the future fund of public services (World Bank 2003c).

Furthermore, some studies suggest that governments have political incentives to improve the accountability and quality of public services because this will increase people's trust in their leadership and thus its legitimacy, particularly so because people have certain expectations of government officials in development (Christensen and Lægreid 2005). Moreover, citizens will carry out their civic obligations voluntarily rather than needing the threat of punishment or reward (Tyler 2006). This, in turn, will make governance more efficient (McLoughlin 2015). This argument provides a counter to the WDR's emphasis on marketization because it shows that the long route of accountability, involving the relations between citizens and state, is viable.

The problem is that the state and market models of accountability are both flawed. The most significant flaw of the government is created by weaknesses in developing country governance system since these often tend to serve the interests of elites rather than the local population. Meanwhile, the direct transactions approach causes high transaction costs which make it difficult for the poor to access adequate healthcare services. Also, in domestic politics, local government has to face the power of pressure groups, such as health workers associations, pharmaceutical companies and patients' unions, which have interests in healthcare policies. These can be powerful and able to challenge the power of government (see Buse and Nalyor (2009) explanation about commercial sector interests in development). In addition, state employees involved in corruption might feel government health reform might jeopardise their corrupt practices and will use any possibility to prevent the new policy from

doing so. Meanwhile, other sectors (e.g., education, military) may claim that they deserve more priority on the budget, resulting in contending priorities that make reforms significantly more problematic.

E. The Paris Declaration and the Politics of Ownership

The idea of ownership that was introduced in the Paris Declaration of Aid Effectiveness has been widely regarded within the development aid community as a key ingredient for successful international aid programmes. Here, however, this belief is critiqued on the grounds that it is too confident in assuming that political leaders in recipient countries are committed to national development and that it ignores the fact that public policies are complex processes involving various interests from different actors. Different access to power and opportunities among these actors means that development ownership belongs to a particular group of people, not the rest of population.

As presented in the section above, the idea of country ownership became a key ingredient to improving the quality of aid delivery and was firstly introduced in the Paris Declaration on Aid Effectiveness in 2005. The failure of economic development post crisis in Africa in the 1980s resulted in the proliferation of donors and projects, poor coordination of aid activities with local development actors, and a limited role of recipient actors in designing and implementing of aid projects. Several studies on aid effectiveness suggest aid would give greater impact if it was aligned with local priorities and preferences, and if local officials became the major actors in designing and implementing aid activities (World Bank 1998). Meanwhile, to make good use of aid resources recipient governments expected donors to support a greater role of local leadership in directing development of their country. Arguably, political leaders know which model of development suits local needs and which is the most suitable approach to achieve it. According to this argument, when local leaders take the lead and own more roles on the initiation and implementation of national agenda, sustainable development can be easily to achieve (Mbacke 2013).

However, this research argues that ownership is a vague term which has various meanings across development actors (donors, governments, civil societies and private sectors). A report by the OECD even admitted that ownership is “the most poorly defined of the Declaration’s principles” (OECD

2008; see also Wood et al. 2008). Meanwhile Bergamaschi (2009) and Whitfield (2009) argue there are two potentially competing, and potentially contradictory, usages of the term. The first is ownership as commitment to policies. This means donors trust that governments know what they should do in development efforts. However, this idea has often resulted in donors' distrust. This is because the weak political commitment of the local policy makers has meant that reform programmes have had very little success. To avoid such risk and to ensure that aid reaches its intended beneficiaries, donors tended to target countries with a stronger commitment to development (Conyers and Mellors 2005; Dietrich 2013). The second usage understands ownership to be defined as control over the process and outcome of choosing policies. This means recipient governments choose policy design and its implementation based on domestic decision-making processes with minimum foreign influence. However, this definition denies the fact that donors are still dominant in aid practices and always demand greater control over recipient governments' policy preferences and strategies (Whitfield and Fraser 2009).

The Paris Declaration encouraged both donor and recipient countries to play their roles in development practices by ensuring local ownership to increase the performance of aid implementation. This means donors were requested to reduce their domination and let the leaders in Southern countries 'drive' development processes according to the principle of ownership, as stated in the Paris Declaration:

> Partner countries commit to: (1) Exercise leadership in developing and implementing their national development strategies through broad consultative processes; (2) Translate these national development strategies into prioritised results-oriented operational programmes as expressed in medium-term expenditure frameworks and annual budgets; (3) Take the lead in co-ordinating aid at all levels in conjunction with other development resources in dialogue with donors and encouraging the participation of civil society and the private sector. Meanwhile donors commit to: Respect partner country leadership and help strengthen their capacity to exercise it (DAC 2008b: p.3).

According to the point above, recipient leadership has to have greater authority to lead in putting sound systems and policies in place. In reality, donor agencies still had dominant roles in preparing such reforms, making it difficult for the local government to take ownership of aid activities. For instance, to strengthen the implementation of particular policy donors may provide the lacking capacity. And technical assistance and capacity-building programmes are indeed powerful ways of inculcating certain attitudes and understanding of what development is and how it ought to be achieved; so, to achieve the development targets, donors determine which kind of capacity building is needed by recipient countries. This weakens local leadership and undermines genuine policy learning, at the same time as increasing donor power. Some individuals might be able to disagree with donors' preferences but this would cause the "delay the arrival of the much-needed resources" (Rakner et al. 2001: p.587). Thus, the situation was not nearly as simple as the Declaration assumed.

A few years after they were agreed, the Paris Declaration's objectives regarding ownership have made some progress, even though there are still serious problems in practice. As de Renzio et al. (2008) investigation found out in many African countries donors were still dominated decision-making and their projects were also fragmented, making it difficult for local government to coordinate aid according to their national development plan. These practices, then, have undermined policy ownership on the side of African leaders.

So, why has the principle of ownership not had significant success in achieving its goals? An answer to this question can be found in the political aspect of ownership, as suggested by the above criticisms of the Paris Declaration's assumptions, rather than in the abstract definition of the term. Aid relationships involve power and power relations between different actors (within the state and between the state and other agents, within and between donor and civil society organizations, within and between different social, gender and age groups in society) and contested interests. Ownership reflects the continuing contest of power in which all parties who have different viewpoints and power resources seek to influence decisions and outcomes (Castel-Branco 2008; Mahmud 2008). While ownership-seeking strategies may vary between agents, different power and structural positions among them will make

development policies and directions reflect the power struggle among powerful actors rather than reflecting democratic solutions.

Some might argue that the reasons behind the small achievement of the ownership principle targets are the recipient's fragile institutions, poor political leadership, and weak policies – and that the ownership agenda could be well implemented in better performing states. In fact, there may also be other factors that contribute to the poor performance on achieving ownership targets. In his article, *Better Aid, Less Ownership*, Carbone (2008) explains that the behaviour of donors can also be a factor that contributes to the lack of achievement at ownership level. He discusses the example of European Commission, whose commitment to ownership is hampered by two sets of political interests within Europe:

> The first is the excessive concern of the European Commission with showing that it is able to commit and spend money quickly, in response to the continuous threats of aid repatriation by various Member States. The second is that the new emphasis on ensuring increased coordination and complementarity with the Member States results in a reduced space for negotiations with recipient countries (2008: p.227).

As a consequence, the voice of the recipients was not fully included in the policy design. Meanwhile, other factors like natural disasters (e.g., tsunamis, earthquakes) and armed conflict against or within a previously peaceful nation can also make a country with strong institutions, quality political leadership and sound policies become disorganised and not fully capable of leading development (Buiter 2007).

Fraser and Whitfield (2009) argue that the practice of respecting and supporting recipient governments' greater ownership in economic policy, governance, and social welfare systems is a way to transfer responsibility to recipient leadership on the aid coordination efforts. In fact, as mentioned in the Paris Declaration (2005), donors were required to be "more harmonised, transparent and collectively effective [in their aid activities]" (DAC 2008b: p.6). However, this has not really been fulfilled (see Harrison and Mulley 2009), which suggests that donors' power and interests are still dominant in aid delivery practices. In addition, by using the ownership agenda, donors can also

gain legitimation to distance themselves from the process and outcomes of aid-supported reforms (Fraser and Whitfield 2009). Thus, they can avoid taking responsibility for unsuccessful programme implementation by blaming the recipient domestic conditions, thus, enabling them to 'save face' – while, if the development is successful, donors can claim that it because of their support.

Another author asserts that the transfer to local ownership can be understood as donors' shorthand for making recipient governments increase their development budget and thus reduce aid flows (Helleiner 2002). But this does not mean that the donor's influence over development becomes weaker. As noted earlier, development agencies still retain a great deal of control over development because they have many features of power (like knowledge, ideas and politics) to achieve their development targets. In the case of Peru, for instance, although, to some extent, leadership of the country had control over resource allocation (including aid resources from donors), donors still used a 'doctor knows best' approach (based on their technical expertise) to improve the functioning and quality of the healthcare system to 'better' address the needs of Peruvian citizens. Consequently, donor agencies and their foreign implementing agents took a major role in fund management and programme implementation with limited ownership on the part of local leaders (Buffardi 2013).

In Rwanda and Tanzania, donors provide small amounts of money in budget support so that they can obtain a seat at the 'policy dialogue' table. This then allows them to meet with key groups and determine which are the key reforms and policies (Swedlund 2013). However, donors' reform agendas are not always easy to achieve because of the 'powers' in the local context that are also interested in influencing development design, and able to challenge donors' domination. As a consequence, local actors will always have a share of the 'ownership', regardless of the level of the group. Once again, it can be seen that the commitment to ownership expressed in the Paris High Level Forum was only good in theory. In practice, as Bräutigam argues, ownership denotes "the extent to which there is a coincidence of interest and ideas between aid agencies and the political leadership regarding the design and implementation of certain programs and policies favoured by the aid agencies" (2000: p. 32).

F. Conclusion

This chapter discussed the political economy framework used to understand relationships among actors in aid delivery and its implications for our understanding of ownership. This provided a basis from which to understand the approaches and strategies donors use to exercise power through health programmes and to go beyond the assumptions of liberal governmentality to take into account how local actors contest this. The discussion highlighted that the political interests of relevant actors need to be considered central to understanding donor-recipient relationships in aid delivery. Both donors and local elites view aid resources as important tools for achieving their interests: on the donor side, aid can be used as a technology to change attitudes of people in developing countries so they conform to neoliberal ideals. Meanwhile, for local elites, aid flow is a source of power for supporting political interests. However, the nature of political process in the local country also affects relationships among actors and thus also shapes outcomes of aid programme implementation. This means that development policies are shared among particular groups of development actors (donors, elites and non-elite groups) with different interests and power resources. This, in turn, makes national ownership (as promoted by the Paris Declaration on improving aid delivery) impossible to achieve because it is contested and so privileges the more powerful groups in the community.

In following chapters, this structuralist political economy approach is used as a theoretical framework to examine ownership in healthcare policy-making in Timor-Leste post-dependence. In relation to this, some argue that aid dependency would make the Timorese government listen predominately to donor-priorities at the expense of its ownership of development since it would enable donors to exercise more power to set a neoliberal development agenda rather than make changes based on local aspirations. However, as discussed in Chapters 5 and 6, findings from the fieldwork demonstrate that although the Timorese government was dependent on aid allocation, elites who were empowered by institutional and political party were able to establish some policies that aligned with their interests.

In terms of the politics of health in Timor-Leste and the dynamics of relationships among development actors, the political economy perspective provides insight into the roles of the key actors determining health policies, their

political interests, and how relationships among these actors shape development agendas – issues that are fundamental to this research. To date, there are limited studies that discuss the politics of ownership among development actors in Timor-Leste, including donors, elites and non-elite groups and there is little understanding of how relationships among them affect policy direction in the health sector and policy ownership on the part of the MoH and healthcare professionals. Thus, this research aims to make a substantial contribution to the topic of ownership politics and development policy in the context of fragile states like Timor-Leste.

The next chapter explores the politics of policy ownership in post-conflict contexts with particular attention given to the shift of development mode from aid-dependence to oil-dependence, and how does this affects elites and their policy-making and its implications for healthcare service delivery. From a political economy perspective, the key questions are: Who is empowered to make decisions in healthcare? and: What kinds of approaches have been used to legitimise policy in this area?

Chapter 3: The Political Economy of Policy-Making: Liberal, Neopatrimonial and Populist

The previous chapter discussed how aid delivery involves political contestation among various (international and local) development actors who seek greater 'ownership' over aid distribution. The present chapter develops the structuralist political economy framework introduced above to examine the strategies used by local elites to maintain power and gain ownership of development programming, which in turn affects the implementation of aid agendas. In post-conflict contexts, policy-making becomes particularly subject to patronage and populist politics rather than following a rationalist public service approach for building elite political supports. Moreover, in the specific situation of Timor-Leste, while the shift from aid-dependence to oil-dependence has enabled local elites to have more flexibility in decision-making, this will further patronage politics in the allocation of state resources. This has the potential to exacerbate the effects of the so-called resource curse, despite efforts to avoid this by instituting petroleum sovereign funds.

The chapter is divided into four sections: The first discusses the politics of local ownership and reviews three different broad approaches to policy-making – liberal-technocratic, patronage-based and populist. This section also examines the strategies of elites in using development policy as means to build political support. The second section examines the political economy literature on the specific problems posed by oil as a source of development finance, and discusses the use of sovereign funds to mitigate these problems. The third section examines the shift from aid-dependence to oil-dependence in the context of Timor-Leste, focusing on the establishment of a Timorese oil fund as a strategy to reduce resource curse risks and make oil wealth benefit Timorese future generations. The last section then explores the implications of access to funds from oil resources for health development in Timor-Leste.

A. Ownership, Power and Public Policy

This section develops the discussion on ownership in Chapter 2, which argued that the Paris Declaration oversimplified the concept of ownership by assuming common interests among diverse sets of actors – an idea which also based on

the argument promoted by the liberal institutionalist approach. However, political economists argue that actors have conflicting interests over development and therefore common interests are unlikely to emerge at national and sub-national levels. Rather, one set of interests will successfully dominate or accommodate another. To offer a better understanding of the context, this section discusses the power of elites in post-conflict situations and the kinds of political strategies they promote to win 'ownership' of development agendas and how it can affect the success of donor interventions. This focusses on the political background against which ownership has been embedded in Timor's institutions and political parties during the post-independence era.

1. Elites Pacts, Political Settlements and Post-Conflict Development Policy

This subsection focuses on policy-making in early post-conflict or post-authoritarian situations; in particular, how policies become the result of political contestation between social forces. To clarify the situation, the discussion is divided into two parts. The first explores the differing perspectives of liberal institutionalists and political economists in their understanding of actors in policy-making, as well as the dominant political economy understanding of the networks of powerful elites and the way they consolidate power in post-conflict situations. To further this analysis, the second part focuses on how policy-making on the ground becomes a political arena which involves elites and non-elite power and interests.

There is an ongoing debate between institutionalists and political economists regarding politics and decision-making. Institutionalists argue that institutions are central actors or frameworks for development because strong institutions have the ability to formulate and deliver effective policies. In this context, Paris (2004) and Fukuyama (2004) suggest that aid delivery should focus on promoting good governance because effective public institutions are able to conduct service delivery and maintain development in the longer-term for the success of neoliberal reform agendas. Political economists, who have a similar perspective to liberal structuralists, on the other hand, suggest that powerful elites are those people who have structural advantages. They dominate institutions and the decisions they make, while weaker actors attempt

to contest, accommodate and limit these. Institutions are not actors but sites of contestation among different groups. In Timor-Leste, for instance, it has a highly divided elites and unstable party where populist politics become the tool of political leaders to gain support from population. This means that institutions and their policies reflect the power and interests of those coming from groups who have always become leaders in the country.

In the post-conflict environment, according to the political economy perspective, understanding elites and their domination practices can be facilitated through political settlement frameworks based on the argument that "governance, stability, and the quality and pace of development are viewed as the outcome of struggles and ensuing arrangements among powerful elites" (Parks and Cole 2010: p.5). According to this, institutions and policies are viewed as a space of contestation among different groups of elites (sometimes the product of many years of struggle). These have important influence on political and economic outcomes, which involves informal power arrangements among them in distributing resource benefits and accumulation from state institutions (Khan 2010; Khan 2011; Khan 2017).

Each elite faction has their own power and interests and this will often bring factions into conflict and negotiation. This can lead to the establishment of political agreements among powerful elites – that is "political settlements". In the context of conflict-affected and fragile states where power relations are often fluid and dynamic, and institutions are extremely weak, political settlements will become subject to renegotiation and contestation and consequently new agreements may emerge over time (Parks and Cole 2010).

Political settlements are sometimes identified with elite pacts since the two concepts are very similar as is apparent from O'Donnell and Schmitter's definition of an elite pact:

> an explicit, but not always publicly explicated or justified, agreement among a select set of actors which seeks to define (or, better, to redefine) rules governing exercise of power on the basis of mutual guarantees for the "vital interest" of those entering to it (1986: p.37).

However, in practice, elite settlements and elite pacts differ in focus: while political settlements focus more on bargaining power among powerful actors, pacts are often means by which elite actors use their power for consolidating

support from key groups to allow them to hold power and dominate other groups. This understanding of pacts links to Karl's insight:

> [Pacts] are anti-democratic mechanisms, bargained by elites, which seek to create a deliberate socioeconomic and political contract that demobilizes emerging mass actors while delineating the extent to which all actors can participate or wield power in the future. They may accomplish this task by restricting contestation..., by restricting the policy agenda itself..., or restricting the franchise...regardless of which strategic option is chosen, the net effect of these options is the same: the nature and parameters of the initial democracy that results is markedly circumscribed (Karl 1990: p.11-12).

In order to ensure the sustainability of domination practices, besides using electoral politics, elite actors will apply some pact-making strategies and this includes getting support from the media (which then enables them to set new agendas that support their positions and possibilities) and the military (to ensure against a coup if they win an election). It is important to note, besides using political settlements and elite pacts, elites also need different political supports to sustain and maintain their power. This includes money to fund their election campaigns while factors, such as tolerance from the United States and possibly regional influences, are also needed for protecting and maintaining the power and influence of local political leaders.

These points suggest that the elites have various ways of getting political support and becoming more powerful in leadership. Moreover, it is important to note, the power of social forces vary from place to place depending on the socio-economic structure (for instance, whether it is a rural subsistence economy or an advanced industrialised country) and the historical trajectory of the institutions. This explains why in some countries the support of military, media and/or trade unions are vital while, in other cases, traditional non-state actors, such as tribes, are essential. Thus, certain questions become very relevant: Is there a vibrant civil society of community-based organizations? Is the military highly politicised? The answers can be helpful to identify the power of social forces in the context of post-conflict countries.

In general, political economists regard institutions in any context as sites of contestation between different social forces, and consider that the

emergence of a ‘power elite’, particularly in an unequal society, reflects the establishment of a dominant class. Moreover, in post-conflict settings, institutions are often weak and will not be able to prevent elite domination practices that ignore or undermine the function of state institutions. In the case of elites in Southeast Asian countries, for instance, oligarchs or actors in government decision-makers are in interlocking positions across political, corporate and military hierarchies; arguably, this allowing less possibility of opposition (Anderson 2001; Kingsbury 2017). For instance, monopoly on political power in Cambodia (under Hun Sen) and Indonesia (under Suharto) has been demonstrated to be a product of relationships between political leaders and military organizations. To secure his power, Hun Sen established a basis for oligarchic rule through a resource generated strategy (in terms of profits, bribes, etc.) that enabled his monopoly of power while letting the elites (including entrepreneurial military leaders) increase their wealth and provide them with funds for elections (Hughes 2003; 2006). Similarly, state capitalism in Indonesia enabled top politicians, bureaucrats and generals to be deeply involved in business, with rents gained through this financing them in becoming more influential (Dogan 2003; Robison 2009). Even after economic crisis and the fall of Suharto in 1998, patronage and corruption continued as the major political culture in Indonesia, although spread among the new layers of actors (Hadiz 2010).

In Southeast Asia, excessive elite control over economic and political power has also existed under more genuinely democratic rule. Following the military and bureaucratic elites’ domination of the political sphere from the 1930s to 1970s, new business groups grew powerful through the influence of their wealth as urban areas experienced an economic boom during the late 1980s and began to involve themselves in politics to further their business. Ironically, their consequent demands for a parliamentary system, as a means to facilitating this, contributed to elections being held for the first time in Thailand at the end of 1992 (Phongpaichit and Baker 2014). However, the resultant business elite dominations seldom lasted long, as military elites challenged their positions and gained more control over political institutions. Similarly, the quality of the Philippines’s democracy remains poor mainly due to the persistence of weak state institutions allows powerful kindship networks to extract benefit from a largely incoherent bureaucracy and accumulate wealth through the state

apparatus (McCoy 1993; Hutchcraft 1998; Clarke and Sison 2005). For instance, since 1986, three of five presidents came to power through political support based on powerful family coalitions indicating the power family groups have to dominate the politics and command institutions in the country.

The discussion of political settlements and elite pacts presented above provides a means to understanding the ways that elite actors try to consolidate post-war orders. Some types of powerful elites in the Southeast Asian context were highlighted from a structuralist political economy perspective, including military, business and family based networks that function to preserve power and influence within these groups. Also, the various ways they exploit their connections with the military or their democratic and economic positions to serve their own interests were described, highlighting that this form of corruption happens under authoritarian rule and in democracies. The next part expands on this to focus on the political economy of the relationships among elites involved in interacting with each other and with influential groups in local contexts. In Chapter 2 discussed how the Paris Declaration proposed an agenda aiming to ensure national ownership through liberal institutionalist ideal in which local leaders take the lead on programme policies on behalf of the people to create sustainable development. Meanwhile, political economists argue that the idea of ownership is too optimistic since local elites and aid partners seldom have coinciding interests in development. In fact, this is not altogether the case, many interests do overlap, otherwise programmes would be impossible to implement.

Also, political economists argue that states do not really 'own' policies, rather, they respond to political pressures. Meanwhile, donors still have the power to give or not give aid money – for example, many donors have dropped conditionality but instead introduced 'selectivity', i.e., if a country puts forward policies that do not suit the donor, the latter does not provide aid to that country. Even if donors do allocate money, policy formulation, programme implementation and monitoring and evaluating results is not primarily technical but a political process in which contestation may occur between donors and national elites. For political economists, the consequence of switching from aid-dependence to oil-dependence is that donors might become relatively weaker in their ability to exert political pressure and the most powerful pressures then come from the elites – for example, local elites (such as ex-combatants, local

business elites etc.). Thus, when oil money becomes available government will start responding more to local elites than to international pressures.

The Paris Declaration also encourages national leadership to formulate and implement national development strategies under liberal democratic processes involving aspirations from the whole population (DAC 2008b). Again, this idea has proved too optimistic since it idealises politics on the ground. In reality, national government priorities are determined by the outcome of struggles over policies, priorities and resources between various elite and non-elite groups. Thus development directions will be heavily weighted in favour of particular development players rather than the majority of the population (see Wood et al. 2008). In the case of the Philippines, for instance, since the country has a Medium-term Philippine Development Plan, the Government argues the Plan is a result of consultative processes, and thus it becomes the symbol of 'national ownership' over development. In fact, it is designed and formulated by elite actors in the capital with limited consultation with general population (Africa 2008). Similarly, the same elites domination practices also occur in many African countries (see Harrison 2004) and also in Asia-Pacific region (see Hameiri 2010; Dornan 2017) – which show that this is a widespread phenomenon.

A key area where intra-elite contestation over development policy becomes manifest is in budget allocations. While for Gosling (2016), the national budget plan represents accountability and transparency, in most cases, elites in government and the legislative house have low levels of accountability. This is a result of development agendas being set by powerful lobbying groups, such as big business of the military, rather than by ordinary voters. The context of Southeast Asian money politics, for instance, can be seen as indicative of the high level of corruption within parliaments due to heavy dependence on campaign donations from big business across the region. Also, as Savoie (2010) argues, for some, promoting greater transparency diminishes effectiveness as it means allowing criticism that slows down 'decision-making' over resources, potentially reducing their power. So they seek to narrow the scope of their decision making by insulating their power from democratic pressures (Ayittey 2011; Duncan 2014). Thus, "when power confronts transparency [and accountability], those with power win" (Savoie 2010: p.126).

For political economists, public budgeting reflects conflicting purposes; since it can only be accessed by those in power it makes the direction of development favour a small group of people (Shively 2014; Morgan et al. 2015). Thus, the ideal of liberal democracy is undermined and the commitments made, even by elected officials, tend to reflect the interests of the elites and non-elite power groups rather than the broader population.

Political economists argue that political actors are groups of people with competing agendas, interests, commitments and beliefs about what development should be. Thus, oil income which supports development budgets tends to be seen by elites as a vehicle to serve their priorities and purposes. Different interests among groups tend to create political tensions and competition to capture budget expenditure to maintain political power rather than fostering widespread development. In some cases, political elites are also capable of applying different strategies in order to get maximum benefit from the budget allocation, including cooperating with other group of elites (or forming coalitions) (Niskanen 1991); in which case, both groups benefit from budget allocation at the expense of the populace.

The democratic ideal incorporates a role for political parties in linking legislatures to public opinion and the ordinary voter. However, in early post-conflict or post-authoritarian situations, this can be problematic. According to Ware, a party is "an institution that (a) seeks influence in a state, often by attempting to occupy positions in government, and (b) usually consists of more than a single interest in the society and so to some degree attempts to aggregate interest" (1995: p.5). This implies that the primary characteristic of political party is about representation and implementation of particular goals through government. To do so, they train their candidates according to party norms and values; when elected these then organize their work and administration following the set of policy objectives already mandated to them (Dodd 1986; Ware 1995; Diamond and Gunther 2001; Dalton et al. 2011; Heywood 2013). Consequently, democratic contests are important for political parties to access institutional power and achieve their political purposes.

Parties can be classified according to different criteria: some can be divided according to their social class representation, others can be distinguished according to their socio-political objectives. However, to promote their objectives over those of others, parties need access to resources;

consequently, substantial donations by party members are required to support this. This is a problem in contexts where a) parties are formed from the top down and therefore voters expect to be paid by them, rather than paying to support them; and b) there are high levels of inequality so that rich donors can easily dominate a party's political agenda. Thus, only those parties with disproportionate access to resources are able to survive (Butler 2010). At this point, it is clear that a political party is a vehicle to dominate populations with elites in the top and the poor at the bottom. Consequently, while parties have a vested interest in maintaining inequality, they also have a responsibility to communicate 'transparently' with the populace.

Similarly, interest groups have enough power to influence policy made by executive and legislative leaders. The liberal literature sees this as positive as it improves the flow of information and encourages government to be responsive to social needs. For political economists, the problem with interest groups is that there are massive, persistent, structural inequalities of power between them (Hughes 2015). For instance, lobbyists working on behalf of big businesses have more power than those working on behalf of the poor and lobbying can quickly degrade into corruption. This is particularly salient in healthcare; for example, there are plenty of antiretroviral therapies for adults but a lack of these for children, because HIV is almost exclusively an adult disease in the West but affects a lot of children through mother-to-child transmission in developing countries. Again, the resultant contests mean that policy-making favours more powerful groups, reinforcing others' disadvantaged position.

Many studies show that parties make very limited contributions to development in post-conflict situations because, at such times, they are very weak and not well-entrenched features of the political system. Consequently, the democratic arena "will end in an election that reaffirms the power and enhances the authority of those groups and leaders that developed during the war" (Lyons 2005; and Guterres 2006; see also Hughes 2009). In such highly unequal contexts, how do policy priorities become established and how does the policy process function? The next sub-section addresses these questions.

2. Elites, Ownership and Policy-Making in Post-Conflict Contexts

This section outlines three models of political action in post-conflict situations that may be involved in the policy process: the liberal-technocratic ideal, neopatrimonial and populist model. Special focus is placed on the process of policy formulation and how it functions in each type of policy-making in order to understand political interactions between elites and among influential groups in conflict-affected countries.

a. The Ideal Liberal-Technocratic Model

Proponents of the liberal democratic approach tend to assume that bureaucratic administration will be responsive to the public interest and apply a knowledge-based approach to address various problems of citizens – this then becomes the feature of rational decision-making model in public policy. This idea comes from the combination of liberal and Weberian models of the state: while liberals see the state as brokering societal interests (Dahl 1971), Weberians see it as intervening in society for progressive ends, both these approaches regard the state as serving a “public good” through the formulation and implementation of policies (Weber 1978b). In practice, this model is incorporated into the liberal state building agenda in post-conflict states through the “good governance” paradigm (Fukuyama 2004).

In the liberal democratic model, political power will be concentrated in the hands of identifiable governments chosen by the electorate (or by appointment). These governments make policies based on problem-solving mindsets in addressing public issues that need serious and active attention. According to Anderson (2003), there are four stages in the policy-making process. In the first, policy makers identify conditions and/or situations that have become a concern of the people and for which governmental action is needed. The second stage involves analysis of the problem, which may use various methods including a theoretical approach, comparison studies or other systematic methods that can direct analysis attention specifically to those facts that are relevant to the situation and issues involved (Lindblom 1959).

In the third step, the decision-maker lists policy options which may offer possible opportunities to achieve their goals, make choices according to the best fitting policy, and then implement it. As policies are intended either to make things happen or to make them not happen, the last step focuses on monitoring

and evaluation of the policy adopted to ensure whether it has been successful in achieving its aims, whether these aims are the desired ones, and whether the means adopted are acceptable – or if there should be there any adjustment. It is important to note that the function of monitoring and evaluation is not merely to satisfy our curiosity but also to guide present or future policy-making.

Based on the above argument, political actors such as presidents, prime ministers and ministers, have prominent roles as agenda setters of development. However, although political leaders take central positions in institutional decision-making, in theory, the policy process is conducted through democratic means in which the preferences of all cabinet members and bureaucratic staffs (bottom up aspirations) are respected and all actors (regardless lower or higher rank) are treated equally (Weber 1978b). Thus, policies are directed towards public aims with no discrimination (Weber 1978b).

The liberal democratic approach also emphasises the involvement of technical expertise as a way to strengthening policy-making capacity to resolve complex problems (Lindblom 1959; Anderson 2003). However, since political leaders seldom have technical qualifications, at least some of their cabinet members and administrative staffs need to have adequate technical qualifications to assist them in making informed decisions. Or, if necessary, specialized training may be required to enable administrative staffs to be adequately equipped for their appointed positions and responsibilities (Weber 1978b). Such technical staffs, with natural science backgrounds, find statistical and factual evidence more useful than opinions to policy-making aimed at improving the technical efficiency of public policies in formulating policy decision. As a chemist in government office pointed out, “We're happier with figures and with facts. We're happier weighing up probabilities to which we can attach a number than we are in dealing with less tangible outcomes” (Putnam 1977: p.396).

Another important element of the liberal democratic approach is that it involves participation of all stakeholders (like business, trade unions, NGOs and others) for consulting policies which will affect public interests (Anderson 2003; OECD 2010). Their contributions may be limited (only included in a few stages of policy process) or they may be involve in the whole policy cycle (starting from agenda setting, analysis, policy formation, implementation, to policy review and evaluation) (Anderson 2003; OECD 2010). The aim is to encourage a

transparent and accountable policy process which is suitable and even supported by all groups in the community so that policy implementation is effective and achievable.

b. The Neopatrimonial Model

In contrast to liberal institutionalist approach, which believes the state produces rational and democratic policy procedures for national betterment, political economists argue that policy formation and policy execution are a political strategy for maintaining power and interests. One main strategy used by elites to link them with supporters or rivals is based on neopatrimonialism which means that the allocation of state resources benefit only certain groups rather than the whole populace. This type of political system actually derives from the writing of Max Weber, who used the term “patrimonialism” to explain the traditional form of political domination by a chief or royal household in control of bureaucratic power through an administrative apparatus staffed by family and friends, and who ran the government for their benefit (Weber 1978a). Under this political system, Weber argued: “The patrimonial office lacks above all the bureaucratic separation of the ‘private’ and the ‘official’ sphere. For the political administration is treated as a purely personal affair of the ruler, and political power is considered part of his personal property…” (Weber 1978a: p.1028-1029).

The work of Weber was further developed by Eisenstadt (1973) by introducing the term “neopatrimonialism” to describe the modern practice of which combines elements of traditional patrimonialism with modern legal-rational bureaucracy practices as the principal mechanism on policy-making. This reflects the situation in contemporary democratic systems in which there is understood to be a clear distinction between the private/personal and official or public domains. Policy creation and implementation are discussed in terms of legitimation and accountability and often supported by officials appointed on the basis of merit and expertise to produce good policies which serve public interests.

However, the actual operation of the government remains at core a matter of sharing state resources with particular clients in exchange for their loyalty and support (Erdmann and Engel 2006). The specifics of what patrons give away to clients vary depending on their circumstances and their followers’

demands but may include government positions, public contracts, money and services. In short, this political practice provides mutually beneficial transactions between elites and their networks of supporters, and thus, governments' policies are oriented toward particular considerations related to this, rather than pursuing a vision of public good. Thus, for the elites, patronage politics is profitable to connect them with political constituencies that enable them to stay in power (Barma 2016).

Furthermore, a study conducted by Barma (2016) shows that, in post conflict countries, neopatrimonialism also becomes a particular basis of resource distributional strategies which bind elites to each other as well as to their social sources of support. This is because the persistence of weak institutions which unable to perform the functions and this affects, not just parties, but also bureaucracies which become vehicles for distributing political rents to support intra-elite relations as well as key constituencies (Erdmann and Engel 2006; de Waal 2015). This political attitude therefore makes democratic institutions and programmatic public policies become mere formalities – in reality, it represents neopatrimonialism relationships in which political actors bargain over the allocation of resources that suit their ends.

One particular form of patronage practice in Timor-Leste is prevalent in the formulation of development planning which involves approval from Parliament. Although, the Constitution gives the government bureaucracy rights over the control of national wealth which includes the right to use, possess and manage property and the capital needed for development efforts. However, government policy and budget allocation will always be challenged by the power of legislative elites, who are able to find opportunities to review and modify plans so they are in line with their own interests. This pattern means that policy outcomes continuously reflect contending interests among powerful groups, and provides a space for corrupt practices because state resources are allocated for private gain rather than promoting the welfare of the people.

In the meantime, parties which are supposed to be vehicles for representation and to reflect their constituents' interests impose some sort of discipline on their members by educating them regarding the limits of what is acceptable and then use their loyalty to generate support for particular political positions. Thus, in neopatrimonial systems, parties become vehicles for patronage, with support from the electorate flowing up through the party and

patronage resources flowing back down (Müller 2006). In these conditions, it becomes very difficult to trust a political party to provide protection to the poor except by distributing money to its members to ensure their support.

c. The Populist Model

As discussed above, patronage politics form a major part of elites' political strategies to maintain their power and interests and how it is conducted through allocating public resources to particular groups in exchange for their political support. This section discusses the political strategy that is especially significant in healthcare development, and which has become a significant political tool in development in many Southeast Asian countries; namely, populism. One characteristic of populist politics is, in fact, a top-down approach used by political leaders in government whereby they appeal to the people through symbolic substance in policies (visible and unsophisticated) that connects to moods and emotions (like enthusiasm, anger, frustration, resentment). Consequently, the policies themselves tend to shift according to popular opinion rather than rational decisions.

Most political leaders seek to present themselves as strong but, in the case of populist leaders, this is accentuated. In particular, these 'strongmen' project an image of themselves as concerned with action rather than words, often speaking against 'expert' advice and, instead, relying on charisma to attract support (Mudde and Kaltwasser 2017). According to Max Weber (1864–1920), charismatic leadership involves "the authority of the extraordinary and personal gift of grace (charisma), the absolutely personal devotion and personal confidence in revelation, heroism, or other qualities of individual leadership" (Weber 1946: p.4). From this definition, it is clear that there are several ways to gain charismatic power, including a set of historical 'conditions' linking popular elites and the people (Panizza 2005). Weber called this "revolutionary charisma" (Weber 1946). For instance, Nelson Mandela became a charismatic hero of South Africa due to his successful resistance against the apartheid policy. With charismatic power (combined with control of institutional decision-making), political leaders have strong emotional and affective bonds with the populace. These empower leaders to defend the interests of the masses and uphold national dignity, which requires a large degree of discretion in defining, framing, and pursuing popular interests.

Many authors have argued that, in most cases, populist leaders have used popular programmes as vehicles to carry their own ideology(s) of development (such as agrarianism, nationalism, neoliberalism, or socialism) (Pasquino 2008; Conniff 2012; Mudde and Kaltwasser 2017). Meanwhile, they continuously promise that their 'reforms' will improve the national destiny (Moffitt 2016). For example, the implementation of Venezuela's health revolution programme with the support of the Cuban government (from 2003 to 2013) was decided by Chavez' leadership without consultation with the populace. Instead, elites continuously emphasised the necessity of the policy to enable social transformation following the crisis in the 1980s (Hawkins 2010). While the programme successfully applied a combination of populist and socialist ideas to improve healthcare delivery, it largely served the elites' interests.

Interestingly, some authors argue that when it comes to redistributing resources, populists largely apply patronage machinery to deliver a 'better' life for the masses (Conniff 2012; Pappas 2014; Müller 2016; Kenny 2017). This indicates how a combination of populism and patronage political strategies can constitute a powerful way to sustain elite power whereby populism provides a space for politicians to engage with masses of voters and expand political networks, while servicing patron-client relationships.

Therefore, as Müller (2016) explains, populism promises nothing except reflecting the political orientation of the elites rather than that of the general population. Even where accountability mechanisms exist to evaluate reform programmes, populist elites are still able to subvert these (Kampwirth 2010). Moreover, as with patronage strategies, elites also maintain their popularity through being strategic about sharing information.

Some scholars argue that the routinization of charismatic revolutionary heroic leadership can be institutionalised within political organizations, leading to charismatic parties rather than simply charismatic leaders (Weber 1946; Panebianco 1988; Mudde and Kaltwasser 2017). According to Panebianco (1988: p.45), these involve "an objectification of re-utilization of charisma" which then constitutes the party's identity and "a transfer of loyalties from the leader to the organization". According to this, it can be argued that, in some contexts, regardless of their own level of charisma, political leaders could still use a charismatic revolutionary party as a vehicle (or mediator) to attract voters through the appeal of popular ideas to the electorate. Furthermore, many

studies have shown that a party's identity can become a decider of voter preference independently of leaders and political ideas (Marsh 2007; Taylor and Johnston 2014). Indeed, some research has found that this has a larger impact on voting choices than other factors (Lee et al. 2016).

From consideration of the issues relating to powerful elites and policy ownership, including the three main models of policy-making used by elites in development efforts in post-conflict environments, it is clear that elites may adopt liberal-technocratic, patronage and populist strategies in their leadership. It is important to make clear the fundamental differences between neopatrimonialism and populism in policy implementation as this is useful to understand the operationalisation of the two political strategies in Timor-Leste post-independence. As mentioned previously, neopatrimonialism/patron-clientism is a specific type of relationship in which people form vertical relationships with 'patrons' who provide benefits and protection in return for the loyal support of the client. Corruption tends to be patronage-based because money can easily be moved through personal networks; thus, development projects can be a form of patronage when they are used to strengthen links between certain leaders and particular communities. Meanwhile, populist politics focuses more on spending indiscriminately to ensure support from a large mass of people by implementing policies identified as reflecting a romantic idea of national identity, rather than reasoned analysis. Moreover, as discussed in the next two chapters, in Timor-Leste, elites use a combination of these two political approaches. In the meantime, it is very relevant to know how oil income from the Timor Sea affects the greater ownership of development in Timor-Leste, within the context of these three main approaches. To what extent does the oil wealth affect political relationships among actors in the country? Do petroleum revenues allow the Timorese government to have more autonomy in development? Do donors still have significant roles in development and who sets the development agendas and finances? Are social forces more or less able to loosen elites' grip on power? To answer these questions, it is important, first, to understand how oil revenues affect development policy, both generally and particularly, in the case of Timor-Leste.

B. Oil Revenues, Sovereign Wealth Funds and Elites' Political Control of Development

Previously, I have discussed three different types of policy-making. This section explores the link between the presence of oil money and the predominant types of policy-making, both in strong and weak states. Arguably, the existence of oil money in fragile institutions will be impacted by the resource curse as it encourages competition among powerful groups and exacerbates the dominance of patronage politics in state resource distribution. The institutionalist solution is to institute sovereign funds as a means to control oil assets and so mitigate the pernicious effects of natural resource wealth and benefit future development. However, the section concludes by arguing that this is not effective in preventing patronage practices because, in fragile states, institutions are weak so powerful social groups can simply dominate or abuse them for political ends.

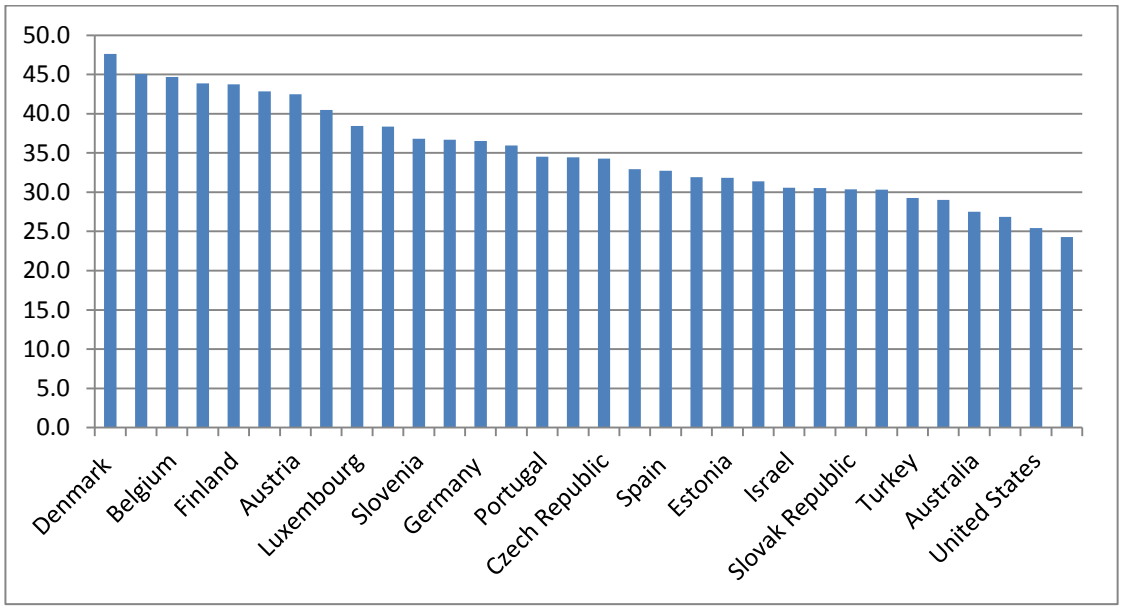
The term "resource curse" gained popularity after being introduced by Sachs and Warner (1995; 2001) and others; it is also called the "paradox of plenty" (Karl 1997). The basic premise is that countries with rich natural resources, such as oil and natural gas, tend to experience low levels of growth performance and poor democratic government compared to non-resource-rich countries. This is because the existence of oil money tends to make local leaders unable to create pro-poor policies (Ross 2012) and instead using it for their political ends (Humphreys et al. 2007; Luong and Weinthal 2010; de Waal 2015; Hicks 2015).

Some studies suggest the benefits/damage of oil wealth can be categorized along a scale that has Norway at one end, as a West European country that benefits from its oil resources, and Nigeria at the other, reflecting the experience of developing countries that are strongly affected by the resource curse. Following the presence of oil money, Norway experienced rapid and sustained growth during which its citizens were able to demand policies that benefited them, and the government responded positively to this. According to many authors, the key success of this oil rich state in avoiding the resource curse is the quality of its liberal democratic institutions which are able to produce quality policies and implement them effectively (Ross 2012; Shaffer and Ziyadov 2012).

Political economists argue that resources lead to competition among elites, and between elites and social forces. However, the key difference between Norway and Nigeria is the ability of the government to extract revenues from the people and distribute it as formal development expenditures so that it benefits the whole country. In his book, entitled *Strong Societies and Weak States*, Joel Migdal argues that only strong states are able to survive the resource curse – because they are able to extract resources and distribute them in accountable and transparent ways (Migdal 1988). In this context, countries in Western Europe (such as Norway and England) are considered strong states because they have the capacity to regulate oil incomes and collect extensive taxes from their citizens and distribute these resources for public needs.

As the bar chart in Figure 3.1 shows, Western Europe continues to have higher tax revenues compared to other states in the world, which also suggests the region's incomes are largely supported by tax schemes.

Figure 3.1: Total (All Levels) Tax Revenues as Percentage of GDP (2013)



Source: (OECD 2016)

The overall benefits of this tax money filter down to the general population through various redistribution programmes (Kessler-Harris and Vaudagna 2017). This suggests that extracting money through bureaucratized taxation has successfully enabled states to accumulate capital to fund their activities through payments from the population in transparent ways that can be challenged and that provide good quality public services (Burton 2013).

In contrast, the success experienced in healthcare development in Western Europe does not seem to be occurring in developing countries. Migdal argues that governments in these countries do not have the capabilities (particularly as relates to regulating and extracting resources) to achieve changes in society and he refers to these as the weak states, and asserts that they mainly exist in sub-Saharan Africa (Migdal 1988) Thus, the question arises: Why did these African states have fragile institutions and poor economies? What causal factors lie behind this situation? Bayart, in his effort to historicise African rule, seeks to answer these questions by arguing that the politics of patron-client networks made African states become weak (Bayart 2009). This political attitude means that resource allocation is distributed through informal ways (i.e., through patronage and corruption) instead of through formal processes (i.e., public expenditure and taxation) and this in turn means that development projects benefit small groups of people rather than the population as a whole.

Several authors have also demonstrated that patronage decision-makings have become a major vehicle for political power in many Asian and Middle Eastern weak countries that are rich in oil resources (Hinnebusch 2016; Kenny 2017). Although political leaders of these countries also used populism in their policy practices, this is just symbolic substance because the end result is that such policies are tailored with a particular focus on benefiting a narrow societal group which supports the elites in power. This is also the reason why, in his book *What is Populism?,* Müller (2016) argues that neopatrimonialism becomes one of the main features of populist governance.

According to liberal institutionalists, Sovereign Wealth Funds (SWFs)[12] are institutions that can be used to reduce the risk of the resource curse by enabling the state, on behalf of the citizens, to exploit and manage resource wealth and convert it to income for the public welfare. However, according to a political economy perspective, if powerful groups want to override institutional safeguards, they can and will easily do so. This links back to Migdal's argument on strong and weak states. Countries with stronger institutions (like Norway) are

[12]According to The International Working Group of Sovereign Wealth Funds definition:
"[SWFs are] special purpose investment funds or arrangements that are owned by the general government. Created by the general government for macroeconomic purposes, SWFs hold, manage, or administer assets to achieve financial objectives, and employ a set of investment strategies that include investing in foreign financial assets" (International Working Group of Sovereign Wealth Funds 2008: p.3).

more able to address the challenges of resource wealth and development and so benefit socially from petroleum funds. In contrast, managing petroleum funds in countries with weak institutions might not simply be about new policy on investment, but becomes a part of the ongoing political struggles among powerful social groups (elites and non-elites) which have agendas and interests in development. As a result, the effectivity of SWFs will depend on the political 'ideas' of the actors in the local context. For example, after creating SWFs, Papua New Guinea and Vietnam experienced economic loss because of corruption and asset mismanagement (Truman 2011).

The above argument shows that existing oil revenues will affect local ownership of development. As occurs in many weak states, the presence of oil revenues is followed by competition among actors over access to these resources. Since there is inequality of opportunity among people in society, development agendas will intensify this, predominantly benefiting elites and their power bases, since they own more control of resource allocation. This practice will almost inevitably exacerbate neopatrimonial attitudes in development, making policy ownership of oil budgets even more problematic. Thus, the impact on development policy in sectors such as healthcare then depends on elite and non-elite interventions and their relative powers in this field, meaning that ownership is a function of these rather than reflecting the needs of the populace.

C. Oil and Development Finance in Timor-Leste

The previous section explained how the liberal institutionalist idea to establish SWF institution as strategies for countries rich with oil resources to reduce the effects of the resource curse could not prevent elite political control on the allocation of the fund. In this section, the focus is on the specific situation in Timor-Leste post-independence where oil has become an important source of development. Here, the fear of the resource curse encouraged elites (with strong support from development partners) to establish the Timor Petroleum Fund. The purpose of this is both to reduce the effect of the resource curse and to share the oil wealth with the future generations.

In Chapter 1 highlighted that the massive scale of conflict and violence in Timor-Leste post referendum damaged infrastructures and encouraged many healthcare providers to leave the country, and was consequently followed by

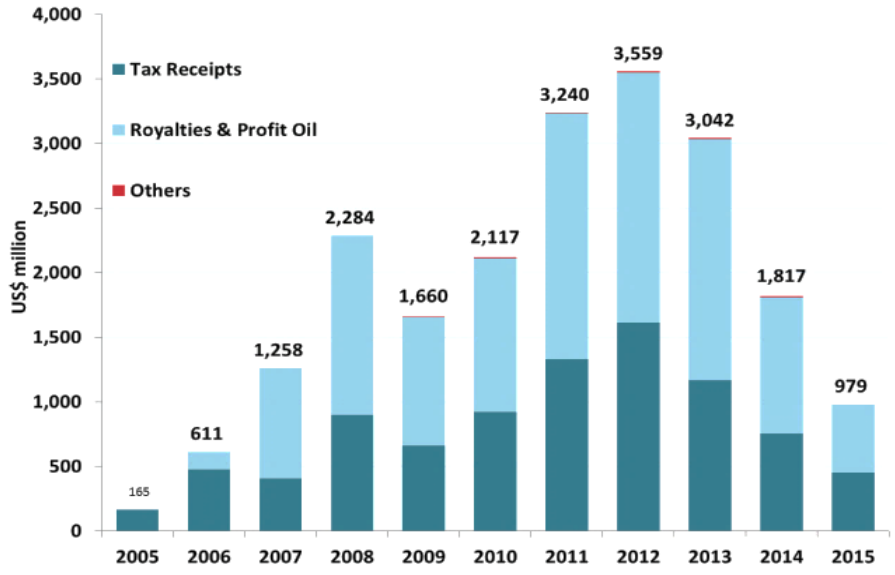
the collapse of the healthcare system. The existence of oil revenues from the Timor Sea gave some optimism to the Timorese people through the belief that these could be used as capital for the government to rebuild the health sector. Currently most of Timor-Leste's petroleum revenues have come from the oil fields of Bayu-Undan and Kitan. The Bayu-Undan field has the highest oil reserves, estimated to be about 400 million barrels, with the value of US$ 6-7 billion (Lundahl and Sjöholm 2008). Meanwhile, the Kitan field's reserves are estimated at only about 30-40 million barrels of oil (Offshore Technology 2016). Under the existing treaty, operations in the Bayu-Undan and Kitan fields are conducted under the Timor Sea Treaty (2002), which established the Joint Petroleum Development Area (JPDA), to be jointly managed by Timor-Leste and Australia, the two countries receiving 90 percent and 10 percent of the revenue field production, respectively.

Bayu-Undan went into production in 2004, but its profits increased significantly between 2007 and 2013 after the rise in oil prices and the massive scale of contemporary production. Kitan began oil production in 2011; however, since the field had limited oil reserves, production ended in 2016. According to expert predictions, Bayu-Undan's profitability can only lasted until 2022. After this, the Greater Sunrise field, which was discovered in 1995, will become a new important source of petroleum revenue for Timor-Leste and is expected to be larger than the Bayu-Undan field. It promises oil and natural gas reserves which are estimated at 226 million barrels and 5.13 trillion cubic feet, respectively (Seabra 2013). However, the Timorese government expectations to gain substantial additional revenues from the Sunrise project hit an obstacle due to maritime boundary disputes with Australia, which have stalled the Sunrise project. Consequently, it is still uncertain when the field will be developed, as discussed below.

Timor-Leste is extremely dependent on petroleum exports since oil money contributes more than 90 percent of the total Timorese government revenues. Since about 2007, Timor-Leste has received approximately US$ 2 billion a year on average from offshore petroleum projects (see Figure 3.2 below). However, huge and significant oil revenues are necessary for the future of Timorese health development to be managed in the ways that benefit both current and future generations; but problems associated with the resource curse, such as corruption and wasteful spending, are always likely to be a challenge to this.

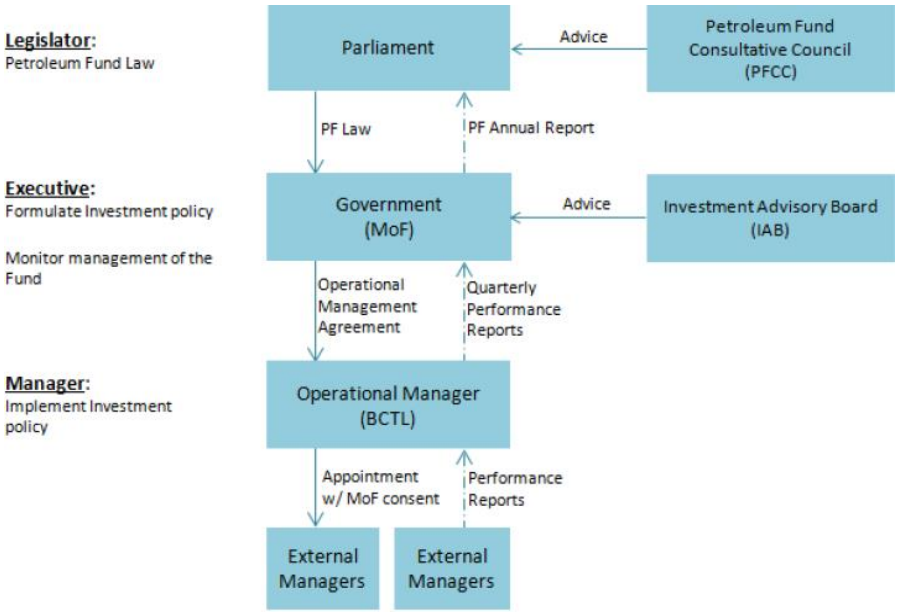
Therefore, the Timorese government considered the best way to reduce the effect this and to manage the oil revenues effectively is by setting up mechanisms such as establishing the petroleum fund.

Figure 3.2: Annual Petroleum Revenue



Source: (MoF Timor-Leste 2016)

Figure 3.3: Petroleum Fund Governance Structure



Source: (MoF Timor-Leste 2016)

Therefore, the Timor Petroleum Fund was established in 2005, following six months of public consultation involving local and international actors (Drysdale 2007; IMF 2007). It is based on the Norwegian model which is considered the best practice of petroleum sovereign management. Figure 3.3 (above) shows the clear division of roles in the Fund management. To assist the government in managing petroleum revenues, Parliament enacted the Petroleum Fund Law, which contains the main objectives of the Fund and the asset allocation guidelines. The Petroleum Fund Consultative Council is a forum consisting of various actors, including civil society organizations, mass media and private business sector, and has a mandate to control transparency and accountability of Parliament in relation to the Fund and to give advice regarding the performance and operation of the Fund and the effective use of withdrawals in the state budget.

MoF is responsible for the whole management of the Fund including formulating investment policy and strategy, monitoring and reporting progress (especially the Fund's financial status and investment portfolio) annually to Parliament for review and approval. According to the Petroleum Fund Law, the Investment Advisory Board (IAB) members are the Director of Treasury, the Head of the Central Bank, two persons with significant experience in investment management appointed by the Minister of Finance, and one other person appointed by the Minister. Its function is to give advice to the MoF regarding the investment strategy and management of the Petroleum Fund. Meanwhile, Sub-article 16.2 of the Law also strongly requires the MoF to get opinion from the IAB before making decisions regarding any investment or management of the Fund.

The Central Bank of Timor-Leste (CBTL) is responsible for the operational management and investment of the Fund. In keeping with the principle of transparency and accountability, minutes from the meetings of the IAB and CBTL are routinely posted on the CBTL website (Joseph and Hamaguchi 2014). The CBTL must also publish quarterly reports on Petroleum Fund's performance and activities (Government of Timor-Leste 2005).

Moreover, the Timorese government employs an internationally accredited external auditor to audit and report annually on the Fund's performance. As a member of the International Forum for SWFs, the Timor Petroleum Fund also conducts six annual self-assessments to ensure its management is in

accordance with the Santiago Principles.[13] All reports are shared with the public and available on both MoF and CBTL websites.[14] Internationally, the Timor Petroleum Fund has been recognized as having a high level of transparent and accountable management: “In 2010, Peter G. Peterson Institute for International Economics Ranked the Fund eight in its transparency index for sovereign funds, just behind the pension funds managed by the government of Norway, Canada, and France, and two US states” (Joseph and Hamaguchi 2014: p.52). Four years later, the Linaburg-Maduell index for sovereign funds also scored the Fund’s transparency and accountability as 8 out of 10 points (10 is excellent, 1 is poor) (MoF Timor-Leste 2016).

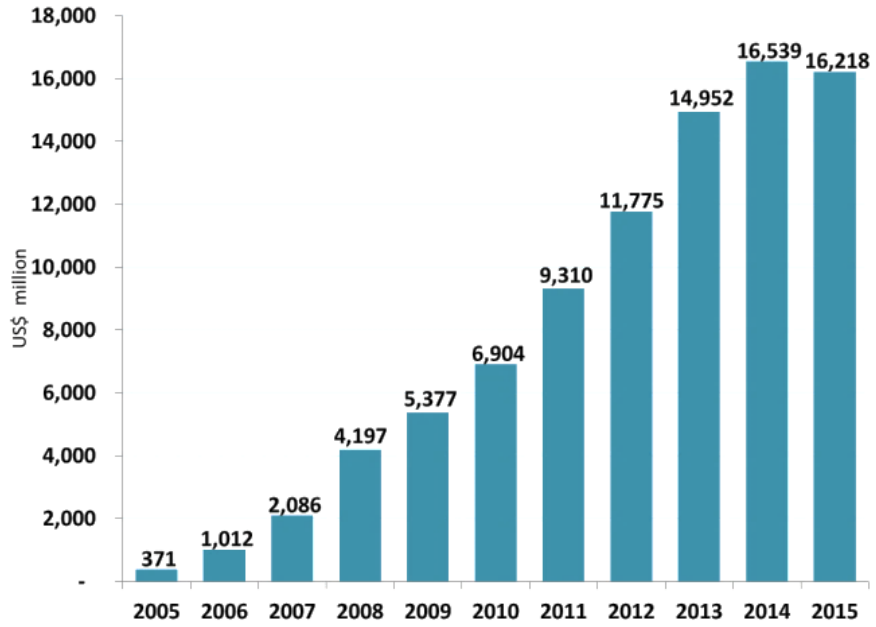
The National Petroleum Authority (ANP) is a Timor-Leste public institution which has duty for managing and regulating petroleum activities in Timor-Leste, covering the exploration, development, production, transportation and distribution of the fuel. The ANP is also required to report petroleum activities performance to the CBTL. The mechanism for managing petroleum revenues can be explained as follows: all of Timor-Leste’s petroleum incomes from Bayu-Undan and Kitan joint ventures are deposited into the Petroleum Fund. These incomes are invested according to the type of investment required by the Petroleum Law. Some of the interest generated from these investments is withdrawn to finance the state budget; however, based on the Estimated Sustainable Income (ESI),[15] this should not exceed three percent of the total interest for each fiscal year. When the government wants to withdraw more than this, it needs approval from Parliament (RDTL 2005). This is to ensure the sustainability of revenues so as to protect the economy from revenue shocks that arise because of the unpredictable nature of resource extraction and petroleum prices, and to ensure intergenerational equity in the distribution of benefits from petroleum wealth (McKechnie 2013).

According to the MoF, three factors affect the balance of the Fund, namely, petroleum revenues, withdrawals and net investment return. As shown in Figure 3.4, the market value of Timor’s petroleum fund has increased

[13]The Santiago Principles are a set of 24 voluntary guidelines for SWFs that were introduced in 2008 through a joint effort between the IMF and the International Working Group of Sovereign Wealth Funds.
[14]See www.mof.gov.tl and www.bancocentral.tl, respectively.
[15]Petroleum Fund Law defines it as “the maximum amount that can be appropriated from the Petroleum Fund in that fiscal year and leave sufficient resources in the Petroleum Fund for an amount of the equal real value to be appropriated in all later fiscal years” (RDTL 2005).

significantly for time to time. In 2005, it was only worth US$ 371 million while a year later, it went up to US$ 1,012 million, more than three times bigger. Similarly, from 2006 to 2007, the Fund's market value doubled, from US$ 1,012 to US$ 2,086 million, and again from 2007 to 2008. The highest market value was recorded in 2014 at US$ 16,539 million. However, a year later the Fund's balance slightly decreased to US$ 16,218 million. Interestingly, this fall of US$ 321 million was the first recorded since the Fund established and was related to the decline in global oil prices (MoF Timor-Leste 2016).

Figure 3.4: Market Value of the Petroleum Fund

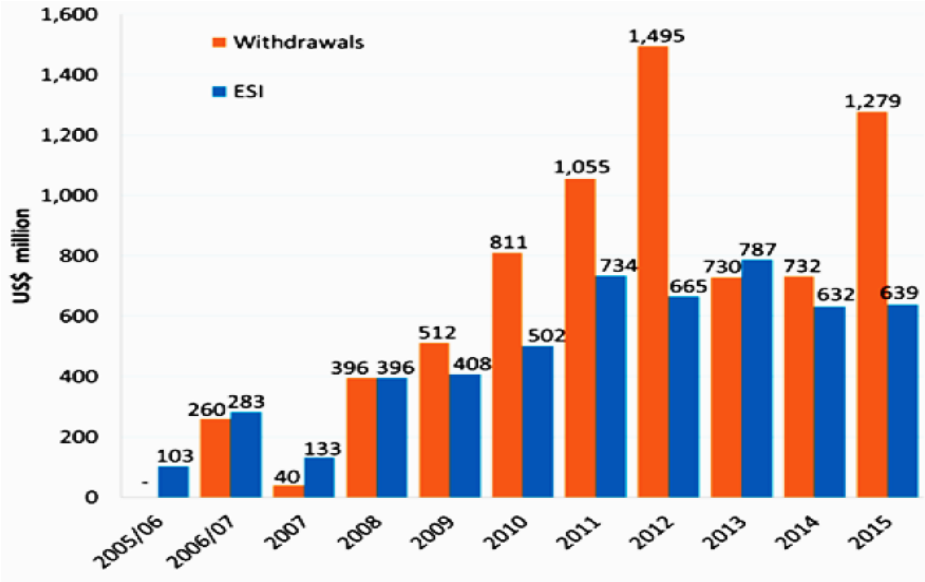


Source: (MoF Timor-Leste 2016)

The Petroleum Fund Law permits some income from oil exploration to be allocated to the state budget, as long as it is approved by Parliament. Interestingly, the use of oil money itself has become a debate inside Timor-Leste. Some leaders argue that the use of these funds should be controlled according to the Timorese Petroleum Fund Law so that it benefits current and future generations (FRETILIN 2007b). Meanwhile, others argue that the Timorese people have suffered a lot under many years of colonisation and they need to be liberated from all of their problems and poverty. There are two solutions put forward by this group: massive development programmes (particularly focused on improving infrastructure) and direct cash transfers to

widows, war veterans and the elderly (quoted in Aarons 2007). This demonstrates how the presence of oil money has created a new contest of power among Timorese elites in which actors use populist and patronage policies to capture oil resource allocation.

Figure 3.5: Transfer to the State Budget



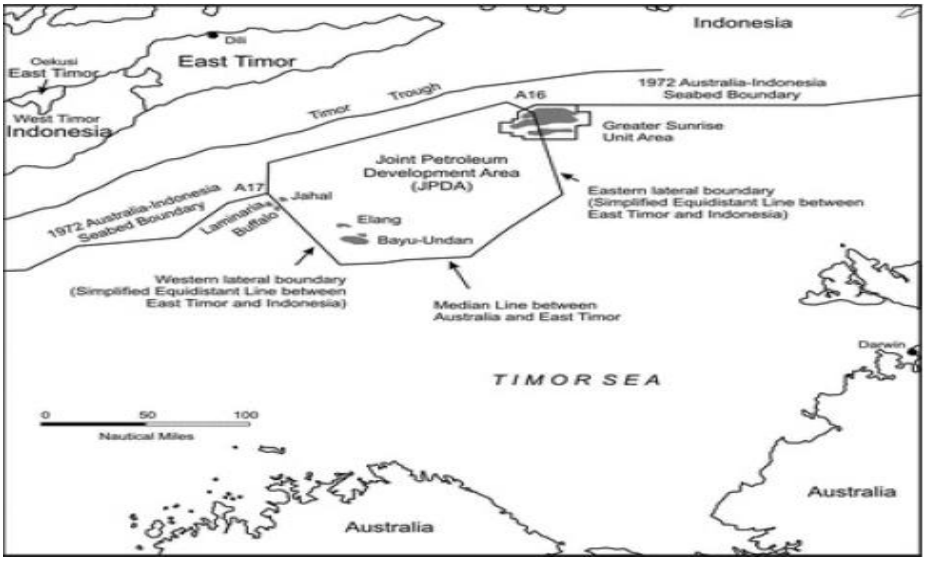
Source: (MoF Timor-Leste 2016)

Since Timor-Leste's development programmes are completely dependent on petroleum wealth (See Figure 3.5 above), the discovery of the Greater Sunrise field was very significant. However, the Timor Sea Treaty of 2002 stated that only 20.1 percent of the Greater Sunrise field falls within the JPDA; thus, Timor-Leste would get 90 percent of 20.1 percent (i.e., 18 percent) of the Sunrise oil revenues.

Later, Alkatiri, the prime minister at the time, argued that according to international law all known fields in the Timor Sea, including the richest deposits of the Sunrise field, should come under Timor-Leste's jurisdiction and, therefore, the country deserved the higher share of revenues (see the median line between Timor-Leste and Australia on the map in Figure 3.6). However, to date, the matter remains unresolved. Meanwhile, development of the Greater Sunrise field faced another obstacle in 2011 because the operator, Woodside Petroleum (an Australian company), wanted to process the oil in Darwin, Australia because there were already well-constructed oil production facilities there, while the Timorese government insisted that the oil be processed in

Timor-Leste so it would benefit the national economy. This would involve serious engineering difficulties and, since Woodside also had concerns about the political risks in investing in Timor-Leste, it has suspended its operations.

Figure 3.6: Oil and Gas Fields in Timor Sea



Source: (Joseph and Hamaguchi 2014)

Thus, the future development of the Greater Sunrise field remains uncertain while, if the petroleum reserves from Bayu-Undan become exhausted, future health development in Timor-Leste will rely on oil revenues from this – making the future of health development very uncertain.

D. Conclusion

This chapter elaborated on the conceptual framework used for understanding the relationship between policy-making in service delivery, powerful elites and institutions. It presented a critique of the liberal institutionalist approach, put forward by Fukuyama and Paris regarding the importance of good institutions for development policies. This argued that, in the context of early post-conflict environments, institutions are dominated by powerful groups and their political practices undermine the government's ability to create effective policies. Thus, this presents a critical point for understanding aid policy which tends to assume a liberal rationalist public service approach whereby policy is formulated primarily as a means to solve problems efficiently. However, it is well-recognised that policy formulation rarely if ever conforms to this ideal and that,

in post-conflict contexts, development policy offers an opportunity for elites to build political support through patronage and populist politics in state decision-making. This means that policy formulation and implementation will be 'owned' by particular groups of people rather than effectively delivered for the benefit of the whole population.

In the light of this, the rest of the chapter explored the implications of the shift away from the country's heavy dependence on international donors' aid to dependence on money from oil. Arguably, this would have given more flexibility to elites to establish development policies and so increase the potential for patronage politics. The liberal institutionalist approach of setting up SWFs sought to ameliorate this by providing a mechanism for controlling development spending and seeking to ensure that it would benefit the populace on a long term basis. Nevertheless, although regulations have been formulated to control the allocation of SWF income into the national budget, the weakness of Timorese institutions means that elites were still able to exercise power by introducing policy which was, in effect, an excuse for them to withdraw more money from SWF income in the name of securing 'development'.

Despite the use of SWFs, the literature suggests that the resource curse is a real danger for countries with weak institutions, like Timor-Leste in the early 2000s. This raises the question of whether the use of oil funding for Timorese healthcare budgets had a positive or negative influence on health policy and ownership. However, although some scholars have talked about a resource curse in Timor-Leste since the presence of oil money for development, this does not seem to have been an issue in healthcare. As explored in the following three chapters, patronage politics was not so significant in the health sector. In fact, while the oil money gave the government some scope for dealing more assertively with donors, policy-making in this area has tended to be populist rather than patronage-oriented. This has meant that the resource curse, which is strongly associated with patronage politics, is less significant in healthcare than in other areas of development.

While populist and patronage politics serve the interests of certain groups, the key to effectiveness in healthcare depends on how great contribution health professionals make to decision-making, and whether they have any degree of ownership of the processes involved in policy-making and implementation. Doctors and nurses have intensive communication with patients, giving these

professionals a good understanding of social and cultural context of the health service, and insight into the best delivery approach to improve the conditions. Therefore, it is especially important in relation to healthcare, that government, as policy maker, applies a bottom-up approach, responding positively to the opinion of health professionals about what makes an effective healthcare system. Through this, a contextual health delivery model can be established, living conditions improved and more lives saved.

The remainder of this thesis explores whether the availability of oil money empowered the MoH vis-à-vis donors, and considers the evidence that this prompted a strong emergence of patronage policies in the healthcare field despite the absence of strong economic interests in this area. It also examines how healthcare decisions were driven by a mixture of populism on the part of political elites and pragmatism or technocracy on the part of the MoH, looking also at the extent to which ordinary healthcare professionals had a voice in this process, if at all. To make clear the context of these arguments, the next chapter looks specifically at the development of elite groups in Timor and the pattern of their political strategies to sustain power and to benefit from health policy since colonial times until the recent period of government.

Chapter 4: The Political Economy of Healthcare in Timor-Leste: Legacies of Colonization and Revolution

This chapter examines the ways in which healthcare in Timor-Leste has been approached under the various administrations since Portuguese colonial times. This demonstrates how, since the presence of the first colonial power, the politics of development has often been a tool of elites to maintain their power and interests. In particular, elite political practice has affected the quality, quantity, access to, and availability of healthcare. The previous chapter highlighted three aspects of this that are considered particularly decisive in producing a specific pattern of outcomes regarding healthcare: populist policy-making, patronage politics, and public service-oriented/liberal-technocratic approaches. As discussed earlier, populist policy-making is policy-making that is concerned with promoting a particular party identity to win votes or mobilize support, but which pays little attention to the details of implementation or with evidence of success. Patronage-based politics is primarily oriented towards the ability to reward loyal sections of the population at the expense of others, often through special treatment or through misappropriation of funds. Public-service oriented policy-making is focused on diagnosing problems and adopting a technical approach to resolving those problems based upon ideas about best practice, but in practice, this also largely benefits elites to access better public services.

These separate tendencies operate in a social context of a strong culture of traditionalism in Timorese villages where the majority of the population live, which has also significantly affected the outcomes of healthcare policies. This chapter also reviews the historical context – Portuguese colonialism, the first FRETILIN administration, and the Indonesian colonial system – to show the precedents of the contemporary actors and their ideas and approaches. These discussions are important to a political economy approach to understanding the context of the struggle among actors over development in Timor-Leste post-independence.

The structure of chapter is as follow: The first section examines how the health system has been developed in the post-independence era and how the politics of elites has had a limiting effect on the efforts of the MoH to deliver

better healthcare to the population. The next three sections focus on phases of the historical development using some original interviews with professionals from Indonesian era (despite their potential bias) and archival work from Indonesian documents to supplement the academic research. The discussion starts with the politics of elites during the Portuguese era and also introduces the early significance of the Church in Timor in the second section. Following this, the third section examines healthcare development and the politics of elites under FRETILIN authority (1974-1978), and then explores the formation of Timorese elites that followed the Portuguese occupation, highlighting their political ideas and where their political inspiration came from. The fourth section follows a similar structure: it examines efforts that the Indonesian government made to develop the health system of Timor-Timur (as East Timor then became known) and how the politics of elites continued to affect healthcare delivery. In this section, the discussion demonstrates the influence of the neoliberal approach to health on current senior healthcare professionals who now work as civil servants in the MoH Timor-Leste, having received a medical education from the Indonesian government. Finally, the last sections will give summary of the argument of this chapter and discusses its implications for the overall thesis.

A. The Politics of Healthcare in the current Timorese Government

This section introduces the key actors who play important roles in shaping development policy in Timor-Leste, namely, the MoH, the different political parties and the key healthcare professionals. It starts with a brief overview of the current healthcare system to show how it has been developed in the post-independence era, focussing on the achievements and shortcomings of the MoH efforts to improve the health status of the Timorese population. However, as discussed in the second part of this section, the politics of the elites has a greater influence on the design and implementation of healthcare programmes that aim to deliver quality services.

The first chapter of this thesis explained how post-referendum conflict caused the total breakdown of the healthcare system. As a result, the health status of the population was in an alarming condition. In response to this situation, the Ministry of Health (MoH) – as the institution responsible for coordinating all healthcare policies and activities – has made proactive efforts to

upgrade services through imaginative policies and introduced a national health system with aims to ensure that access to health services is extended to the rural population.

Currently, Timor-Leste has private and public healthcare providers, both of which are monitored and regulated by Central Government. The private sector includes for-profit clinics and offers professional health services: it has local and international, multilingual medical teams and specialists with a great deal of experience in healthcare, and who are supported by convenient facilities, 24-hour medical services and quality drug supplies (Stamford Medical Lda 2013). Studies have suggested that these private health providers offer better services than those supplied by government (see World Bank 2006c; Palagyi et al. 2008). Some private clinics also have partnerships with international healthcare providers, which allows them to get international specialist support and, in certain circumstances, may enable patients to receive treatment abroad. Patients seeking treatment at private clinics, most of which operate in the cities of Dili and Baucau, are required to pay the full cost of medical treatments; for instance, Stamford Medical Clinic in Dili charges US$ 70 for a health consultation (excluding medication) (Stamford Medical Lda 2013).

Meanwhile, the Constitution guarantees that all Timorese people are entitled to get free healthcare (even for treatment abroad) using the public services provided by the national health system, which the government funds through the MoH. The service operates at three levels: subdistrict, district and national level. Subdistrict health services focus on delivering primary healthcare services and comprise community-based healthcare activities (integrated using mobile clinics), health posts and community health centres. The community-based activities and motorbike clinics have a central role in the healthcare system because they constitute the first medical contact with the Timorese population who predominantly live in mountainous areas where it is difficult to access health facilities due to geography and distance. For instance, some poor families in the Manufahi and Lautem districts have to travel more than 50 km to reach healthcare facilities (Wild et al. 2012); this means that some have to walk more than two hours and face other difficulties to access health centres due to poor transport infrastructure (Amin et al. 2013). Health data relating to the population is collected through these community and mobile-based activities, along with health promotion and education programmes. These aim to ensure

the population is able to get proper health intervention and knows how to follow healthy living practices.

Health posts are situated in villages with populations between 1,500 to 2,000 people. These form the first line of the curative and preventive care services, and each consists of a team of one nurse and one midwife, and has facilities for medications and drug supplies. By 2020, according to government plan, there will be a health post for every 1,000 to 5,000 people, staffed by a doctor, two nurses and two midwives. For villages located more than one hour's walking distance from a health post, the MoH will allocate a trained midwife or community health worker, equipped with health kits and transportation (RDTL 2011).

The community health centres consist of 10-14 health staff and mobile clinic services (i.e., ambulance and motorbike), and can be accessed through a radio communication network. These health centres offer different types of service depending on the size of the catchment population and the distance from referral health facilities. Few have inpatient facilities, many do not; some provide basic health services like curative consultations, maternal and child healthcare, mental support, immunization and nutrition programmes, and health education and health promotion activities. Small portions are also equipped with additional services like dental clinics, laboratories for antenatal care and treatment of malaria and tuberculosis; some have 2-4 beds for inpatient observation, while others have 10-20 beds with laboratory facilities for essential tests. At present, at subdistrict level, Timor-Leste has 66 community health centres, 212 health posts, 42 maternity clinics and 477 integrated community health activities operating in 65 subdistricts, 442 villages and 2,225 hamlets (National Statistics Directorate RDTL 2010). By 2020, Central Government targets aim for each community health centre to provide healthcare for 5,000 to 15,000 people, coordinate health services in four health posts and focus treatment to specialist care (RDTL 2011).

Timor-Leste also has referral hospitals in five districts: Baucau (Baucau Referral Hospital, with 114 beds); Bobonaro (Maliana Referral Hospital, with 24 beds); Ainaro (Maubisse Referral Hospital, with 24 beds); Oecusse (Oecusse Referral Hospital, with 24 beds); and Covalima (Suai Referral Hospital, with 24 beds). These referral hospitals provide secondary care services in response to referral by a primary care professional. To fulfil its primary function, each of the

referral hospitals has inpatient, outpatient and emergency departments and is staffed with general practitioners and specialists in four clinical areas: surgery, paediatrics, gyneco-obstetrics and internal medicine. Tertiary care services are provided by the National Hospital Guido Valadares (HNGV) with 264 beds in the capital city, Dili. In addition, HNGV also has links with hospitals in Australia, Indonesia, Malaysia and Singapore, for patients needing special tertiary treatments unavailable in Timor-Leste. By 2030, the Central Government expects to have 13 district hospitals plus a specialist hospital in Dili; moreover, all health facilities will function continuously and be able to treat chronic diseases (RDTL 2011).

There is evidence that the implementation of the current health system has made considerable progress. Between 2003 to 2010, there were reductions in the infant mortality rate (from 88 to 44 per 1,000 live births) and the under-fives mortality rate (from 115 to 64 per 1,000 live births) (RDTL 2012b). The coverage for three key immunization vaccines (BCG, OPV3, Penta3)[16] has increased from 41 percent in 2002 to more than 80 percent nationwide in 2013 (Global Vaccine Alliance 2014). In 2014, the WHO for the Southeast Asia Region (WHO-SEARO) has given an award to Timor-Leste because the country had successfully reduced the number of malaria deaths: from 68 in 2006 to 3 in 2013 (WHO-SEARO 2014). Moreover, the MoH has been able to recruit a huge amount of human resources for healthcare. For instance, under a bilateral agreement with the Cuban government, the country has successfully educated around 800 Timorese doctors in Cuba; all of whom have graduated and been deployed in public health facilities. In addition, a number of doctors, nurses, midwifes and public health officers have been trained either in local or overseas institutions (Asante et al. 2014). Data in 2010 shows Timor had 9 medical specialists, 30 doctors, 1007 nurses, 431 midwifes, 128 laboratory technicians, 137 pharmacists, 17 radiologists, 164 public health officers and 1101 health managers and administrators (MoH Timor-Leste 2011).

Despite the positive developments described above, some challenges still remain, and these occur at all levels. At village level, for example, only half of the 477 integrated community-based activities were fully functioning across the country (Martins and Trevena 2014). Pregnant women in villages with low living

[16]BCG is the vaccine for tuberculosis; OPV3 is the vaccine for polio; Penta3 is the vaccine for diphtheria, tetanus, pertussis, hepatitis B and haemophilus influenza type B.

standards[17] seldom received help from a skilled birth attendant: only 12 percent, compared to 50 percent in villages with the highest living standards (Asian Development Bank 2013). In addition, a number of health posts and community health centres have recently been built with inadequate physical conditions, insufficient health staff and specialists, poor technology and mobile facilities, no clean water, lack of drug supplies, limited access roads and electricity (Amin et al. 2013; Anderson 2014a; Asante et al. 2014; Asian Development Bank 2014; Diario Nacional 2015b). Although some health centres have ambulance facilities, the number is still limited and cannot serve all patients with serious illnesses. This often means that people receive medical treatment too late and some die, both on the journey and in the district hospital (Centre of Studies for Peace and Development 2010).

According to a MoH report, some districts like Baucau, Manatuto and Viqueque have a larger coverage of measles vaccination (above 80 percent) compared to the other districts (RDTL 2012b). Also, although the National Hospital is considered to provide the highest standard of healthcare service across the country, many Timorese still question its professionality. This was highlighted by several recent cases. For instance, the capacity of Dili National Hospital often does not have adequate room for the number of patients as reported by the Timor Post, the local newspaper, on 11 January 2016: 300 patients visited the HNGV and the hospital has only 264 beds. This situation forced some patients to use additional beds and stay in the hospital's halls (Timor Post 2016). The author personally witnessed this situation on several occasions when visiting the HNGV to interview doctors, midwives and nurses.

Moreover, the weak management and leadership capacity have also partially contributed to a number of deaths in the National Hospital. During the fieldwork, the author heard information from local people that a patient had just died in the HNGV due to lack of oxygen supplies. On enquiry, a Member of Parliament from Commission F (which is in charge of the health sector) explained that the problem was not because there was no oxygen but, rather, the person who was responsible for giving replacement oxygen to the patient was not in place when their services were needed (Respondent 43). Meanwhile, other staff did not have the capacity to access the oxygen necessary to save

[17] Typically, they work in agriculture, live in a poor housing, have limited means of transport, and stay far away from Dili and district centres.

the patient's life. In response, through a letter addressed to the MoH, Commission F requested the Ministry to conduct an investigation and improve hospital management and human capacity to avoid the same problem occurring in the future (Comission F National Parliament Timor-Leste 2016).

Medical facilities and human resources for certain diseases are not available in the HNGV although it offers tertiary treatment. McCall says: "Timor-Leste has no MRI scanner. There is one CT scanner but it is old. The only radiologists are two Cuban doctors. Radiology is limited and the machines often break down because of overuse" (McCall 2014: p.201). Even when the health technology is available, it is limited in quantity and none of the local health specialists are capable of using the machines, safely and effectively; some cannot work the machines properly or are not capable of dealing with complex medical surgeries. As with the case mentioned above, patients have been reported to have died as a result of the limited technology and human resources, including the nephew of a national parliamentary member (Diario Nacional 2015c). Furthermore, Timor has no medical specialists for diseases like tumours and cancer (Quintão 2016b). This means that patients with certain 'special' health issues have to be sent abroad – through a local newspaper in May 2015, Director of HNGV states that there were 30 patients received international medical treatment and the details as follow: 25 kidney failure patients and 5 dialysis patients (Diario Nacional 2015a).

In terms of drug supply, there is poor coordination between the MoH, the Timor-Leste Medical and Pharmaceutical Supply Agency and HNGV regarding the procurement of pharmaceuticals; consequently, some types of medicines are often out of stock. In 2015, the Head of the Pharmacy and Nutrition Department in HNGV reported that 120 types of vital drugs were not available in the country. These included antibiotics and drugs for malaria, pain, tetanus, and high cholesterol etc. (Timor Agora 2015). Meanwhile, some health facilities have experienced unequal supplies of drugs (World Bank 2006c; see also Norris et al. 2007), and some medical supplies were found to have expired due to discoordination and delays in procurement and distribution (Quintão 2016a).

Political decision-makers are important actors in determining healthcare priorities and processes. The next part of this section introduces key features of the political elites' activities in Timor-Leste; while the origins of the different parties and factions are discussed in later sections. Arguably, the existence of

poor performance in healthcare service delivery is partially rooted in the politics of elites who used their power and control to decide priorities of development that benefits particular groups, at the expense of the general Timorese people who largely live in rural areas and struggle to get better access to healthcare.

The rest of this section examines how elites have used the three political tools, introduced in Chapter 3, as a means to winning 'ownership' of development agendas and so sustain their power in the healthcare context of Timor-Leste post-independence. Firstly, populist policies have been used as a way of capturing public political support. For instance, in 2010, the Central Government launched the National Strategic Development Plan (NSDP) 2011-2030 which arguably reflects the 'wishes' of the Timorese regarding development, including the commitment to strengthen the health sector. This has been incorporated into an infrastructure strategy that focuses on highly visible items designed to impress the public, while also offering opportunities for patronage through procurement (see RDTL 2011). Under the Plan, the Central Government gained a legitimate means to withdraw more money than was covered by its ESI for the overt purpose of improving public infrastructures (Shoesmith 2011). However, in reality, some sources indicate that this strategy was not so much concerned with improving and increasing access to public health in rural areas as with political trade among Dili-based elites. For example, Xanana Gusmão, the Prime Minister at the time (2007-2015) awarded certain infrastructure projects in Oecusse District to the opposition party which, in exchange, now supports Gusmao's leadership and policies – this is discussed further in next chapter (Leach 2014; Office of the Presidency 2016; Strating 2016; Leach 2017a).

Not surprisingly, anecdotal evidence suggests that the political strategy of the elites in building legitimacy via populist policies received at least some public healthcare users support in relation to the government's policy of equating improved health with infrastructure investment rather than healthcare deliver issues. One user interviewed during the fieldwork, for example, commented: "How can we have quality health services if we don't have a better hospital infrastructure?" [author's personal translation] (Field journal notes, 20 February 2016).

Secondly, neopatrimonial practices have become increasingly important in political decisions; instead of responding effectively to the needs of the people,

elites allocate public resources in ways that benefit their powerbases, increasing corruption and nepotism in the government. A clear example of this can be seen from the implementation of the international referral system which benefits elite political networks rather than the general public (Scheiner 2015). For instance, some Timorese officials accused the government of prioritizing international treatment for Ronaldo Guterres, the son of former pro-autonomy guerrilla, Eurico Guterres, while many other pro-independence veterans living in the districts were sick and eventually died due to physical and/or mental illness. Arguably, this 'special treatment' was made possible because some Ronaldo's families and friend-connections were holding positions in the government, and thus was able to 'press' MoH to provide authorization so that Ronaldo can get medical treatment in Singapore (Jornal Nacional Diario 2016a). Meanwhile, due to limited facilities and health specialists both in urban and rural areas, poor people continue to be only able to access inadequate quality healthcare (Diario Nacional 2015a; Murdoch 2017). For example the patient, described above, who died in the National Hospital due to lack of oxygen.

Thirdly, although a liberal-technocratic approach has been used to improve healthcare services, the implementation of the policy has – again – given more benefit to the elites rather than the larger population. This is particularly in relation to policy covering healthcare referrals abroad whereby political leaders control the allocation of resources to benefit themselves. Therefore, although the quality of tertiary care in Timor-Leste is poor, this does not seriously affect the elites. Officially, the MoH has a team to evaluate whether a patient should be sent abroad or not – considering how chronic the disease is and how likely it is to be cured. If the National Hospital has the ability to treat the patient, then the committee will recommend that the person should get medical care in Timor-Leste. However, this is not how the system works for elites; rather, a number of sources suggested that people with the appropriate connections can use the referral policy at any time and for any health issues, without following the official procedure. For instance, when Gusmão had a back problem, he was sent to Indonesia to get medical treatment at the country's expense (Tempo Semanal 2014a; 2014b).

On the other hand, the amount of public debate over a widely reported case of a woman who could not obtain a referral for treatment abroad suggests widespread distrust of political elites and the popular belief in Timor-Leste that

connections count. This was happen to a patient with a tumour in which her referral trip to Bali was cancelled because MoH argued the operation can be done in Timor. She explained in an interview with a local newspaper about this unfair treatment which also experienced by many Timorese patients: “We’re not blaming the government, they have a good policy, but those who implement it must implement it well, not treat their families better than others and take them abroad for healthcare because in reality, some women have died on the plane on the way” (quoted in Quintão 2013). Meanwhile, the MoH argued that in this case an international referral was unnecessary and the woman did not have the appropriate paperwork from her healthcare facility (quoted in Quintão 2013).

However, in a different case, the National Director of Hospital Support Work in the MoH, Horacio Sarmento da Costa, admitted that the MoH had transferred a patient to Surabaya, Indonesia, because the patient (and his family) had made a contribution in struggle for independence; this referral was also supported by the Ministry of Justice (quoted in Quintão 2013). During a fieldwork interview, a current employee of the Commission for Anti-Corruption (CAC) also criticised the lack of transparency regarding the cost of referring people abroad (Respondent 42). This highlights the potential for corruption whereby some elites divert the government budget away from primary healthcare in rural areas and towards referrals abroad, which largely benefit elites. These examples suggest that, in some cases, the MoH prioritised some people’s need to get international medical treatment because of their past contributions combined with pressure from elite actors, rather than implementing policy in accountable and transparent ways.

The three political strategies of elites, described above, have contributed to the lack of quality and general accessibility of healthcare delivery and so is a significant constraint on the programme to make modern healthcare more beneficial and accessible to the poor. As a consequence, poor rural villagers continue to use traditional healthcare because it is affordable and accessible compare to modern medicine (Price et al. 2016). Although the health service is free, many Timorese people still believe that traditional medicines and treatments are more efficacious than modern ones. Some even argue modern medicines might be harmful to them and their family members (Pillay 2014). This is the main reason why more than 80 percent of women in Timor-Leste give birth at home with the help of traditional birth attendants, despite clear

government policy stating that all women should give birth in a health facility (World Bank 2006c; see also Global Vaccine Alliance 2011). Arguably, the availability of international referrals for well-connected elite and middle-class families, combined with the availability of the alternative of traditional medicine for the poor, has contributed to a lack of significant public pressure for better healthcare in Timor-Leste. This situation also reflects decades of failure to provide modern healthcare for the poor, which arguably has led to low expectations in this area.

This section provided an overview of the current situation regarding healthcare in Timor-Leste and discussed the politics of elites that exacerbates the unequal access and quality of healthcare in post-independence Timor. The remainder of the chapter analyses the politics of healthcare since the colonial era in Timor-Leste and discuss the pattern regarding the three key aspects of the political economy affecting health services; namely, populism, patronage politics and the desire to focus on technocratic policies that support elite interests.

B. The Politics of Healthcare during the Portuguese era

Long before the arrival of the Portuguese, the island of Timor was populated by about 300,000 people who largely lived in the mountainous interior (Brière 2004). The island was divided into 40 to 50 autonomous kingdoms, with a *liurai* (king) at the top of each social structure (Hill 1976; Robinson 2001). The kingdoms were made up of a number of *sucos* (villages), each led by a *dato* (prince), whom the Portuguese called *chefe de suco*. Sucos consisted of *ahi matan* (clans or hamlet units), which the Portuguese called *povoacoes,* each of which also had a dato. The lowest rank in the traditional administrative system was the *umakain* (settlements), which were also controlled by a chief who had direct contact with the *ema-reino* (commoners), who largely lived by subsistence agriculture from crops such as corn, potatoes, cassava, rice, coconuts, and bananas. Over time, these various kingdoms and chiefdoms intermarried, feuded and traded relationships with each other, while maintaining the geographical boundaries between territories and using *Tetum* as the *lingua franca* for social interaction.

In Timorese traditional autocracies, the liurai was known as the greater chief. Meanwhile, the datos in sucos and povoacoes were known as the lesser chiefs and fulfilled advisory roles to the liurais (Taudevin 1999). These three classes were considered to have noble blood and were eligible to be elected as political rulers. The appointment of political leaders, however, was based on rituals where elders sat, discussed and chose the most skilled person from the 'right' descendants. As the central part of society, the liurais held absolute power at the top of a structure that enabled them to gain most benefit from civilization. They emphasised their high position by wearing better clothes and they had ceremonial and ritual duties, married only within their class, and received free healthcare and herbal medicine from *matan-dook* (indigenous healers), who came from the dato class (Morris 1992; Davidson 1994). Liurais also received agricultural tribute from the community (Davidson 1994). Lastly, through their power and control, the liurais were able to declare war or make deals with foreign and other leaders, and generate resources from their political decisions (Ospina and Hohe 2002; Gunn 2007).

The arrival of the Portuguese between 1512 and 1522 presaged the reduction in the power of the liurais. The territory was declared a Portuguese territory and became incorporated into the colonialists' administrative system. Initially, they built their administrative centre in Lifau, Oecusse. The presence of the Portuguese colonisers played a dual role in Portuguese Timor with military commanders imposing colonial rule while priests facilitated the assimilation of the local people into Portuguese 'colonial norms'. This was because, instead of getting economic and political benefits from the occupation, the Portuguese government through their priests was able to build monasteries and schools as instruments of a 'civilising mission': they educated people about Catholic and Portuguese cultural values (Aritonang and Steenbrink 2008). The Catholic church also provided a mix of modern and traditional healthcare treatment (such as detection and neutralization of sorcery, and magical practices appealing to spirits) for the Timorese population (Soares 2002).

However, Portugal's stronghold was interrupted in the 16th century when the Dutch landed in the western part of the island and became a competitor of its colonial rule. Rivalry among the two colonial powers ended in 1859 when both agreed on a colonial border: the east and the north coast pocket of Oecussi in the west were to belong to Portugal, while Holland controlled the rest

of the west. Consequently, the Portuguese moved their base to Dili and focused their colonial practices on the eastern half of the island.

Since early colonisation, Portuguese military administration used the politics of divide and rule to control the Timorese people (Traube 1995; Carter et al. 2001; CAVR 2005). They took advantage of conflicts between liurai elites, particularly in dynastic feuding, by empowering some groups and disempowering others. In his doctoral research paper, Davidson (Davidson 1994: p.143) provides an example of this strategy:

> Governor Affonso de Castro sent Major Cabreira to make secret negotiations among various kingdoms, here promising money or extra land, there dispensing tribute or titles or promotions among the elites. The result of his intriguing was to draw other liurais, particularly Vemasse and Manatuto, into the conflict. At the height of the fighting Liquica, Hermera, Cailaco, Deribate, Leimean, Atsabe, Caimauc and Maubara were supplying *arraiais* (traditional militias) to fight on the Government side against the peoples of Ulmera, Laclo, Hera and Manatuto.

After successfully weakening the 'rebel' kingdoms, the Portuguese authorities awarded military positions and power to pro-Portuguese liurais and their families, who thus gained privileges and economic benefits from the colonial administration that the majority of the people could not access. Constâncio Pinto, a former activist of the Timorese self-determination movement, explained:

> My mother comes from a liurai family ... My mother's family led a modest life. They had a few animals and possessed some land and, like all liurais to varying degrees, were Portuguese collaborators, helping to uphold Portuguese colonial law (Pinto and Jardine 1997: p.27).

At the same time, the politics of divide and rule was successful in localising resistance to Portuguese authority, weakening and disuniting Timorese society in the process. For instance, various forms of uprisings emerged, including rebellions against local liurais and datos and wars among

clans or ethnic groups, as well as assaults on Portuguese power per se (Gunn 2001).

In the late 19th century, having benefitted from rapid advances in military technology, Portugal had ambitions to increase its territorial administration. This included the integration of traditional system into the colonial structure of administration. Under this new administrative system, Timor became an overseas Portuguese province, headed by a governor who was the most powerful actor on the island. Although the liurais continued to exist, they were not included in the new system.

Under the governor, there were the district administrator (*administrador do concelho*), the subdistrict administrator (*administrador or chefe do posto*), the head of village (*chefe de suco*), and the head of hamlet (*chefe de povoacao*). According to Portuguese regulations, only those of noble blood were permitted to hold the position of village or hamlet head (Saldanha 1994). The introduction of the new structure of administration had two political implications for the traditional rulership. First, it undercut the position of the liurais while empowering leaders at the suco level, whose appointment as administrators was subject to Portuguese approval. Secondly, since the power of traditional aristocracies was destroyed, kinship alliances among liurais were further diminished and, thus, the Portuguese were able to exercise more effective political control over their colony (Taylor 1995).

In the economy sector, the colonial power introduced coffee as a new cash crop for export, replacing sandalwood. However, unlike sandalwood, coffee plantations needed intensive labour. For this reason, the Portuguese forced Timorese labourers to work on large plantations, with inadequate working conditions, low wages, and severe punishments to those who slackened or fled. Meanwhile, they changed the traditional payment of tributes into a system of tax that was compulsory for all males over the age of 18, whether working or not. Interestingly, they also applied the politics of divide and rule to tax law; they employed the liurais as tax collectors, giving them a 25 percent collection fee, those who could not pay were to be beaten up (Carter et al. 2001).

However, while some liurais cooperated with this, many were not happy with the Portuguese political economic policies and formed an alliance to fight against the colonial power. In 1912, the tensions between this alliance and the

Portuguese military escalated into the Manufahi War; this was led by the liurai of Manufahi, Dom Boaventura, and cost 25,000 lives. With the help from colonial armies in other colonies, the Portuguese were able to crush the rebellion and, following this, they were able to have full control of the administration of the territory until 1975 – apart from a single major armed challenge in 1959, which was initiated by Indonesian exiles rather than locals.

While the Portuguese remained powerful in the territory, the fascist New Order regime emerged in Portugal. This introduced a 'civilizing mission', according to which the population of Timor were divided into two categories: assimilated and unassimilated. Assimilated referred to those who had capabilities equal to 'Portuguese standards' of civilization (such as educated, Christian and able to speak Portuguese) (Hill 2002). By denying equality of rights among assimilated and unassimilated people, the mission was able to justify oppression of the majority unassimilated population by the few assimilated elites. A census conducted in 1950 showed that only 1,541 Timorese were assimilated, a further 2,022 inhabitants were *mestiço* (the offspring of white Portuguese and indigenous women) and 3,902 were non-indigenous, including Europeans, Chinese and Goans (Weatherbee 1996). Meanwhile, the rest of the Timorese population (434,907 persons) were unassimilated. Most assimilated elites had voting rights and lived in Dili, which had health facilities and supporting infrastructures (Goodman 1997). Thus, they enjoyed the 'luxury' of a health service provided by the colonial authority. Meanwhile, the larger part of the population lived in rural villages spread throughout the mountains, and continued to use traditional healthcare practices (Saldanha 1994).

Public health began receiving attention from about 1918 through to the 1930s, based on a rationalist approach. During this time, the Portuguese trained health personnel established two hospitals (one for public and another one for military) and four clinics to provide healthcare service for the population (Jose Martins, in Krieger 1997; Ingram 2008; Fonseca and Almeida 2014). A more substantial effort to improve healthcare services started after World War II. Under a Five-Year Development Plan, the colonial power allocated 500 million escudos (US$ 20 million) to upgrade port, road, communications, education, and health infrastructures (Hoadley 1975). It also introduced a free healthcare treatment policy for those families that lived under the poverty line (Saldanha

1994). The amount of money that Portuguese really spent in Timor is not known but the health sector experienced a visible improvement. For instance, some scholars claim that, by 1972, the primary care network had expanded to include 30 health clinics in 60 subdistricts (Goncalves, in Krieger 1997), while others note that Timor had three hospitals and 51 health posts (Durand 2016). Regular vaccination programmes were also made available for the rural villagers (Ingram 2008).

Despite this positive progress, healthcare service delivery remained a serious issue in the territory. For instance, at the end of the colonial period, there were two hospitals providing health services to the community, but these were both located in Dili and it made difficult for residents living outside of Dili to access quality healthcare services due to inadequate public facilities and poverty (Goncalves, in Krieger 1997). Meanwhile, Timorese people living in the 12 districts outside the city had no access to quality healthcare or had to face difficulties visiting the hospital in Dili due to inadequate transport facilities and infrastructures (Mohanty 2002).

There were also health clinics in 30 of the 58 subdistricts; however, as noted by Martins (in Krieger 1997: p.74), these were operated with “no doctors and no equipment, and the medicine supply was poor” (see also Dunn 2003; Van Schoor 2005; Gunn 2011). Meanwhile, the larger population, who lived in dozens of subdistricts and hundreds small village scattered across the country, had no access to healthcare. According to Ingram (2008: p.157), in 1972, “there were only three civilian doctors and two dentists for a population of around 670,000, 19 army medical officers were providing part-time services in rural areas”. Consequently, infant mortality rate was high and many people died from malaria, influenza, tuberculosis and malnutrition (Saldanha 1994). Although, in 1967, the Portuguese expanded access to public healthcare by establishing district and subdistrict health facilities and a referral system, healthcare quality did not change much due the concentration of the health workforce in Dili rather than other regions (Soares 2002).

Three main reasons have been cited to explain why the health system during this colonial period did not function effectively. First, the Portuguese attempted to use their Five-Year Plan and free healthcare policy as a populist means to creating an image, both locally and internationally, that Timor was no longer a colony but part of the Portuguese nation. While the budget allocation

for the health sector indicated that they had a commitment to ensuring a better life for the inhabitants of its overseas province, in reality, as made clear above, public facilities were limited and almost all the allocated money went into developing public services in the two major Timorese cities, Dili and Bacau, in which the majority of assimilated elites were domiciled (Nicol 2002). Thus, by prioritizing development in two cities, the Portuguese intended to extend public support to the privileged minority group. Meanwhile, 90 percent of the population outside urban areas lived with inadequate health services.

Secondly, health development during colonial times involved patronage politics among Portuguese and local elites. During the colonial period, the main power base of the government was the assimilated group, who occupied many positions in the civil service in Dili (Hicks 2004; Millo and Barnett 2004). As with improvements in education, the establishment of Dili hospital was an 'award' given by the Portuguese government in return for the loyalty of their client group in supporting colonial rule (Davidson 1994). Through this, the local elites could enjoy almost the same scale of access to health service as Portuguese elites (Soares 2011), and so could be counted on to continue to support Portuguese colonial policy.

Lastly, while the Portuguese used a liberal-technocratic approach to public service, this was largely focused on health development in the metropole and had limited attention to health issues in its overseas province. Thus, the claim that Timor was treated equally to Portugal is clearly rebutted by the statistics. For instance, although Dili hospital offered better health services than elsewhere in the territory, the facilities were largely too inadequate with limited health personnel (Mohanty 2002). Many people died because the hospital was not able to treat patients with tuberculosis, malaria, peritonitis, leprosy, liver and gastrointestinal infections (Hill 2002). Consequently, in 1974, Timorese life expectancy was about 35 years and infant mortality rate was at 50-75 percent (Gunn 2007). Meanwhile, in 1970, Portugal itself had 634 hospitals in 11 provinces to serve 8.68 million population (Barros and de Almeida Simões 2007) and, in 1974, it owned 2,000 medical units in health posts located throughout in 21 districts (Santana 2011). Democratic transition in Portugal, in the 1970s, also encouraged the Portuguese government to "improve efficiency of primary medical care and of a wider and more efficient hospital network", while giving "professional support to some groups at risk" (Veiga et al. 2004:

p.264, 266). These efforts resulted in better access and quality of healthcare services and reduced the infant mortality rate in Portugal from 17.1 percent in 1970/71 to 13.1 percent in 1980/1981 (Veiga et al. 2004).

On the other hand, according to Saldanha, the local practice that tended to favour traditional health treatment rather than modern medicine also contributed to the lack of achievement toward health development in Timor (Saldanha 1994). Thus, when a Timorese was sick, the family would first use medicines from traditional healers instead of reporting the illness to the official medical personnel. Under these conditions, however well the Portuguese health system progressed, the health conditions of the Timorese would not change much because people would still continue with their traditional practices and beliefs, and so avoid modern healthcare.

C. Elite Formation and the Politics of Healthcare under FRETILIN

The Portuguese maintained their presence in the country until, following the Carnation Revolution in Portugal in April 1974, the newly established democratic Portuguese government proposed that they would hold a referendum by which the Timorese people could decide their political future – between full independence, integration with the closest neighbour (Indonesia), or continued integration with Portugal. This prospect divided the Timorese elites and, although the referendum was not held till decades later, when Timor was under Indonesian occupation, the main political parties – the Timorese Democratic Union (UDT) and the Revolutionary Front for the Independence of East Timor (FRETILIN) – formed in 1974 in response to this possibility.

The UDT was the first party to emerge, and most of its members, although Timorese, had previously been employed in the Portuguese administration, or were plantation owners and many had been part of the National Popular Association, the former ruling party in Portugal. Therefore, many authors assert that the UDT was characterised as pro-Portuguese because its elites were those who had gained political advantages during Portuguese colonialism; conversely, the Portuguese authority favoured the UDT because they knew “its leaders and appreciated their pro-Portuguese sentiments” (Hoadley 1975: p.12). Political actors in the UDT preferred gradual independence under the Portugal flag rather than immediate total independence, arguing that, due to the

socio economic conditions of the people in that period, they were not yet capable of sustaining independence in the long term. The UDT elites expected the Portuguese to support Timor in reaching a necessary level of development before it, finally, became ready to function as an independent country (Carrascalao, in Krieger 1997).

The FRETILIN party formed soon after the UDT. It had a complex political structure since it was formed by elites ranging from the right to the extreme left. It was divided into three groups: The first was a pro-Western group, represented by Jose Ramos-Horta. The second was made up of students who had studied in Portugal and returned heavily influenced by Marxism. This group represented the radical wing of the party and had Mari Alkatiri as their spokesperson. The third group, led by Nicolau and Rogerio Lobato, comprised soldiers from the Portuguese colonial army (Hughes 2009). These groups were all influenced by the movement to oust Portuguese colonial liberalism from Mozambique in the 1970s - the choice of its name reflected its similarity in vision to the Mozambiquan movement, the Frente de Libertação de Moçambique (FRELIMO) or Mozambique Liberation Front (Cribb and Kahin 2004; Tanter et al. 2006).

At this time, there were three major influences on FRETILIN: its own ideologies, the Armed Forces for the National Liberation of East Timor (FALINTIL)[18] and the Catholic Church. Due to its wide range of political ideas among its small group of leading members, FRETILIN was focused on two agendas. The first aimed to eliminate the colonial influence by fostering social revolutionary projects and was inspired by FRELIMO's socialist programme. This included the second, which focussed on creating a 'modern' health system that would serve the whole Timorese population and fight against obscurantist practices (including the traditional healthcare methods introduced by the Portuguese during colonial period).

Meanwhile, FALINTIL formed in 1975 and brought together soldiers from the Portuguese colonial army and the urban nationalists by adopting the Mauberism ideology. This identified the nation with the *Maubere* – the poor illiterate peasants who lived in the hills. To a great extent, this involved an

[18]In 1987, FALINTIL seceded from FRETILIN structure and performed the politics of national unity in the struggle for independence through establishing the National Council of Maubere - later this became the National Council of Timorese Resistance.

idealized vision of the relationship between FALINTIL and the rural people, who were accustomed to establishing their identity according to various intricate social hierarchies and factions and for whom Mauberism became a source of change in consciousness (Hughes 2009). For the FALINTIL leaders, this involved assuming Timorese names (for example, Alexander (Xanana) Gusmao adopted the name Kay Rala, while Francisco Guterrez became Lu-Olo) and participating in certain animist rituals. Through this, they aimed to link elite Portuguese-Timorese nationalism with a nationalized form of 'traditional culture' which they associated with the so-called Maubere. Since these traditional Timorese people had inadequate healthcare, the priority of health education in resistance bases was to teach Timorese students some basic medical treatments and traditional medicines; it was also designed to support the national liberation struggle and encourage a spirit of nationalism (CAVR 2005).

Around the same time, in the 1970s, the Church expanded its influence in Timor, reinforcing the ideology of Catholicism so that it retained a powerful position among the local population, even more so because, during resistance struggles, the Church was very pro-active in their support of the clandestine resistance movement (Niner 2017).[19] Thus, during the early post-independence era, these three groups played a significant role in shaping public policies in Timor.

The elites of both UDT and FRETILIN predominantly lived in Dili although they maintained connections with the rural areas where they came from, and built their power bases there (Jolliffe 1978; Shoesmith 2003). During an interview with the Commission for Reception, Truth and Reconciliation (CAVR) commission member, Mario Pires, a Portuguese citizen who became the former governor of Portuguese Timor, pointed out that many Timorese people made choices about party membership or political affiliation based on kinship relationships rather than the party's political ideology or policies (CAVR 2005). Between April and June 1974, UDT elites claimed to have more supporters than FRETILIN because, of the 472 existing sucos in Timor, 236 (about 50 percent) supported them (Carrascalao, in Krieger 1997; see also Alatas 2006). This remained the case until early 1975 when FRETILIN began their social and economic development programmes in the country's rural areas, which focused

[19]In post-independence era, high numbers of the former activists of the clandestine movement become Timorese professional class.

on education, economics and health. To ensure the success of their policy, FRETILIN developed a populist strategy of mass mobilisation and the plan was described by one of FRETILIN leaders, Jose Ramos-Horta, as follows:

> Every FRETILIN militant in Dili to give up their job; Dili become a branch with just few members. Students and teachers will be mobilised for this campaign; I think we can mobilise roughly 50 members of the Central Committee and a few hundred students and teachers; they will go out in groups to the villages stay here for a program of 'political conscientisation' (quoted in Hill 2002: p.131).

To support the programme, FRETILIN formed the Revolutionary Brigades. Each of these Brigades consisted of 10 to 60 people, including FRETILIN's leaders, secondary students, teachers and nurses. These people stayed in villages and taught the villagers intensively – including how to read and write, as well as about hygiene, sanitation and their agricultural system (Hill 2002; da Silva 2012). Before the programme was implemented, pilot projects were conducted in Aileu, Baucau, Liquica and Oecusse, aiming to map the needs of the Timorese people (da Silva 2012). They ran for two and a half months until civil war broke out between the UDT and FRETILIN in August 1975.

During the civil war, FRETILIN, with the support of FALINTIL, its armed wing, was able to defeat the UDT forces. The remnants of the UDT fled across the border to West Timor to seek Indonesian assistance. The war lasted only three weeks but resulted in a death toll of two to three thousand lives. Interestingly, the Portuguese administration, which still had the higher authority on the island, announced that its policy was "not to take sides in the fighting", and departed to Atauro island (Robinson 2010: p.33). This made it possible for FRETILIN to successfully control Dili and other areas. An example of FRETILIN's strategy to ensure its dominance can be seen in its decision to allow aid agencies to enter all areas of Timor post-conflict since several scholars argue that this was not based on humanitarian considerations so much as the desire to control the food aid supplied by the Australian Council for Overseas Aid (ACFOA), which was distributed in FRETILIN-controlled zones (Jolliffe 1978; CAVR 2005). FRETILIN was also able to benefit from the flow of humanitarian health workers through health trainings conducted by international

doctors for their cadres (Hill 1980). In 1975, after winning the civil war, FRETILIN made more effort to promote its powerful role in the territory by declaring Timor an independent country with a cabinet consisting of eleven ministries and seven vice-ministries (Jolliffe 1978).

In the aftermath of the civil war, FRETILIN formed the Popular Organisation of East Timorese Women (OPMT), an organisation consisting mostly of young women, and a few men, from the Revolutionary Brigades. Through this, the party attempted to introduce a public service technocratic approach to healthcare. Some members of the OPMT were health workers and were responsible for conducting health campaigns that aimed to train people in preventive healthcare and to ensure the fulfilment of the basic health needs of the population (Aditjondro 2000). For instance, OPMT members had responsibility for the operationalisation of childcare centres and crèches – two facilities that were established by FRETILIN for the civil war orphans. Through these, OPMT members provided nutrition, medical treatment, moral and logistical support for children (da Silva 2012). Crèches were built in Dili, Baucau, Maubisse, and Turiscai (Jolliffe 1978) and these not only functioned as orphan care but also aimed to provide healthcare training for men and women involved in OPMT, while they looked after the children (Kiernan 2009). According to Jolliffe, there were several hundred orphaned children at Maubisse crèche; the number, however, was reduced to ninety-four after many children were placed with local families. Furthermore, this crèche had a medical school, established and led by a local infirmarian who had experience working in Portuguese hospitals, which ran a healthcare class for FRETILIN cadres in the evenings (Jolliffe 1978). It is important to note that FRETILIN's post-civil war health programme was supported by the International Red Cross Committee (ICRC) and ACFOA. Thus, the party had additional resources to fund and operate their health projects.

However, FRETILIN's dominance created concern among many Western countries, as well as its allies in Indonesia. Spurred by local and international interests, and supported by Western governments, Indonesia invaded Timor on 7th December, 1975. In response, FRETILIN retreated to the hills and renewed its socio-economic programme according to a governance structure that divided the areas that remained under FRETILIN control (known as the liberated zones) into sectors (see Figure 4.1). In each sector, the political leadership shared

power with military commanders, governing through a system of commissions, with the health commission being under the control of the OPMT.

Figure 4.1: FRETILIN Regional Structure from May 1976

Sectors	Districts	Commissar
Ponta-Leste (Eastern End)	Lautem	Juvenal Inacio (Sera Key)
Centro-Leste (Central East)	Baucau, Viqueque	Vicente dos Reis (Sahe)
Centro Norte (Central North)	Manatuto, Aileu, Dili	Joao Bosco Soares
Centro Sul (Central South)	Manufahi, Ainaro	Hamis Bassarewan (Hata)
Fronteira Norte (Northern Border)	Ermere, Liquica, some parts of Bobonaro	Helio Pina (Mau Cruma)
Fronteira Sul (Southern Border)	Covalima, some parts of Bobonaro	Cesar Correia (Cesar Mau Laka)

Source: (CAVR 2005)

While the Indonesian government undertook ‘reforms’ in the rest of East Timor, as described in the next section, FRETILIN, with the support of OPMT, attempted to ‘address’ the crisis in healthcare following the invasion using a number of approaches in these six sectors. For instance, in June 1976, FRETILIN leaders established the East Timor Red Cross, hoping to get medical supplies and healthcare treatment from the ICRC, especially for families involved in the struggle for national liberation. This effort did not succeed since most of the country was under control of the Indonesian military and its Western allies (da Silva 2012). As medical supplies became exhausted, FRETILIN encouraged the party cadres responsible for health to turn back to traditional medicine. Consequently, OPMT health workers conducted research on plants and their healing abilities and produced medicines to cure malaria, tuberculosis, elephantiasis, wounds and pain relief (Cox and Carey 1995; Taylor 1995; Ingram 2008).

Between 1975 and 1977, FRETILIN developed five health centres and a clinic within the areas it controlled. These had four functions: to improve

research and produce traditional medicines, to educate people about medicinal plants, and to provide health services for people. In Baucau District, FRETILIN had health centres in Samalari, Bibela, Kaisae-Hoo (including a branch in Uato-Lari), Manu-baha and a clinic in Kaisaho'o. Meanwhile, in Aileu District, FRETILIN had only one health centre in the town of Remexio; however, it managed to train hundreds of people including FALINTIL soldiers and villagers in their medical school programme, and successfully produced medicines like "tablets and syrups to treat fevers, diarrhoea and other stomach sicknesses, TB [tuberculosis], flesh wounds, respiratory diseases, and skin diseases, and they provided maternity care" (quoted in da Silva 2012: p.221).

Interestingly, the participants of medical training were not just taught about diseases and medical production but also taught about populist rhetoric of health services. Inácio da Costa, a member of health brigade who gave training at medical school pointed out that students were taught: "The health service is for all, for human beings that are in need. When people get sick we are there to help" (quoted in da Silva 2012: p.220). This approach is reflected later in the Cuban programme adopted under the current Government as discussed in detail in Chapter 5 and 6. Meanwhile, the trained villagers established another programme of health classes to teach people how to become health workers, and they also set up small medicine cabinets in villages (da Silva 2012).

In late 1978, FRETILIN's resistance bases (the liberated zones) including its health clinics were forced to close by the Indonesian military. Consequently, FRETILIN reorganised as a guerrilla movement and its healthcare services became clandestine operations, aided by supporters living in villages who provided food and basic essentials. Interestingly, this situation did not significantly affect FRETILIN's ability to provide to healthcare services and its dependency on traditional medicine even gradually reduced. This was because some members of the clandestine movement worked as health workers in Indonesian health centres and, thus, had access to modern medicines. These Timorese health workers were able to treat FRETILIN's wounded fighters in safe houses and churches or even travel into the mountains to provide modern medicine supplies and healthcare services (Pinto and Jardine 1997; Ingram 2008).

During the field research, an Indonesian doctor respondent, who had been working in East Timor during this time, admitted that he had heard that some

Timorese health workers had given health support to the FRETILIN movement. However, he explained that, for him, it was not really a problem as long as it was for healthcare. Indeed, he asserted that he would treat FRETILIN and non-FRETILIN patients equally because his job was to provide care (Interview 40). Nevertheless, as discussed in next section, this did not reflect a generally accepted view as some reported that healthcare development in East Timor benefited the Indonesian government rather than Timorese people.

Alongside its good intentions, development of healthcare services during FRETILIN's administration also became a political instrument among elites in the party. Consequently, there was potential tension between the ideology of "the fight against obscurantism" – which led FRETILIN to spend a lot of resources trying to set up 'modern' social services – and the established practices of patronage and discrimination in favour of certain groups (Pinto and Jardine 1997). Indeed, from the outset, FRETILIN understood that the Timorese people had experienced poor healthcare during Portuguese colonisation, so they introduced their intensive socio-economic programme in rural areas as a political campaign to attract voters (Hill 2002). Where health services and trainings in childcare or health centres were successful, FRETILIN enjoyed a high degree of popularity and support within the local population (Robinson 2010; Leach 2017a). Consequently, the party won the village head elections in July 1975 with a 55 percent vote for FRETILIN candidates (Taylor 1995; Robinson 2010). In contrast, UDT lost a great deal of its early support due to relying heavily on Portuguese support and patron-client networks.

Although health training and food aid allocation from international agencies may have highlighted FRETILIN's concern to address the needs of the villagers; clearly, this concern was also a political tool which benefited FRETILIN in two ways. Firstly, It was part of populist strategy used to attract voter support for FRETILIN and practical support for the resistance movement. Moreover, this overt concern for the welfare of the populace also became an important part of FRETILIN's self-identity and its own understanding of its appeal to the population.

Secondly, through supporters who had medical capacity and were working for the Indonesian administration, FRETILIN was able to access healthcare and modern medicines from the Indonesian government surreptitiously and, thus, both enjoyed a better quality of healthcare treatment (Ingram 2008) while

enhancing the technical quality of their healthcare. FRETILIN also benefited in many ways from access to resources available to Timorese who were part of the clandestine movement; for example, one of the Timorese informants, who worked as a civil servant for the Indonesian administration, claimed that in the 1990s every single Timorese worker in the area had to give 30 percent of their salaries to the FRETILIN struggle (Field journal notes, 7 February 2016). Indeed, this was compulsory and part of party policy.

Thus, although FRETILIN's health system was in theory based on a rational model purposed to serve all Timorese, in fact, there were significant problems. For one, the operationalisation was conducted through patron-client networks. As explained above, FRETILIN established various projects within the liberated zones and this included teaching civilians about healthcare treatment and on how to produce traditional medicines (CAVR 2005). These projects then provided FRETILIN and FALINTIL troops with healthcare and other logistical support while, at the same time, it also offered those parts of society that supported the resistance movement with some level of safety against the Indonesian military threat (Weldemichael 2013).

In spite of all FRETILIN's efforts to develop the health system, like the Portuguese attempts before it, these were continually challenged by the practice of traditional doctors who offered health treatment using magic cures. This often involved FRETILIN supporters who resisted the shift towards modern medicine, and was most prevalent in the Central North Sector. According to one of da Silva's respondents, FRETILIN reacted by creating policy to punish those health personnel and patients who used this type of traditional healthcare due to the party's policy to combat obscurantism (da Silva 2012: p.221).

Thus, FRETILIN was able to develop a certain level of healthcare system, based to some extent on a liberal-technocratic approach, even after it had to retreat to the liberated zones despite contending both with the effects of occupation and resistance to modernisation. However, while this success served to increase its popularity, it also enabled patronage practices remained rife undermining its socialist motivation. Meanwhile, the Indonesian administration developed its own health care system outside the liberated zones.

D. The Politics of Healthcare under the Indonesian Administration

Following Timor's integration into Indonesia in July 1976, the Indonesian National Government established a new structure of local government similar to that in its other provinces. According to this, public health activities were operated by the Provincial Department of Health, with policies, programmes and small funds falling under the responsibility of the Ministry of Health Indonesia (MoHI). Meanwhile, the National Government was responsible for allocating larger funds to develop the public health system in Timor-Timur, as the province became known. Although the results of this were ambiguous, creating some significant improvements but uncertain in terms overall effect on Timorese health, the Indonesian approach created a change in expectations among health professionals.

Figure 4.2: Summary of Governmental Expenditures in the Province of Timor-Timur (in million Rupiah[20])

Fiscal Year	Sectoral	Inpres	Routine	Total
1976/1977	233	552	1,476	2,260
1977/1978	3,500	3,360	3,262	10,122
1978/1979	4,334	3,997	3,135	11,464
1979/1980	7,517	5,152	3,150	15,820
1980/1981	12,416	9,087	6,954	28,458
1981/1982	11,213	14,885	8,436	34,532
1982/1983	28,221	19,114	8,847	56,182
1983/1984	22,871	20,826	9,432	53,156
1984/1985	23,695	22,941	20,015	66,650
1985/1986	35,181	24,192	13,039	72,412
1986/1987	25,556	22,735	13,071	61,362

Source: (Department of Foreign Affairs Republic Indonesia 1986)

In an effort to promote equal rights and opportunities with other Indonesian provinces, the National Government set the following goal: "To increase health

[20] Currency exchange was approximately Rp 415 per US$ in 1976; Rp 626 in 1978-1979; Rp 702 in 1982; Rp 970 in 1983-84; Rp 1,110 in 1985; 1,664 in 1986-87.

and medical facilities, such as through the establishment of hospitals, clinics and public (rural) health centres, by increasing the number of doctors and medical personnel as well as by initiating programmes of preventive health care" (Department of Foreign Affairs Republic Indonesia 1986: p.6). Meanwhile, the financing of these efforts was sourced from three different funds: the Inpres (Presidential Instructions), routine and sectoral budgets.[21] Figure 4.2, above, shows the total amount of funds spent (not solely for healthcare) in the different sectors in Timor-Timur and specific information on health budget allocation is provided in Figure 4.3.[22]

Figure 4.3: Expenditures for Health Sector in the Province of Timor-Timur (in Rupiah)

Fiscal Year	Project to raise health condition in East Timor	Presidential Instruction Project	Assistance by the Department of Health
1976/77	11 million	32 million	41 million
1977/78	169 million	214 million	30 million
1978/79	120 million	511 million	4 mobile Doctors
1979/80	70 million	Not yet fixed	4 Doctor's accommodations

Source: (Department of Information Republic Indonesia 1979)

As can be seen in Figure 4.3, the funding was not always in the form of cash; it could be involve facilities that supported health delivery. Moreover, during the field research, several Indonesian doctors, who had worked in Timor under the Indonesian administration, explained that, although MoHI and the National Government had allocated a specific amount of money to develop the health sector in Timor each year, in reality, the amount did not have a limit. As long as it was purposed for the improvement of health services in Timor, they – the MoHI and the National Government – would give as much as was needed

[21]Both Inpres and routine funding came from the National Government. Inpres is a special fund allocated by the President to support development in the eastern regions of Indonesia including Timor which were less developed compared to the most provinces in the western part (see Aziz 1996). Meanwhile, routine funding refers to development subsidies given to provinces. Sectoral budget means project and budget assistance provided by the Central Department of Health.
[22]Please note, the data for 1976 to 1980 is limited.

without requiring a detailed review (Respondents 37, 38, 39, 40). However, for other provinces, a detailed selection process was applied. Thus, Timor-Timur always received the highest budget allocation per capita compared to the other 26 provinces in Indonesia (MoH Indonesia 1995).

Efforts to provide better public medical services to the people made considerable progress. In health infrastructure, for example, the MoHI successfully rebuilt and re-equipped Wira Husada hospital in Dili, and designated it to be the central hub of medical treatment in the province. The number hospitals was also increased from five (two in Dili, two in Baucau and one in Bobonaro, with 550 beds in all)[23] in 1981 to ten in 1988, the extra five being located in Covalima, Ainaro, Viqueque, Lautem and Ambeno[24] (Central Board of Statistics of East Timor Province 1988). When Timor-Leste gained its independent status, the number of hospitals remained 10 for 13 districts.

At subdistrict level, the MoHI successfully built *Puskesmas* (public health centres), which were able to provide primary healthcare services (including disease prevention and minor emergency treatment) and to implement health programmes for the community. Some Puskesmas were equipped with inpatient facilities and designed to give 24 hours healthcare services. Others provided health treatment without inpatient facilities and opened daily during office hours. Some also had simple laboratory facilities and refrigerators to store vaccines and other medical products. For Puskesmas in areas with a limited electricity supply, the MoHI allocated gasoline generators or solar cells and, in these areas, the refrigerators were fuelled with kerosene. In 1981, 15 Puskesmas existed in all 62 *kecamatan* (subdistricts) (Central Board of Statistics of East Timor Province 1981). Sixteen years later, in 1997, the number increased to 67 (21 with inpatient facilities and 46 without) (Central Board of Statistics of East Timor Province 1997; Department of Health Republic Indonesia 1997). The MoHI also constructed *Puskesmas Pembantu* (Public Health Sub Centres). Similarly to Puskesmas, the number of Puskesmas Pembantu also grew: from 114 in 1984 to 305 in 1997, serving 62 subdistricts in Timor-Timur (Central

[23]The beds were distributed as follows: two hospitals in Dili had 200 beds between them; two hospitals in Baucau had 50 beds between them; and one hospital in Bobonaro had 50 beds (Central Board of Statistics of East Timor Province 1981: p.59).

[24]The beds were then distributed as follows: the two hospitals in Dili had 250 beds between them; two hospitals in Baucau had 100 beds between them; one hospital in Bobonaro had 50 beds; one hospital in Covalima had 20 beds; one hospital in Ainaro had 20 beds; one hospital in Viqueque had 32 beds; one hospital in Lautem had 20 beds; and one hospital in Ambeno had 20 beds (Central Board of Statistics of East Timor Province 1988: p.86).

Board of Statistics of East Timor Province 1997). This met the MoHI target: every subdistrict had at least one Puskesmas and either two or three Puskesmas Pembantu (Department of Information Republic Indonesia 1989; see also report by Mubyarto et al. 1990).

For rural and mountainous areas which did not yet have Puskesmas or Puskesmas Pembantu, the MoHI provided *Puskesmas Keliling* (health mobile units which used cars, motorcycles, horses, helicopters or speed boats). After integration, 26 Puskesmas Keliling where introduced to visit various *desa* (villages) in the interior (Department of Foreign Affairs Republic Indonesia 1986) and, in 1996, the number increased to 108 units (Department of Health Republic Indonesia 1997). For desa level, the MoHI also established *Posyandu* (Integrated Health Services), which became the first contact with the health system for the population. Posyandu were organized by and for the community at the village or hamlet level, and were conducted in any home or open space in the neighbourhood. The major programme of a Posyandu included mother and child health, family planning, nutrition, immunization and diarrhoeal disease control (MoH Indonesia 2012). In 1984, there were 362 Posyandu operating in 442 villages; this number increased in 1997 to 1,151 Posyandu (Central Board of Statistics of East Timor Province 1997). In addition, the MoHI also established *balai pengobatan* (medical clinics) and *apotik* (drug stores). In 1997, Timor had 27 balai pengobatan and 22 apotik (Central Board of Statistics of East Timor Province 1997).

In short, as noted by an Indonesian doctor respondent, as long as something was for better healthcare access and treatment for the Timorese, the MoHI would provide it. This was to ensure Timor had healthcare standards similar to those available in Java and other Indonesian provinces (Respondent 40). Although the public healthcare system was under subsidy from the MoHI and National Government, to receive medical care at all levels, people were charged user fees, which varied across the country. Sometimes it was less than a dollar or between one and five dollars, depending on the affluence of the community; sometimes it was even free of charge (Respondent 40). However, as indicated by interviews with local people, when a Timorese needed an operation, it cost them Rp 150,000 (see McNaughtan 1999; Taylor 1999).

Indonesia's public health system in Timor-Timur worked similarly to Timor-Leste’s current system. Patients who could not be cured in Posyandu were

referred to Puskesmas. If Puskesmas could not help them, the patient was sent to the district or provincial hospital, then to Dili hospital. Finally, if this was unable to cure them, they were referred to hospitals in other Indonesian provinces. Respondent 40 worked at the Provincial Department of Health and had responsibility for managing the transferal fund. He explained that he had sent patients to Surabaya in Java for medical treatment. For poor families, expenses for the patient, and a family member and a health staff accompanying the patient, were covered by the MoHI and National Government. According to the respondent, Timor had a special fund allocation for this which was not available to other Indonesian provinces (Respondent 40). Meanwhile, patients from families who could afford it had to cover their healthcare expenses themselves.

Alongside the public healthcare system, private healthcare providers offered similar medical services to the Puskesmas and Puskesmas Pembantu (McNaughtan 1999; Pedersen and Arneberg 1999). Largely, these were run by the Catholic Church and predominantly existed in Dili and Baucau (Central Board of Statistics of East Timor Province 1996). Regarding quality health services and fees, authors are divided. Some believe medical treatment in Puskesmas was far better but more expensive than in private clinics (Pedersen and Arneberg 1999). Whereas others assert that the Catholic Church clinics provided more modern healthcare treatment, as well as tuberculosis eradication programmes funded by Caritas (the Norwegian Catholic aid agency) (McNaughtan 1999).

To provide better access to healthcare services, the National Government built roads and bridges:

> The effect, for example, was that a 180 kilometres of road, which had previously taken a day (or even more during rainy season because the road and river were impassable, so I had to stay overnight and continue delivering healthcare services in villages the next day), can now be travelled within three hours (Respondent 40).

Respondent 38, another Indonesian doctor, expressed a similar opinion.

During a visit in 1981 to 1989, a team from the Indonesian Gadjah Mada University[25] also noted: “Almost all the provincial and district roads are now well asphalted. Dili, the capital of the province, has been connected to all district centres by an adequate transportation system” (Mubyarto et al. 1990: p.3). With regard to the land transportation network, 2,957 kilometres of paved roads in 1984 (Provincial Government of East Timor 1985) grew to more than 3,795 kilometres by 1989 (Mohanty 2002). Meanwhile, by 1984, 19 bridges were successfully constructed, including the 240 metre Laclo River Bridge (Provincial Government of East Timor 1985). For the environmental health service in rural areas, by 1984, the National Government had built “160 fresh water resources, 3,751 wells with water pumps, 140 sewers, 1,600 toilets etc.” (Department of Information Republic Indonesia 1984), and provided electricity in every districts, subdistrict and village (Respondent 38, Department of Information Republic Indonesia 1983; Mohanty 2002; Kartasasmita 2013).

In addition, the National Government developed air transportation and communication facilities as a mean to support the healthcare system. In 1981, Dili airport was completed and able to serve daily flights to Jakarta, Bali, Kupang and Java; followed by some pioneer airports in districts like Baucau, Maliana, Covalima (Provincial Government of East Timor 1985). For communication among regions within the province and with other parts of Indonesia, the Government provided a satellite-based telephone system and a postal service (Provincial Government of East Timor 1985; Mohanty 2002; see also Kartasasmita 2013). It is important to note that development programmes post-integration (which mainly involved infrastructures) also served the Indonesian army in their operations.

Regarding human resources, the MoHI created two programmes to increase the number of health personnel in the territory. First, the Ministry supplied Timor-Timur with medical staff from different provinces in Indonesia. In 1981, there were 4 specialists, 22 medical doctors (general practitioners), 5 dentists, 75 nurses, 4 dental nurses and 8 midwives. By 1997, Timor had 7 specialists, 134 medical doctors (general practitioners), 30 dentists, 1,124 nurses, 58 dental nurses and 383 midwives (Central Board of Statistics of East

[25]This team was from the Gadjah Mada University Research Centre for Village and Regional Development. The visit was part of a study organised in cooperation with the Bank of Indonesia and the Local Development Planning Board for the Province of East Timor.

Timor Province 1997). However, Indonesian health workers were reluctant to accept assignments in Timor due to the distance from their homes (e.g., Java) and conflict issues; therefore, the MoHI offered larger salaries (twice standard rates) under a special treatment policy (Respondent 39, 40, Soempeno 2008). It also encouraged medical students to come to Timor by allowing them 1-2 year internships in Timor rather than the compulsory 3-5 years in rural areas normally required before becoming a doctor (Respondent 40, Soempeno 2008). However, to date, this research could not find information on how many medical students did their internship in the province between 1979 and 1999.

The MoHI also created a programme to recruit local health workers, which was conducted in two ways. First, from 1979, the MoHI established several health schools for basic and secondary (Diploma 1 and 3) health providers, which included a nursing school, *Sekolah Perawat Kesehatan*) and a midwifery school (*Program Pendidikan Bidan*), and a health academy with nursing, environmental health and nutritional departments (Respondent 38, 39, see also National Development Planning Agency Republic Indonesia 1983). These were taught by Indonesian health workers posted in Timor. Second, from 1978, the MoHI awarded scholarships to graduates of Timor-Timur high schools to study health in different Indonesian cities like Malang, Bandung, Sukabumi, Manado, Jakarta, Denpasar, Surabaya, Yogyakarta, Ujungpandang, and Palangkaraya. In 1989, it was calculated that 1,500 Timorese students obtained scholarships to pursue diploma level education and *Sarjana* (graduate degree) in Indonesia (Department of Foreign Affairs Republic Indonesia 1992). Rui de Araujo, the current prime minister of Timor-Leste, was included in the first wave of Timorese students who gained scholarships to study medicine (Respondent 37).

Some groups of Timorese students were also sent to different Indonesian cities to train in special health classes. For instance, “nurses were upgraded through up-grading courses in Java which lasted for 2.5 months” (Department of Information Republic Indonesia 1979: p.12). This aimed to make nurses more able to assist the MoHI in reducing the infant mortality rate, which had become one of the most serious health problems of Timor-Timur. Another group of Timorese participated in a course called the School for Nutrient Helper (*Sekolah Pembantu Ahli Gizi*) in Mataram, West Nusa Tenggara Province (Respondent

37). This course ran for three waves; each wave consisting of 20-25 participants.

Some scholars argue that the implementation of the Indonesian technocratic public health approach achieved positive results. For example, regarding nutritional issues, MoHI had successfully introduced new varieties of food and vegetable (like tempeh, water spinach and cassava leaf) to the population. Also, through Posyandu, the Supplemental Feeding Programme for children under five years old was also conducted. As consequence, according to former Indonesian health workers responsible for the nutritional programme, the incidence of malnutrition reduced from 30 percent of the population in 1983 (Department of Information Republic Indonesia 1984) to 2.5 percent in 1997, which brought it into line with the Indonesian national standard (Respondent 38). Thousands of patients suffering from common diseases like malaria, tuberculosis, elephantiasis and yaws were successfully treated every year (Department of Information Republic Indonesia 1984; Department of Foreign Affairs Republic Indonesia 1986).

However, other authors state that the quality of healthcare in Timor was far from adequate due to lack of nutrition, health workers and medical facilities (Retbøll 1998; Beazley 1999; CAVR 2005). Therefore, the infant mortality rate remained high compared to other provinces in Indonesia: 93/1,000 live births in 1985; 105/1,000 live births in 1990; 67/1,000 live births in 1994; 78/1,000 live births in 1995 (Rai 1991; Saldanha 1994; Provincial Government of East Timor 1996; Jones 2001). Meanwhile, infant mortality rates in Jakarta were: 31/1,000 live births in 1990; 29/1,000 live births in 1996; 26/1,000 live births in 1997; 25/1,000 live births in 1999 and Bali was at: 38//1,000 live births in 1990; 37/1,000 live births in 1996; 33/1,000 live births in 1997; 32/1,000 live births in 1999 (International Labour Organization-Japan-Government of Indonesia 2002). From 1974 to 1999, it is estimated that 84,200 Timorese died due to hunger and illness (Silva and Ball 2006). Although MoHI programmed many health activities, according to statistical data, malaria (from 1983 to 1997) and respiratory tract infections (from 1988 to 1997) were still the two most common diseases experienced by Timorese population, although they decreased significantly (See Figure 4.4 below).

Figure 4.4: The Number of New Case of Malaria and ISPA[26] Diseases in East Timor Province

Year	Diseases				Total Percentage Malaria and ISPA
	Malaria		ISPA		
	Number of patients	Percentage total patients	Number of patients	Percentage total patients	
1988	114,121	14.20	124,196	15.45	29,65
1989	93,738	13.82	124,227	18.31	32.13
1990	97,385	14.37	156,360	23.08	51.82
1991	60,470	13.42	106,072	23.52	36.94
1992	48,938	12.13	102,453	24.40	36.53
1993	86,288	13.03	128,387	20.88	33.91
1994	78,281	13.31	50,673	8.62	21.93
1995	67,119	10.73	95,765	15.31	26.04
1997	25.587	10.02	62,779	24.57	34.59

Source: (Central Board of Statistics of East Timor Province 1988)

The discussion above indicates that, although the National Government invested huge amounts of funds in developing public health infrastructure and personnel, healthcare in Timor-Timur remained poor compared to other Indonesian provinces. The first reason for this is the practice of corruption and nepotism in delivery of the health service. For instance, some medicines that were allocated to health centres were found to be sold to private pharmacists and shops (Taylor 1999; Niner 2000). This made medicines scarce in the hospital, and when the poor people need particular drugs, doctors had to request them to buy at private shops at an expensive price that some Timorese could not afford (Taylor 1999). Another shortcoming was that, under Indonesian rule, health workers were predominantly non-East Timorese. They did not speak Tetum and had no friends or relatives nearby during their assignment. As a consequence, they lacked commitment and had little motivation to give professional healthcare treatment (Cox and Carey 1995; CAVR 2005).

[26] This stands for: Infection of Respiratory Tract.

Meanwhile, some groups of doctors gave priority medical treatment to the local Timorese who favoured integration (CAVR 2005).

Arguably, the politics of elites contributed to the poor performance of the health system under Indonesian administration in a number of ways. First, similarly to Portuguese elites, the 'special treatment' policy intended to capture support from the local population (and international actors) for integration as the best option for Timor. This was based on the argument that Indonesia had the capacity and experience in development (as evidenced in Java Island), to ensure that the Timorese people would have a happier life and brighter future as part of Indonesia. In reality, development projects were largely allocated for infrastructure supporting Indonesian military operations and to provide administrative facilities for the Local Government (Saldanha 1994; Cox and Carey 1995). Cox and Carey (1995) provide further evidence that, in the period 1983 to 1989, 50 percent of the US$ 270 million funding had been spent on road building and local government expenses for administrative facilities. Meanwhile sectors like health, education and culture had received less than seven percent. As a consequence, the eastern part of the province, where fighting with FRETILIN guerrillas largely took place, had better access to roads than western districts. This was demonstrated by "[t]he rows of gleaming new provincial government buildings" that existed in Dili (Cox and Carey 1995: p.46).

Some Indonesian military personnel involved in providing healthcare services were taught to 'recruit' many young women to the national family planning programme (*Keluarga Berencana Nasional*). Later, under military orders, these recruited-health workers singled out Timorese women and girls to be "sterilised or injected with Depo[-Provera the contraceptive injection] without their knowledge" (Beazley 1999: p.50). Many believe that this became a strategy to limit generations of resistance (Sissons 1997). Meanwhile, Mario Carrascalao, the Indonesia-appointed East Timorese governor, argued that "limiting the growth of the population was imperative because there simply were not enough schools, hospitals, and jobs for all the new children being born" (Mohanty 2002: p.65). According to Sissons (1997), some groups of Timorese women were also given lethal injections by the military due to political disloyalty. Consequently, "a deep seated distrust exists towards government health services, with people (particularly women) refusing to take malaria tablets and vitamins, or accept vaccinations, for fear of being sterilised or poisoned"

(Beazley 1999: p.50). This situation encouraged local people to continue using traditional treatments as a safe way to solve their health problems.

Secondly, the integration of Timor-Timur and the development activities under Indonesian administration mainly benefited the political clients of the Indonesian elites in Jakarta: military, businessmen and local bureaucrats. In the Indonesian context, the defence sector has always faced two traditional problems: insufficient military budget to satisfy operational needs and low official public service rates of pay. Thus, the involvement of the Indonesian military in Timor-Timur became an excuse to boost defence funds to modernise military equipment. For instance, in 1977/1978, the military received Rp 30 billion for routine expenditure in Timor (Aditjondro 1994).

In the same period, however, the total money allocated to the health sector from the three sources (sectoral, Inpres and routine) amounted to approximately Rp 413 million (Department of Information Republic Indonesia 1979). Military personnel also got additional salaries to pay for 'security service' (Aditjondro 1994). Also, according to many Indonesian authors, a lot of military commanders, like Subagyo and Prabowo Subianto, received special promotion due to the success of the military operation in the province (Soempeno 2008; Pambudi 2009). Meanwhile, key military commanders in the East Timor 'operation' (such as Major General Murdani, Brigadier-General Dading Kalbuadi and General Adolf Sahala Rajagukguk) cooperated with Chinese businessman to set up monopoly economic activities in the territory (Aditjondro 1994; Cox and Carey 1995).

Some Timorese who were committed to integration were awarded positions in the provincial, district and subdistrict structures. Others became civil servants in the local government administrations as rewards for their loyalty. These people received regular cash incomes and benefited from 'development' under Indonesian rule (Budiarjo and Liong 1984; Cristalis 2009). For instance, quality hospitals were located in Dili and a few main towns, and these health facilities were reserved for the military, local bureaucrats and civil servants, while poor Timorese had to go to the poorly equipped Puskesmas (Cox and Carey 1995; Rosser and Bremner 2015b) or suffer illness due to lack of access to treatment (Beazley 1999).

Moreover, according to a workshop on health conducted by CAVR in August 2004, involving Timorese patients who received medical treatment from

Indonesian medical staff during occupation, the health service delivery was conducted through “a patronising style of service that offered little of the information necessary for informed patient choice” (CAVR 2005: Chapter 7.9, p.31). Although some developments in public facilities were enabled by some dedicated healthcare providers, during the fieldwork, an international health worker, who has been improving medical treatment in Timor-Timur/Timor-Leste since 1998, argued that these programmes aimed to prioritise the healthcare needs of Indonesian soldiers and their military operations over those of local people (Respondent 44).

Under Indonesian administration, despite the various liberal-rationalist programmes discussed above, there was a huge difference between the quality and quantity of health facilities and healthcare personnel in Timor and Jakarta province (the capital area where the most Indonesian elites lived). For instance, after 1991, the number of hospitals and beds in Jakarta continued to increase and, in 1996, the province had 98 hospitals (15,056 beds) spread throughout six districts (Department of Health Republic Indonesia 1997). Meanwhile, from 1988 till independence (in 1999), Timor had only 10 hospitals, and two of these were owned by the Indonesian military. According to data, in 1996, these 10 hospitals had only 575 beds in total (Department of Health Republic Indonesia 1997). Moreover, while Timor had around 67 beds per 100,000 population, Jakarta had around 161 beds per 100,000 population, over twice as much (Department of Health Republic Indonesia 1997).

Statistical data also indicates that, in 1996, the ratio of medical specialists to 100,000 population was 23.3 for Jakarta and 1.4 for East Timor (Department of Health Republic Indonesia 1997). This means Timorese had a very low chance to get good medical treatment compare to those living in the capital. Another critical issue was that some health workers in charge of hospitals and medical centres were internship doctors who were not fully trained and lacked experience, without proper supervision (Retbøll 1998; Beazley 1999; McNaughtan 1999; CAVR 2005). Perhaps these are the reasons why, in 1997, East Timor had an infant mortality rate of 70.02 while Jakarta’s was 19.03 (Department of Health Republic Indonesia 1997).

At the same time, there were significant incentives to encourage former Indonesian health professionals to working in Timor Province: the Indonesian government provided double salary and financial subsidies for those who were

willing to stay in Timor and provide medical services. These took the form of successful programmes specifically designed to attract health professionals and boost personnel motivation to deliver better medical treatment in the population (Respondent 40). The same similar experience was also reported by a Timorese healthcare personnel who had always worked under the Indonesian system: “I think in Indonesian time those who did well in their job got a special reward [which came in the form of financial gain]. This is good because it motivates others to do well in their job” (quoted in World Bank 2006c). Some interviews with former Indonesian health professionals who worked in Timor Province and some Timorese civil servants and healthcare professionals, Indonesian influences continue there to the present day due to Indonesian health workers who still come to Timor-Leste, as individuals or institutions, to provide talks, workshops, trainings and seminars (Respondent 37, 38, 39 and 41).

Lastly, as with the situation under Portuguese and FRETILIN administration, traditional intervention was an obstacle to reforming healthcare during Indonesian rule. In some regions, Timorese families preferred to go to traditional birth attendants to help them with deliveries, as well as to treat infants post-delivery, making infant and maternal mortality rates more difficult to reduce. Traditional treatments were often unhygienic and, as a consequence, many people suffered tetanus. Rather than prohibiting the practice, MoHI reacted proactively by sending doctors to give health training to the traditional birth attendants, so that they could adopt safe delivery methods (Respondent 37, see also testimony from a villager quoted in World Bank 2006c: p.25).

Thus, the Indonesian administration left a mixed legacy with significant improvements which did not actually achieve far-reaching reforms. However, the different methods of medical personnel recruitment and capacity enhancement developed the idea of a white-collar professional middle class of health workers in Timor – in particular, the Indonesian neoliberal approach to healthcare which involved high salaries for professionals. The power of this strategy to encourage healthcare professionals was evident from the success of the financial incentives programmes.

E. Conclusion

After reviewing the contemporary situation and indicating how elites exploit the healthcare system through patronage and populism and rationalist-based policies are also hijacked by corrupt practices, this chapter examined the development of the elites in Timor from the colonial era to the post-independence administration. It highlighted the origins of their patronage and populist practices and how these affected the health systems under the various administrations in power since Portuguese colonialism when certain neopatrimonial practices were established. At the same time, the Catholic Church was introduced to the country which developed into a strong populist power source that came to have significant influence on government and healthcare. Following the decolonisation process of Portuguese Timor UDT and FRETILIN elite groups emerged and became the major political players in development. However, the outcome of civil wars involving the two parties meant that FRETILIN became the key actor in the country.

The Indonesian invasion signalled a new power struggle involving Indonesian and FRETILIN elites. Under the first FRETILIN government, although significant efforts had been made to improve the health service along egalitarian lines despite international concern, elite practices continued, compromising the progress of health development. Under Indonesian administration, the same patterns emerged and, again, despite significant reforms and the introduction of healthcare programmes aimed at reaching the rural population, these failed to improve the situation for similar reasons. However, differences in political 'ideas' among the Indonesian and Timorese leaderships encouraged violence and lead to the 24 year conflict process – during which period, new political groups emerged, namely, FALINTIL and the Church. These also became influential in political contestation against Indonesian power. The three groups (FRETILIN, FALINTIL veterans, and the Church) then become the major players of development policy-making during the post-independence era.

The chapter also indicated the role of a further significant influence on healthcare development in the form of obscurantist healthcare practices that were introduced under the Portuguese. FRETILIN and the Indonesian administrations failed to replace these with modern healthcare since they could not make this sufficiently accessible to the people living outside urban areas.

This in turn meant that the healthcare reforms did not receive committed support from the people.

From this review, it is concluded that throughout Timorese history, healthcare has been used as a political tool to control the population in a way that benefits small groups of people. To achieve political purposes, interestingly, elites (during colonial times and post-independence) have used the same strategies of development. Firstly, they introduced populist development policies which cosmetically purposed to improve the level of health conditions for the population but which, in reality, were intended to attract voters to support elites' development agendas. Some politicians also allocated government resources to benefit their political networks so that they could sustain power and interests. Lastly, elites with control of power and resources were able to make liberal-technocratic policy benefit them in terms of quality of healthcare services. This also suggests the idea that policy is developed primarily to solve problems is largely a myth. As this chapter shows, policy-making involves political struggle between different actors and this process is largely responsible for the unequal access to public services – with the broad population only having access to poor healthcare facilities. In response to this situation, traditional medicine becomes the only solution of Timorese people to treat their health problems. Interestingly, while violence following the referendum in 1999 destroyed the infrastructure, the attitudes and approaches of former administrations still continued.

This discussion also demonstrated that different attitudes towards and understandings of healthcare developed within Timor during the periods of occupation. FRETILIN's leaders, many of them in exile, were strongly influenced by socialist approaches, and attempted to introduce these in their support bases in the late 1970s before the population surrendered to the Indonesian occupation. The split between FALINTIL and FRETILIN, however, caused the influence of so-called 'leftist ideologies' to decline within Timor while, at the same time, the Indonesian occupation trained young Timorese health workers in Indonesian neoliberal approaches to health. By rewarding healthcare professionals more generously for their work, this approach of the Indonesian administration caused significant discontent with the subsequent socialist Cuban project introduced following independence, as will be discussed in detail in Chapter 6.

The overall discussion of this chapter illustrates how historically specific struggles between different factions have shaped public service policy and its implementation. In sum, based on the Gramscian framework presented in Chapter 2, the political economy approach enables us to understand how the state and societal institutions are an outcome of contestation between groups. It shows how the changing political economy continues to shape the design of these institutions and how they function; thus, reflecting and reinforcing the strategies of powerful interests and the conflicts or alliances between dominant actors, to the detriment of weaker elements in society. The next two chapters (Chapter 5 and 6) are based largely on the field research and document reviews. They explore the specific ways in which, in the post-independence era, development has continuously been subject to political struggles among groups of actors whereby, although the MoH attempt to introduce public-service oriented policies, elites use patronage and populist politics as dominant strategies to sustain their power and influence.

Chapter 5: Elites, Development and the Politics of Ownership in Healthcare in Timor-Leste (2002-2017)

This chapter firstly examines the extent to which, the Timorese government under FRETILIN's leadership (2002 to 2007) was able to exercise some autonomous decision-making despite being dependent on aid, as was evident in its use of patronage politics in allocating state resources, which led to increased corruption. This practice significantly contributed to the party's decline in popularity and to the political crisis that led to Alkatiri's resignation in 2006.

Following this, it explores political dynamics under the CNRT leadership from 2007 in which elites were empowered by oil resources and able to exercise greater autonomy over development. Unlike the FRETILIN leadership, CNRT elites introduced populist policies which were intended to expand political networks and allow 'political compensation' not only for its own power base but also for the opposition, so as to maintain support for the government. This practice contributed to the government having even less control of corruption but it has successfully sustained peace and stability since the crisis of 2006. The chapter also considers the increasing power of the Church and explains how non-elite groups, like the veterans and the Church, were able to use their influence to change government policy.

While a powerful ideology of modernization regarding healthcare meant that, under both FRETILIN and CNRT government, the health sector tended to be governed through populist policy rather than patronage politics, data collected from the fieldwork suggests that ownership is more complex than a simple distinction between national or international control. Rather, it is negotiated between different groups locally and internationally across a range of types of decision. Consequently, although oil revenues brought some financial independence, ownership of the healthcare system remained compromised by corrupt practices, patronage and populist politics, as well as being hampered by lack of capacity and internal competition.

In order to examine these different social forces and the relations between them, this chapter proceeds as follows: the first section analyses the politics of ownership during the immediate post-independence era – particularly when Timor-Leste became highly dependent on international aid. The second section

examines constraints in local ownership that meant that health projects tended to serve donor interests rather than being primarily based on local aspirations. The third section discusses the context of the crisis of 2006 and how it affected ideas about ownership. The fourth analyses the politics of ownership under the CNRT leadership, especially when income from oil exploration became the main source of development finance. The fifth section discusses the politics of health within the MoH, especially when this institution received financial allocations from the National Government to fund its health agendas. Finally, the last section presents some concluding remarks regarding elite politics in Timor-Leste, with specific reference to healthcare development.

A. Ownership in the Aid-dependent Era (1999-2007)

In post-conflict Timor-Leste, a range of actors vied for control of the new state and its resources. From 1999-2002, the United Nations Transitional Administration in East Timor (UNTAET) was a major player but, under its auspices, nationally-based groups began to organise; these included formal organisations like FRETILIN and informal groups such as veterans' organisations and elite networks formed in the diaspora. At the same time, the new state was also becoming established and professional workers, often Indonesian-trained, were being incorporated into new ministries and government agencies, with differing degrees of power to influence policy. The Transitional Government made certain gestures to support local power and capacity, these were largely ineffective. Following the elections in 2001, when FRETILIN gained power under Mari Alkatiri's leadership, the main influential groups were pro-Western elite individuals who supported Alkatiri, and veterans from the revolutionary forces who supported Gusmao, as did the Church. The Cuban intervention in support of the healthcare reform introduced a further element into the political context. This section explores the dynamics of their interactions and their relationship to ownership, with particular focus on the role of patronage and populist policies.

The UN Security Council authorised a peacekeeping mission and established UNTAET in response to the post-referendum violence accompanying the Indonesian military's departure. Under the UN Security Council resolution 1272, UNTAET had two mandates: first, it was assigned

legislative and executive authority to regulate and allocate development resources. For instance, it had to decide policies to rebuild public services and coordinate activities of international assistance, including in public health (UN 1999a). Secondly, UNTAET had responsibility to develop local capacity and institutions for a fully functioning democratic government. To support this, the resolution stresses the need for close consultation and cooperation with the Timorese people (UN 1999a).

In the area of healthcare, in particular, UNTAET was required "to assist in the development of civil and social services" (UN 1999b) by empowering the local people to decide which health system may be appropriate for Timor-Leste. This effort was intended to improve the sense of ownership, as well as enabling the Timorese leadership to maintain their democratic and independent state. Meanwhile, in order to perform the twofold UNTAET mission, the UN Security Council appointed Sergio Vieira de Mello, a Brazilian-born UN diplomat, as the head of the UNTAET transitional government.

Soon after its establishment, UNTAET launched a wide-ranging rehabilitation programme and initiated sustainable development agendas for the public sector. In terms of results, authors agree this had both achievements and limitations. Some argue that during the two and a half years that it existed, UNTAET fulfilled some of its mandate: for instance, it coordinated distribution of humanitarian assistance and assisted the return of more than 200,000 refugees to their homes (Neves 2006b; Seaman 2016). It also developed a competent group of health staff which was able to respond to public health needs and manage the health budget submission (Francino 2003).

Despite these successes, UNTAET faced criticism, particularly in relation to its highly centralized control of policy and the low capacity of the international peace workers. Moreover, although UNTAET's policy of sharing decision-making with the Timorese started, in 2000, with the establishment of the East Timor Transitional Administration (ETTA) under Timorese leadership, this was widely considered to be merely a courtesy gesture. The final decision regarding regulations still fell to de Mello, who combined executive and legislative powers in the transitional administration; and safeguarded UN interests (Chopra 2002). With respect to health project preparations, for instance, collaboration with Timorese elites was limited to symbolic rhetoric about partnership coupled with unequal decision-making and limited space for intervention (Fonseca and

Almeida 2014). Regarding this, Chopra, a UNTAET staff member based in local government, argues, “the UN had no inclination to share power with [Timorese leaders] during the transition, or to include them in any decision-making beyond perfunctory consultation” (Chopra 2000: p.31). Timorese elites, feeling this lack of political participation, expressed their frustration in a letter to de Mello: “The East Timorese Cabinet ministers are caricatures of ministers in a government of a banana republic. They have no power, no duties, nor resources to function adequately” (quoted in Dodd 2000). This suggests that UNTAET did not fulfil its mandate to build the capacity of the Timorese for self-governance: decision-making was largely the preserve of foreign actors rather than local leaders – any sense of ownership on the part of local elites was minimal.

Some commentators also criticized the limited Timorese participation in UNTAET decision-making (Chopra 2000; Suhrke 2001), despite the transitional government’s mandate which focused on building local capacity of local leaders for future state independence. In response, in 2000, UNTAET introduced ETTA. This consisted of eight departments. Timorese leaders were appointed as the head of four departments – Joao Carrascalão (Infrastructure), Mari Alkatiri (Economy), Ana Pessoa (Internal Administration), and Filomeno Jacob (Social Affairs, which included health) – while the other four – Police and Emergency Services, Political Affairs, Justice, and Finance – was still led by internationals. Some argue this reorganization was part of UNTAET’s commitment to the process of transformation and local institution building (UN 2002). In fact, the proportion of UNTAET’s institutional components headed by international staff indicates that they remained dominant in important aspects of development. Consequently, during the UNTAET era (1999-2002), that foreign actor consistently used their domination and control (visible power) over development directions to make local leaders continually have limited say on policy preferences.

In August 2001, with UNTAET’s support, more than 91 percent of Timor-Leste's eligible voters went to the polls; this time to elect 88 members of the National Parliament. The result saw FRETILIN emerge as the majority party with 57.37 percent of votes with the majority of its support coming from the three eastern districts, Baucau (82 percent), Viqueque (75 percent), and Lautem (62.8 percent). This regional voting pattern, which persists to the present day, suggests that FRETILIN’s party support base remains in the area

which was most closely associated to the historic struggle for independence (McWilliam and Bexley 2008; Aspinall et al. 2018). Regarding this, a local Timorese based in Dili stated: “You could belong to whatever party, but if you showed a bit of resistance or anything, [you were] FRETILIN” (quoted in Toome et al. 2012: p.29). Thus, FRETILIN’s historical association – which constitutes it as a Charismatic party due to routinization of heroic leadership through the struggle for independence – remained strong enough to maintain and expand its constituency during elections, Alkatiri became the first Prime Minister and 24 members of the new Timorese Council of Ministers of the Second Transitional Government were sworn into office. In March 2002, Timor-Leste's National Parliament instituted the territory's first Constitution. Presidential elections involving sixteen parties followed in April and Xanana Gusmão, the towering figure of Timorese independence, won 83 percent of the vote; thus, becoming the president of Timor-Leste. These results indicated the end of the UNTAET mandate and the handover of full executive power to the new Timorese government.

Early in FRETILIN’s administration (2002), the politics of elites at national level was largely driven by competition between Alkatiri, the prime minister and leader of FRETILIN, and Gusmao, president and former commander of FALINTIL. This competition influenced the contest of power in the MoH and divided healthcare professionals into two groups: FRETILIN cadres and Gusmao supporters. Over the period 2002-2007, FRETILIN played an especially influential role in healthcare as the Minister of Health, Rui de Araujo, was a FRETILIN member and had actively supported the party’s struggle for independence through the Clandestine Movement and political campaigns in 2007. Alkatiri and Gusmao had different networks of supporters, which were largely shaped by the nature of their leadership during the struggle for independence. Alkatiri’s network consisted of pro-Western elite individuals from the “external delegation” network, such as Claudio Ximenes, later president of the East Timor Supreme Court of Justice (2003-2014), and Ana Pessoa, Finance Minister (2002-2006). These individuals had spent much of the period of struggle outside Timor – in Portugal or in other Portuguese-speaking countries – promoting the diplomatic interests of the FRETILIN movement. Meanwhile, Gusmao had spent 24 years in the Timorese mountains leading the

guerrilla resistance, consequently becoming the de facto representative of the veterans after independence (Guterres 2006).

Interestingly, Gusmao's dominance of the veteran community was challenged in 2002 by Rogerio Lobato, Minister of Internal Administration, who attempted to build an independent power base using ex-FALINTIL veterans by mobilizing the veterans to ensure that future recruitment would favour his own supporters (Rees 2004; International Crisis Group 2006). Gusmao countered this by demanding the government fire Lobato from his position. For Alkatiri, however, Lobato was not a threat to his leadership; rather, this movement benefited Alkatiri by weakening the opposition groups forming around Gusmao (Rees 2004). Therefore, exerting his executive power, Alkatiri refused Gusmao's request, pointing out: "As head of the Government I will see who has and has not the capacity to be minister. I will be the one to dismiss those incapable of doing their duties" (quoted in Asia Pacific Solidarity Network 2002). These public political conflicts in the earliest days of independence reflected deep divisions within Timorese society and different conceptions of Timorese identity.

The above deep political division among Timorese leaders meant that, in the absence of effective mass political parties, elites attempted to shore up their positions in various ways. Between 2002 and 2006, although Alkatiri headed a government that was heavily dependent on aid, yet, with his power, he was able to control the allocation of state resources using patronage politics. This benefited FRETILIN loyalists in appointments in public service (both nationally and in districts) although the country was in a situation of high unemployment (Hughes 2009; Nuttall 2017). Meanwhile, Alkatiri was also trying to expand his patronage network through the establishment of Timorese armed forces, but this resulted in divisions in the security sector and contributed to political crisis in 2006 – as discussed in a later section of this chapter.

Although the Constitution gave power to the National Parliament to debate, amend, enact or reject development proposals submitted by the government, in fact, Alkatiri controlled most of the executive and legislative power. This was because, as well as leading the government as Prime Minister, Alkatiri was also the leader of FRETILIN, a party that had the dominant influence in Parliament. Therefore, even though Section 95 (point 3) of the Constitution declares that it is exclusively incumbent upon the National

Parliament to deliberate, monitor and execute the state plan and budget (RDTL 2002a), Alkatiri was able to use his power to mould the agenda of government and Parliament in accordance with his development priorities. In particular, one of the most controversial policies related to the Law on Immigration and Asylum proposed under Alkatiri leadership, which was liable to favour FRETILIN members in government. Article 11 of this law stated that it was prohibited for foreigners to: "provide religious assistance" (especially to Timorese army and police) or to "engage in activities of a political nature or interfere, directly or indirectly, in State affairs" (National Parliament Timor-Leste 2003).

According to Fernando Lasama, leader of the Democratic Party (and supporting President Gusmao), the implementation of this law would benefit the FRETILIN government in two ways: firstly, it could be abused and used to close down anti-FRETILIN associations on the pretext of foreigners' illegal political activities. Secondly, the law may enrich the Government and its supporters. During a formal press conference, Lasama pointed out the risk of implementing a tight prohibition law by highlighting what had happened in two authoritarian governments; Suharto's rule in Indonesia and Marcos' in the Philippines. These former governments had also based their immigration laws on strict prohibition that, as Lasama argues, might tend to benefit only the rich government members and their families:

> …black-markets flourished, corruption became endemic, favouritism grew out of proportion, money laundry enriched both public and private officers, opposition parties became illegal, human right violations became the order of the day, people could not speak against the government, police and army were government's private body guards, government members were above the law, people were subjugated to the law and to the gun of the police and army, the poor became poorer and the rich became richer, only government family members had security, and only government members and their families had government projects, etc. (Lasama 2003).

As a representative of an opposition party, Lasama, proposed that the Government revise the 'prohibition' law to make it more effective and suitable for the Timor-Leste context (Lasama 2003). This argument indicates that the opposition was distrustful of the government and concerned about a possible

drift towards authoritarianism which could lead to corruption, beginning with the introduction of the Immigration Law as a means to strengthen security and prevent terrorism.

Some authors argue, under FRETILIN's leadership, corruption in executive government, in the form of misuse of power by senior government leaders, became a significant issue and when Gusmao was elected Prime Minister in 2007, he found evidence of the FRETILIN government's corrupt approach in rice trading:

> When this Government took office it was found that the bank account for revenues from the sale of rice by the State only held US$ 830,000. Considering that around US$ 11.9 million were spent in purchases, these revenues seem extremely low. Is this a good example of good administration and governance? Furthermore, even though the State started its purchases within the first few months of 2006, the bank account statement does not have entries prior to February 2007. Why is that? (RDTL 2008).

According to both local and international commentators, there may be political reasons behind this: the rice had either been used for political purposes during the 2007 election campaigns and/or the rice had been distributed to political allies (Public Library of US Diplomacy 2007; Kingsbury 2009). As a result, the Office of the Inspector General, an internal body responsible for financial inspections and audits in government bodies, investigated 70 corruption cases in 16 institutions, several of which happened under Alkatiri's leadership (2002-2005) (World Bank 2006b). The 2006 Corruption Perceptions Index, compiled by Transparency International, showed that Timor-Leste obtained score 26 on scale from 0 (highly corrupt) to 100 (very clean) (Tranparency International 2006), which means the country faced a serious corruption problems, which were mainly associated with bureaucratic processes.[27]

This evidence indicates that under FRETILIN government leadership, there were corruption scandals in which some were linked to vote buying and

[27]The transparency score during Alkatiri's leadership as Prime Minister (2002-2006) is not available because Transparency International did not begin to calculate Timor's Corruption Perception Index till 2006.

this had significant implications regarding high levels of elite corruption under Alkatiri leadership. At the same time, FRETILIN's embrace of development programmes was the subject of distrust, and accusations of authoritarianism and corruption by FRETILIN's political rivals. National 'ownership' was seen as a threat, particularly as the FRETILIN leadership were portrayed as almost foreign themselves – because they had been outside of the country during the resistance years, they were portrayed as cut-off and out-of-touch with the local population, and also as self-serving in their determination to come back and take power.

While Alkatiri applied patronage and corrupt practices as a means to consolidate power during his leadership, Gusmao sought to use the veterans' support to empower himself so that he could challenge FRETILIN domination. For instance, three months before the national election in 2007, Gusmao established the National Congress for Timorese Reconstruction (CNRT) as a political party and the veterans were involved in supporting his political campaigns (Leach 2017a). This fuelled the rivalry between the two parties including during the election contest. However, ultimately an empty populism took over characterized by vacuous contests regarding national identity. As the discussion below shows, during 2007 election campaign, both FRETILIN and CNRT used their historical and post-independence contributions as a dominant political strategy to attract Timorese voters so that they could win the election.

In 2002, Alkatiri introduced a plan for national development. Ostensibly, the aim of this was to capture Timorese aspirations for independence through a process of national consultation but an underlying goal was to support Alkatiri's ownership of policy directions to sustain his position. It was formulated following a six-week nationwide consultation involving 38,000 Timorese citizens, followed by a series of national workshops, conducted by senior officials, including ministers and vice ministers, to identify which of the chosen aspirations would be taken as the main issues for development. Based on the workshops and feedback from stakeholders (and approved by Parliament), the Government finally launched several strategies for development under the National Development Plan (NDP).

According to Gusmao, while president under the FRETILIN government, the Plan was the work of Timorese people because "the process of preparing the Plan gave thousands of East Timorese, from school children to elderly

people, the opportunity to think about the kind of future they want for themselves and for future generations" (RDTL 2002b: p.xvi). In reality, however, the role of Timorese was limited to suggesting general goals, while elites played the major role of formulating "the highly important means to realize those goals" (Lao Hamutuk 2002a: p.16). Moreover, although elites were able to decide the Plan, their role was limited compared to the influence of donors. According to Lao Hamutuk, only "small groups of East Timorese civil servants, along with foreign consultants from the World Bank, the IMF, the United Nations, and other international bodies did the actual 'planning' and writing of the document" (Lao Hamutuk 2002a: p.16). In fact, in places the document "reads like similar publications written for and/or by the World Bank and IMF in other countries" (Lao Hamutuk 2002a: p.16). These facts show that the national consultation was in fact a populist move on the part of the FRETILIN leaders since it only established broad headings, while the detailed work of developing strategies and action plans was carried out by elite actors, with donors in the fore front. The finalisation of the Plan document, which was written by the Bank but presented as being written by Timorese officials, indicates the successful use of hidden power to make donors' ideology and values significantly influential in development planning among Timorese elites.

In the Plan, the Timorese government recognized that "standards of health in East Timor are poor, and existing health provision is weak" and this was rooted in "acute shortages of doctors, nurses and midwives" post-independence (RDTL 2002b: p.45). In response, FRETILIN leaders called on various foreign institutions that had supported healthcare delivery since 1999 to work closely with government institutions and to put local priorities into their programmes. Also, under this 'Timorization' policy, the process of authority handover from NGOs to government was successfully conducted and implemented, firstly, through an in-depth participatory assessment to identify areas where potential gaps could disrupt health service delivery on NGOs' withdrawal, which was followed by periodical monitoring. The primary area identified was the availability of health professionals and medical facilities in rural areas (Alonso and Brugha 2006).

The problem stemmed from the newly elected FRETILIN government's inability to initiate and implement a systematic approach to development due to donors' lack of political will to assist them in the process, preferring to focus on

promoting their own agendas (Engel and Hanley 2009). Consequently, the Government was encouraged to set up a human resource capacity development programme which would have visible progress in meeting the basic needs of the population. To help implement this, Alkatiri established substantial medical cooperation with the Cuban government. Under this agreement, Cuban doctors came to Timor for medical services and trainings, while hundreds of Timorese students travelled to Cuba to study medicine under full scholarship from the Cuban government – see Chapter 6 on the Cuban capacity programme.

This chapter argues that the decision to have Cuban aid was very much driven by popular sentiment rather than a liberal-technocratic approach because it was a strategy of FRETILIN appealing to the Timorese people through a visible and unsophisticated programme. Under this populist policy, as also explained in Chapter 3, FRETILIN elites that own charismatic leadership due to their huge contribution to the struggle for independence, attempted to convince Timorese people (with their emotions) that Cuban health programme is suitable for the country and will improve the quality and access to healthcare for all Timorese regardless of their status. However, in reality, this policy is based on populist consideration rather than a rationalist decision. Furthermore, the decision to have Cuban capacity programme is decided by the elites without involving technical capacity from healthcare professional.

The implementation of Cuban capacity also shows that the elites had successfully used populist policy as vehicle to carry on their socialist ideology of development, which has already been introduced since struggle for independence (see Chapter 4). This is in accordance with the ideology of FRETILIN which asserts that “all citizens have a right to good health, and to free health care” (FRETILIN 2007a). This view on ideology was countered by de Araujo, a FRETILIN cadre and also the Minister of Health during the party’s term in office (2002-2007), who asserted that, to the contrary, the Cuban capacity-building programme was about “doing purely health work” rather than motivated by “political affinities” among FRETILIN and Cuban leaders (quoted in Barker 2006a). However, during his prime ministerial visit to Cuba in 2005 to further discuss this programme, Alkatiri pointed out the main reason for establishing this bilateral work was not only to train young people from Timor-Leste in medicine but also to affirm solidarity with the Cuban socialist system

(quoted in Cuba Solidarity Campaign 2005). This evidence shows political/ideological connections remain a strong reason behind the cooperation between FRETILIN-led government and the socialist government of Cuba.

However, this cooperation found a cold response within some sectors of Timorese society. Some commentators suggest that Cuban socialist approach was not appropriate in the Timorese context because health professionals in Timor welcomed the neoliberal approach brought by Western donors, having already benefits from the higher salaries under the Indonesian administration, as explained in Chapter 4. More detailed discussion of this is provided in the section on the Cuban health programme in Chapter 6. Most notably, Timor-Leste's close relations with the Cuban government were viewed negatively by the Catholic Church, which was highly influential and, as discussed in Section B below, eventually succeeded in marginalizing Alkatiri as a threat to its interests in promoting a populist Catholic agenda (Fernandes 2010; Boughton 2012). In the meantime, the Church opposed the Cuban programme by campaigning to its churchgoers that FRETILIN government was trying to turn Timor-Leste into a socialist country (Symonds 2006).

However, until recently, many people still remember Cuban aid as the greatest decision of Alkatiri's leadership as a means to address the shortage of medical personnel in the territory (Respondent 4 and 16). During the parliamentary elections in 2007, FRETILIN elites used the successful implementation of Cuban aid as a political commodity to attract voters. For instance, in a media release, FRETILIN stated: "the bilateral health programme with Cuba is one of the main achievements of the FRETILIN government" and it has contributed to better health inputs for the population (FRETILIN 2007a). Thus, it gave the message to the Timorese people that, if they support FRETILIN's leadership, access to high quality healthcare would be widespread, which would mean real improvements in well-being of the people.

From the above discussions, it can be seen that under UNTAET administration, elites quickly took advantage of their position to use public policy as a means of engendering political support. Similarly, under the FRETILIN government, political elites were able to decide and implement development policies benefiting their political supporters. However, as regards healthcare, patronage politics only occurred in service delivery. For instance, some veterans had priority medical operations to remove bullets and shrapnel and

this service was paid by the state (World Bank 2008b). Alkatiri had few resources other than the FRETILIN name and a vague policy of leftist solidarity that had been popular in the 1970s but was no longer. Thus, the decision to have Cuban aid represented a quick and cheap form of assistance and was also a bid to popularise FRETILIN because the party was trying to find a language to use in speaking to the people post-independence. For instance, health facilities (such as hospitals, community health centres, health posts, mobile clinics) were rehabilitated across the country (see MoH Timor-Leste 2002). Although this was unsuccessful in mobilizing support, it indicates that the politisation of healthcare was conducted through populist rather than patronage politics.

Moreover, there is further evidence that the Cuban deal was more about winning votes than focusing on the details of Timor's healthcare programme. For example, neither the MoH nor the healthcare professionals were even consulted about the decision,[28] despite its far-reaching implications for the future of health professional training and management in Timor (Respondent 41 and 45). Furthermore, the decision to have Cuban aid served the purposes of the Timorese government rather than health professionals, who preferred a neoliberal approach to healthcare provision.

Thus, in the context of Timor-Leste, politisation in healthcare resulted in a mix of neoliberal solutions supported by Western donors and health professionals and a more populist-inspired Cuban solution. This served to undermine local ownership of the health system as well as causing specific problems in that it created divisions among healthcare professionals both nationally and within hospitals; and some would also argue it actually damaged medical services in the country (see Chapter 6). Therefore, the evidence shows that donors and FRETILIN elites exercised most control over the health sector in the aid-dependent era – at the expense of ownership by healthcare professionals who had little voice in policy-making.

[28] During this time, the MoH was led by FRETILIN supporter, Rui de Araujo. However, in the early stages of the initiation the programme (2003), he was not involved in the decision-making, although he became one of the country representatives (together with Mari Alkatiri) responsible for signing the official cooperation agreement with Cuban government in 2005.

Ownership in the Health Sector (1999-2007)

This section first examines which groups were significant in driving policy-making in the health sector during this aid-dependent period 1999-2007. The discussion then focuses on how the various forms of decision-making were conducted before considering the extent to which healthcare professionals were able to play a role in decision-making and directing health policies, what factors limited this, and whether this prompted a neoliberal approach to healthcare.

Following the total breakdown of the health system post-referendum, various NGOs, supported by UN agencies and peacekeeping medical staff, provided emergency humanitarian assistance for healthcare across Timor-Leste under the umbrella of the UNTAET in 1999. At the same time, many of the remaining Timorese health professionals organized themselves to form the East Timor Professionals Working Group. Under the assistance of local and international organizations, the Group had been able to draw up both short and longer term plans for health service delivery: for short-term, it conducted an in-depth study regarding the most pressing health needs of the population, and made plans to address them. Meanwhile, for the longer term, the Group (together with donors) discussed and agreed on the idea to establish a bureaucratic authority which may oversee development of the territory's health system. This led to the establishment of the Interim Health Authority (IHA) comprising Timorese and UN staff within the UNTAET structure: it was headed by Jim Tulloch from the UN health sector team and Sergio Lobo, a Timorese surgeon, and supported by 29 Timorese health professionals and six UNTAET health staff (Tulloch et al. 2003). With the establishment of IHA, the end of emergency phase was declared and a long-term approach to health sector development was adopted.

The IHA was located within the Social Services Sector of UNTAET and became the forerunner to the future MoH; it began the process of designing and implementing the national health system, focusing on the following targets:

> to rebuild and rehabilitate health care facilities; to train and support East Timorese health personnel; to ensure an adequate supply of drugs via a central pharmacy for the country; to maintain a communicable disease surveillance system; and to develop a well-coordinated health care system

> [based on three levels of service (subdistrict, district and national level)] (Finkelstein and Finkelstein 2001: p.14).

Some of these efforts were funded by the UNTAET-administered Trust Fund, some by donor agencies through SWAPs.[29] According to the World Bank, the use of SWAPs was an effective way to increase the quality of aid delivery in Timor-Leste because it combined the work at two interrelated levels: "(a) to permit the definition of needs across the board—service delivery, rehabilitation of the health infrastructure, health systems and health policy development; and (b) to coordinate donor financing of the sector" (quoted in Rosser 2007: p.128). As a result, the UN and the international actors hoped that the Timorese government would gain more legitimacy and so more trust from population (Sheikh et al. 2015). Since the IHA consisted of Timorese people with medical capacity it would have credibility in its role in developing the health system (Tulloch et al. 2003). However, although the donors' application of SWAP was intended to let local health professionals be in charge of health service delivery, the IHA continuously faced constraints due to limited facilities allocated by development partners. As Tulloch argues:

> Holding meetings of the newly formed IHA was always a challenge, as the "office" of the IHA was in a huge auditorium shared with many other sectors of the transitional administration. Chairs were in short supply, and the noise level at times so high that communication during meetings was close to impossible (Tulloch et al. 2003: p.8).

With the establishment of ETTA, which assumed responsibility for delivering essential public services from UNTAET, IHA was renamed the Division of Health Services (DHS) and, led by Rui de Araujo, a Timorese doctor who later became the first Minister of Health, it continued the mission to provide basic healthcare services for community. Under de Araujo leadership, DHS successfully recruited 64 Timorese health personnel to work in management and clinical positions in the health services – some of them were appointed as the Heads of DHS in each of the districts (UNTAET Press Office 2002). DHS also planned to spend US$ 70 million over three years (2000-2003). This

[29] Details about SWAPs can be found in Chapter 2.

money came from several sources (including the UNTAET budget) and was allocated largely to build the health infrastructure for a fully functioning healthcare system (Lao Hamutuk 2000). For instance, according to the plan in 2001, DHS planned to establish the following health facilities: Five hospitals (a National Hospital in Dili and district hospitals in Ainaro, Baucau, Maliana and Oecusse), several health clinics with inpatient facilities in some of the remaining districts, 148 health posts (both with and without beds) in each subdistrict – some equipped with mobile clinics to cover outlying villages (Lao Hamutuk 2000). In addition to this, DHS also planned "to construct 25 new clinics in the most needy subdistricts by the end of 2001" (Lao Hamutuk 2000: p.4).

Under FRETILIN leadership, there was some progress in the field of healthcare. In terms of infrastructure, the Government indicated the following achievements:

> Rehabilitating and expanding the National Hospital in Dili at a cost of USD$ 9 million. Five referral hospitals are being built in the districts of Oecussi (west of Dili), Bobonaro (west of Dili), Maubisse (south of Dili), Baucau (east of Dili) and Suai (west of Dili) at a cost of USD$ 16 million. The Government is also overseeing the building of a national laboratory, 47 health centres and 104 health clinics stations across the country (FRETILIN 2007a).

Several authors comment that the involvement of Timorese professionals in the health system rehabilitation resulted in the success of delivering essential public services (Mercer et al. 2014; Barma 2016). To support this observation, Schenk states:

> The health sector showed a rather positive development in the arena of capacity building and service delivery due to the following factors: Timorese staff had taken over responsibility in an early stage and the process of 'Timorization' started early in the Ministry of Health (Schenk 2009: p.42).

This contrasted with critical assessments of the overall UNTAET mission, which asserted that many observers suggested failed to play an effective role in the

rehabilitation and transition of Timor-Leste due to the excessive centralization of power and lack of accountability of the Transitional Administration (Chopra 2002; Barma 2016). For instance, although under ETTA Timorese leaders had 'ownership' of the formulation of public service policies and programmes (including in healthcare delivery), in reality, the final decision-making remained with the UNTAET (Coelho 2008). International staff also continued to dominate central and district administration – for instance, by March 2001, only two of the thirteen district administrators were Timorese (Suhrke 2001).

In the health sector, the limited size of the Timorese workforce, including doctors, gave more power to donors to decide training plans and programmes to fill the gap in human resources following independence (WHO 2001). According to Lao Hamutuk, international donors preferred to select initiatives themselves, and reach particular pre-set developmental results rather than lose time in consultation, negotiation, and 'trial by error' (Lao Hamutuk 2002b). Moreover ETTA was resource-starved in comparison to UNTAET – for example, in 2001, ETTA had a budget of US$ 65 million, more than eight times less than the UNTAET budget of US$ 560 million (Katzenstein 2003).

When FRETILIN took power in 2002, DHS evolved into the MoH Timor-Leste – the only institution responsible to deliver health services. Under a Timorese government, the question of ownership became more pressing; however, even its vision statement reflected international influence. Aiming to fulfil the right of every Timorese to health and medical care, the MoH summed up its vision in the slogan: "Healthy Timor-Leste people in a healthy Timor-Leste" (MoH Timor-Leste 2002: p.12). Consistent with the vision statement, all activities of the MoH would be directed "to strive to ensure the availability, accessibility and affordability of health services to all the people of Timor-Leste, to regulate the health sector and to promote community and stakeholders' participation (including other sectors)" (MoH Timor-Leste 2002: p.13). Interestingly, this vision did not originally come from the MoH, but was prepared by WHO – as can be seen from the foreword by the Rui de Araujo, then Minister of Health, in the MoH health profile document:

> I would like to take this opportunity to thank Dr Alex Andjaparidze, Head of WHO Office in Timor-Leste, for providing useful input on some important topics, and to Mr Sudesh K. Madanpotra, Administrative Officer to the

> Minister for Health, Timor-Leste, for collating the information and preparing this useful document (MoH Timor-Leste 2002).

This evidence strengthens the point presented above which argues that donors consistently used hidden power to affect various aspects of development planning in Timor-Leste and this also occurred in the healthcare sector. Thus, this means that programmes within the MoH have been highly influenced by donor ideas rather than reflecting local leader ownership on decision-making.

To unpack the ownership debate in the specific context of the health sector, it is useful to consider the different types of decision-making evident and how these were distributed between local and international actors. Types of decision-making included: setting priorities, executing programmes, allocating funding, cancelling programmes, allocating human resources and determining agendas. As under UNAET, these roles were constrained, not only by issues of ownership contingent on financial dependence, but also by lack of capacity and resources.

During his term as Minister of Health (2002-2007), de Araujo continued to prioritise basic health care services to the population. However, the major constraints in ensuring full access to health services were lack of funds and capacity to plan and implement health programmes; in addition to the limited number of health facilities and personnel (Snell et al. 2005). For instance, in the fiscal year 2000-2003, the Timorese government planned to spend around US$ 7 million to fund various activities in the health sector. All of this money was received from aid partners (MoH Timor-Leste 2002). Consequently, although MoH had power to set priorities, cancel programmes and allocate human resources, their programmes could not be implemented due to lack of funding and capacity. This made donors' funding allocation became increasingly important and, as a result, only programmes that fit donors' agendas could be implemented. A local nurse working at the National Hospital argued: "[During aid-dependence] not all programmes could be executed. This was because all is dependent on funding which allocated by donors. Therefore, even though MoH had some 'dreams', it has no power to implement them" [author's personal translation] (Respondent 17). Such dreams included improving health technologies and increasing the workforce capable of operating them. This indicates that, during the aid dependence era, with their dominant power and

resources, that donors could successfully control the agenda of healthcare development using their visible power. Even so, it is worth noting that donor support provided the opportunity for MoH to implement liberal-technocratic approach to healthcare. De Araujo argues: "…during the transition and after independence, health policies were shaped by substantial participation of Timorese people, with the support of international experts, always having in mind principles like, evidence-based policy-making, suitability to the Timorese context and sustainability" (quoted in Martins 2010: p.138).

Nevertheless, although the MoH had limited health resources and was dependent on donor support, it was able to decide which healthcare services should be prioritized and to which areas health services should be distributed. According to a senior health services manager based in Dili during political crisis in 2006,[30]

> things that were not too important at that time, like physiotherapy, we cancelled it and all of the staff came to help … and also from the outpatient department, we needed them to cover all the wards, and also we asked help from the Cuban Doctor Brigade and their help was about getting the extra personnel [doctors and nurses] that they have in districts, so we had the support from nationals and from the Cubans (Zwi et al. 2007: p.33).

This does not mean the MoH had full control over policy decisions – many donors were supporting the health sector and these actors had different degrees of influence (through providing capacity training, human resources, health facilities and/or advisers). For instance, Cuban doctors provided training and medical treatment in hospital and rural areas,[31] while part of the WHO intervention focused on providing technical advice and capacity programmes to the MoH.[32]

On many occasions, the MoH had to adopt donor priorities rather than implementing its own agenda. Firstly, while aid-dependent, the MoH did not have enough of its own funds to implement its programmes – at the same time

[30]More details about this crisis are provided in the next section.
[31]See Chapter 6 on the Cuban health programme.
[32]See Chapter 6 on the WHO health programme.

healthcare services became increasingly important politically and practically. This made donor money become increasingly necessary, and when it was provided the MoH had to accept the whole programme design established by foreign agencies. The MoH had no power to make donors conform to its priorities; if they attempted do so, implementation would not be funded. A Timorese civil servant expressed his individual view: “Before [during aid-dependence] we were afraid, if we went against them [donors] we could not get money” [author’s personal translation] (Respondent 7). As consequence of this, the MoH accepted health programmes initiated by foreign agencies (with limited power to ‘go against it’) and hoped that it would have sustainable impact on health development in Timor-Leste [author’s personal translation] (Respondent 7).

Secondly, the MoH lacked capacity to articulate policies and implement healthcare agendas. This made decision and evaluation heavily reliant on foreign advisers, which meant donors continued to exert significant influence over health policy. In other areas, however, although some civil servants had the capacity to formulate and implement programmes, donors still would not let them to do it. In her research, Ana Soares[33] presented a comment from a civil servant at MoH who was involved in policy-making but had only limited capacity and ‘voice’ during the meetings:

> I would say that I was not involved 100% in the process of development of East Timor Health Policy Framework 2002. The reasons were as follows. Firstly, the process was lead and influenced by the donors and international advisors. Secondly, I had a lack of knowledge, qualification, and experience on the subject. And thirdly was the language barrier. I could not involve myself well in the discussion because of the language problem. Our colleagues who speak little bit of English could participate in the discussion but the others depended on the interpreter. I did not know whether what I said was interpreted correctly or not. The important issue from my perspective was ensuring that the health policies and programs conform to and reflect, Timorese local culture and tradition (quoted in Soares 2002: p.103-104).

[33]The current Vice Minister of Health Timor-Leste.

Lastly, human resources for healthcare were limited post-independence, making the presence of international health workers more significant for delivering quality healthcare to the population. I asked a senior nurse about the contribution of international doctors toward medical treatment in the National Hospital and she immediately answered with positive points: “They have made lots of contributions, particularly in providing care to patients” [author’s personal translation] (Respondent 32). However, decades of Indonesian influence on Timorese healthcare development had changed the context for this rhetoric, with the result that the Cuban programme caused significant tension in the healthcare system. This is discussed in detail in Chapter 6.

These examples indicate that, under FRETILIN, visions of local ownership were not translated into practice – donors still played dominant roles in development agendas and health professionals continued to have a limited role in health policies. Meanwhile, despite efforts to introduce public service based reforms, increasingly corrupt practices and elite patronage further undermined the government’s ownership of healthcare policy and implementation, and health professionals were excluded from both.

B. Political Crisis and the Shift in Ownership (2006)

This section elaborates on the context of the political crisis that ended Alkatiri’s leadership, looking specifically at how it affected ideas about ownership. At this point, Alkatiri’s tenuous relationships with the Church and with veterans from the revolution were becoming critical. This was in part due to Alkatiri’s ineffectual attempts to expand his patronage politics in the establishment of Timorese armed forces, which created divisions among military members of groups who benefited and those who were marginalized in the allocation of state development. Unresolved longstanding inequalities heightened tensions till those who felt excluded from state-building expressed their dissatisfaction through a series of demonstrations. Rather than address the problem, Alkatiri reacted using centralized decision-making which was unpopular among the Timorese. As a result, conflicts escalated and eventually led to crisis in 2006. With the growing violence and instability, combined with pressure from different parties, Alkatiri resigned from his position as Prime Minister.

Conflicts of interest between veteran groups had emerged since the start of the process of forming Timorese's security forces in 2001; these stemmed largely from debates over who fought harder during the resistance era. The nature of the FALINTIL struggle, which was mainly based in the east, meant that senior veterans from eastern part of the country (*Lorosae*) dominated the officer ranks.[34] Yet, discrimination manifested in a variety of ways, including unfair promotions, disciplinary measures, long travel distances and communications experienced by new recruits who came from western areas (International Crisis Group 2006; Nuttall 2017). As a result, in January 2006, a group of 158 soldiers signed a petition to President Gusmao, as Supreme Commander of the defence force, requesting him to address the 'biased conditions' against westerners (International Crisis Group 2006).[35]

Receiving no response from the government, the petitioners abandoned their barracks and held a march at the Presidential Palace, hoping to confront the president. Together with Defence Minister Roque Rodrigues and the defence forces Chief of Staff, Colonel Lere Anan Timor, President Gusmao met the petitioners and promised to investigate their grievances, demanding that, in exchange, they should immediately return to their barracks or face dismissal.[36] Following the meeting, President Gusmao established a Commission of Inquiry comprised of military officers and two Members of Parliament. However, the composition of the Commission was rejected by the petitioners because it included three persons who became the target of their discrimination allegations, including Colonel Lere (International Crisis Group 2006).

By the end of February 2006, their number having risen to 593, the protestors declared they would leave their military posts without intention of returning. In response, Taur Matan Ruak, the Defence Force Commander and former guerrilla leader, dismissed the 'petitioners' from the defence force. Through a local newspaper, Alkatiri expressed his support for Ruak's decision, arguing it was correct and just because the soldiers has been absent from their

[34] Former veterans from the eastern districts comprised 85 percent of officer ranks (International Crisis Group 2006).
[35] The document was copied and sent to different parties, including Taur Matan Ruak (Chief of the Defence Forces), the Minister of Defence, bishops and political parties, as well as the ambassadors of Australia, Portugal and the United States.
[36] Only some petitioners returned to their barracks.

jobs for nearly two months (quoted in UNOTIL Daily Media Review 2006).[37] In contrast, President Gusmao, who was out of the country at the time, disagreed with the dismissals and asserted that "the decision was incorrect since it tended to focus more on military discipline than the background and the roots of the problem" (Gusmao 2006). This demonstrates that Alkatiri attempted to bypass the role of the President and exert his own authority to consolidate his control, although the effort was backfired.

Following the dismissals, the demonstration degenerated into violent conflict in the western part of Dili. With Ruak away, Alkatiri took a decision to request assistance from military forces under Colonel Lere, the perpetrator of discrimination against the western soldiers. He recruited special security forces and, according to Commander Rallos (of the security forces), ordered them to eliminate all petitioners (Barker 2006b). The westerners interpreted this as an attempt to support the eastern-dominated soldiers and make reprisals against the westerners (Sahin 2007). As a result, tensions between easterners and westerners became intensive and also involved broader and more generalised regional and political hostility, which led to crisis. It was reported that the violence in several locations around Dili resulted in 32 casualties, more than 1,000 buildings destroyed and around 150,000 people being displaced from their homes (Brady and Timberman 2006). Rather than looking for help from Gusmao to quieten the situation, FRETILIN government decided to request international assistance.

Alkatiri's failure to respond to the demands of the protestors resulted in political crisis and pressure from different parties demanding he step down. First, pressure came from the petitioners who criticized the FRETILIN government for not responding quickly to the original petition (International Crisis Group 2006). Similarly, President Gusmao said Alkatiri should be held responsible for his political decision, which took the country into crisis, and resign; otherwise, Gusmao would resign from his position as President:

> Ask Comrade Mari Alkatiri to take responsibility for this crisis and for the continuation of a democratic state, or tomorrow I will send a letter to the

[37]According to International Crisis Group interviews Alkatiri backed up Ruak's decision because he wanted to 'filter out' the westerners so that FRETILIN loyalist groups would dominated the army (International Crisis Group 2006).

> parliament that I am resigning as president because of the iniquities perpetrated by this government on its people. I can no longer face the public (quoted in International Crisis Group 2006).

Meanwhile, since 2005, Alkatiri's unpopular policy on religious education and his criticisms of the Catholic Church – including accusations of it becoming a political party – had been creating tension between the Government and Church. In particular, in his policy, religious education was defined as an unfunded after-school elective rather than a compulsory part of the curriculum, despite Timor-Leste being a predominantly Catholic country (Berlie 2018). Consequently, Alkatiri had lost the support of the Catholic leaders, who organised mass demonstrations involving up to 10,000 people during April, 2005, which compounded the ongoing crisis. The Church branded Alkatiri as a communist and a Muslim of Yemeni descent (an extreme allegation in a country where 96 percent of the population were Catholic), and campaigned to remove him from office (Afrol News 2006; Tapol 2006; Johnston 2012). The mass demonstrations were to some extent supported by the United States in that the Embassy provided portable toilets for the demonstrators, which increased later suspicions that the United States was involved in Alkatri's downfall. At the same time, banners appeared on the streets declaring he was a Marxist, a terrorist and a dictator. Alkatiri capitulated and agreed to include religious education in the school curriculum; moreover, he also agreed to include abortion and prostitution in the Penal Code as crimes (Cristalis 2009). This formed the starting point when the Church successfully showed its influence as a political player in post-conflict Timor-Leste.

In response to these several pressures from different parties, including Ramos-Horta who threatened to resign, Alkatiri finally announced he was stepping down from his position as Prime Minister in early July 2006.

This whole episode demonstrates the weakness of state institutions in the face of highly mobilized social forces – veterans and the Church – which could override the democratic authority of the Prime Minister. It shows that the Prime Minister had not successfully cultivated a power base either through patronage or through populism – in fact, both the veterans and the Church were successful in portraying Alkatiri as a foreigner. Moreover, a new national identity had emerged during the struggle that was at odds with Alkatiri's vision – as revealed

by the controversial nature of the Cuban programme. Consequently, the ramifications of such political turmoil meant that the notion of national ownership of areas like healthcare developed an even greater sense of confusion.

C. Ownership in the Oil-dependent Period (2007-2017)

The dynamics of elite interactions under the CNRT government (2007-2017) shifted significantly when oil revenues become the main source of development funding. Arguably, during the post crisis era, there was a change of attitude among major actors of development who began to apply lessons learnt during the crisis concerning the rising power of non-elite groups such as the Church. Meanwhile, the oil money gave the newly elected government more power to decide development strategies and sustain peace in the country. In particular, they gave support to their two main power sources, the veterans and the Church. The politics of elites during this time can be divided into two periods. The first was characterised by the continuation of rivalry between Alkatiri's and Gusmao's groups and the second involved their collaboration within a coalition government. From the outset, rather than concentrating on how to tackle poverty and inequality, both parties personalised the issues and focussed on the personal authority of their leaders. This began during the run up to the parliamentary election in May/June 2007 when both FRETILIN and CNRT published campaign posters portraying themselves as representatives both of the heroic past of the nationalist struggle and of modern democratic politics:

> The campaign posters of [Gusmão] featured him alternately dressed in a suit and tie in the manner of a statesman, and as 'warrior hero' in military uniform. Likewise, Francisco Guterres' [the FRETILIN candidate] campaign material included a pamphlet that portrayed him both as 'Lu Olo the Freedom Fighter … in the jungle with FALINTIL', and as a suit clad 'Lu Olo the Political Leader … President of Parliament' (Nygaard-Christensen 2012: p.212).

With 21 seats, FRETILIN failed to achieve a majority vote (33 seats), and CNRT (with 18 seats) formed a majority alliance with three other parties, securing 37 seats in total and appointing Gusmao as Prime Minister. This became a new

political coalition which challenged FRETILIN domination in electoral politics and marked a shift in power within executive government to the CNRT. However, it also divided voters along regional lines: easterners continuing to support FRETILIN while westerners backed CNRT (McWilliam and Bexley 2008).

Moreover, as Alkatiri had done before him, Gusmao then controlled power in executive and legislative government to protect his leadership. For instance, Mario Carrascalao was appointed Deputy Prime Minister for State Administration in 2009 with special responsibility for combating corruption and reforming procurement maladministration and procurement powers were transferred from the MoF to his office. Interestingly, during his investigations, Carrascalao found that US$ 3 million had been lost from the MoF due to elites' misbehaviour. In response to accusations in the media, Gusmao stated:

> This person who has been making statements about these three million dollars lost in the Ministry of Finance is a stupid person and does not have an understanding of the system. I know what Mario Carrascalao wants to show. He wants to say that because he did not want even one cent to fall to the ground he has grabbed onto this three million dollars thing. This only shows his stupidity, that he does not understand the system (quoted in Tempo Semanal 2010).

Carrascalao's attitude and media publications affected the patronage politics and the popularity of the government; therefore, a year later, to secure ownership of his leadership, Gusmao decided to 'eliminate' Carrascalao from the government's role and transferred his power over all government procurement to line ministries.

Under CNRT leadership, executive government had control over access to petroleum revenues. However, to protect Timor-Leste's long-term interests, the Petroleum Law 2005 only allowed transfer of a maximum of three percent of the total income from oil exploration each fiscal year. The law, however, did not limit CNRT domination: with the professed motive of 'securing national interests', after limited consultation with the parliamentary members, Gusmao's leadership (supported by President Ramos-Horta) introduced a Decree-Law on creating Economic Stabilization, ostensibly aimed at combatting the effects of the 2008

global crisis (FRETILIN 2008b). To support this, US$ 240 million dollars were allocated to the state budget for supplying food, fuel, and construction materials – nearly as much as the original budget for 2008 and exceeding the ESI value.[38] FRETILIN leaders opposed the decision, arguing that it was an attempt to withdraw money from the Fund in an opaque and irresponsible manner. In a media release, Guterres, then FRETILIN Parliamentary Leader, stated:

> The objectives of the Decree Law, set out in Article 2, are the procurement and distribution of food for food security, fuels and building materials by the government. But the Decree Law does not establish the procedures, rules and mechanisms for the procurement, administration and financial control of the funds or the distribution of the acquired stock in a transparent or accountable manner. Sections 4, 5 and 6 state that these vital transparency and accountability issues will be dealt with by 'appropriate regulations to be approved' (FRETILIN 2008b).

Further action was taken by 16 members of Parliament who requested a review of the state budget 2008, claiming it was against the Constitution and Petroleum Fund Law. In the end, the Timor-Leste Court of Appeal decided that the Economic Stabilization Fund was unconstitutional and illegal. This put budget transfer from the Fund back to the limits set by the previous legislation (Dizard et al. 2010).

Interestingly, sometimes FRETILIN members agreed with CNRT policy; for instance, according to Ágio Pereira, Official Spokesperson for the Government, FRETILIN supported the coalition government's decision to increase the pension for the elderly (Pereira 2009). This is because cash transfer scheme (like the one for elderly) became an important tool to promote populist appeal and this issue has been used to increase their popularity during 2012 election campaigns (International Crisis Group 2012). This evidence also illustrates how the politics of elites in Timor was a mixture of patronage and populist politics.

CNRT domination continued after the 2012 presidential elections, when CNRT supported Taur Matan Ruak, who stood as an independent candidate, rather than the incumbent president, Ramos-Horta, whose criticism of the budget and corruption involving government officials had affected Gusmao's

[38]See more explanation about ESI in Chapter 3.

patronage politics (Beuman 2016). Ruak was widely respected by all parties (including FRETILIN) and had the image of a home-grown nationalist, as opposed to Ramos-Horta's more cosmopolitan background. In supporting Ruak, Gusmao was both making a move to protect his ownership of executive power and responding to the rising populist politics that was supported by Timorese elites in the 2012 elections (Leach 2017a). With Gusmao's 'blessing', Ruak defeated Lu Olo (FRETILIN's candidate) in the second-round with 61 percent of the national vote and was inaugurated as president for the period of 2012 – 2017. Similarly, CNRT also performed strongly in 2012 parliamentary election with 36.66 per cent of the vote, followed by FRETILIN with just under 30 per cent. Although, again, no single party gained an absolute majority, CNRT again formed a governing alliance with two parties, now controlling 40 seats in Parliament and with Gusmao as Prime Minister for a second time.

Gusmao centralized power and decision-making under the executive government, and both populism and neopatrimonialism became the state's mode of resource distribution, serving to expand elite political networks. The implementation of the pension policy for veterans addressing the roots of the 2006 crisis provides a classic example of this. The beneficiaries of the policy comprised four groups of veterans: 1) a small number of leading resistance figures who had made outstanding contributions in the liberation struggle and, therefore, received the highest amount of pension of US$ 750 per month; 2) veterans who had participated in the resistance for at least eight years or who 'are incapable of work due to physical or mental disabilities resulting from their participation' (Kent and Wallis 2013), received between US$276 and US$ 575 per month; 3) surviving family members of veterans (widows, orphans, elderly parents) of veterans received between US$ 230 and US$ 287.50 per month; and 4) veterans who do not qualified for pensions, but were still eligible for one-off payments (Kent and Wallis 2013; Anderson 2014b).

Following the introduction of the scheme, the number of veterans who received payments increased rapidly. In 2008, 2,011 people received the veterans' pension. Four years later (by 2012), of the 37,704 former combatants initially registered, 22,202 received pensions and 15,502 received one-off payments (Anderson 2014b). This, consequently, increased government spending: in 2009, the government spent US$ 38 million of the state budget for the payment of veterans' pensions (MoF Timor-Leste 2010). Thus, by 2015,

the amount had risen to US$ 130.4 million (MoF Timor-Leste 2015). As well as pensions, veterans and their family were also entitled to special treatment in health and education – for instance, all veterans' children became eligible for government scholarships[39] (World Bank 2008b). This will make an intergenerational impact as veterans and their descendants would be better able to educate their children than most of the populace.

In terms of the political elites' approach, the significant amount of money spent on veterans reflects the highly mobilized nature of this group, their popularity and the political impossibility of being seen to go against them. Thus, the combination of oil money, weak institutions, and highly mobilized constituencies of 'heroes' who claimed to embody national identity would have been difficult for any government to manage. This meant that the pension policy could be also used as a means of buying political support from the veterans – ensuring votes during the 2012 elections (International Crisis Group 2012; Bertrand 2013; Kent and Kinsella 2015; Scambary 2015). As a report by the EU election observer team noted, veterans and the pension scheme had become the key success of CNRT campaign in the 2012 parliamentary election. For instance, the day after the campaign began the incumbent CNRT government announced that it would start to pay a large sum of pension money. Coming directly before the elections - but nine years after the lengthy, and still ongoing, process of registration and verification had first started, has led several commentators to suggest the government was using its power to gain support. Similarly, many veterans who benefited from government contracts were also mobilised in support of the government (EU Election Observation Mission 2012).

Meanwhile, the Church, which had become one of CNRT's key political supports since the 2006 crisis, also received significant allocations of state resources,[40] including money for Church renovations and buildings, money received by priests from individual politicians for religious activities, and government funding for Church activities like anti-violence programmes. A member of a development organisation with a religious identity but some operational autonomy from the Catholic Church explained:

[39] According to 2012 State Budget reports, around 98 scholarships were given to the children of veterans (MoF Timor-Leste 2012).

[40] For instance, the CNRT government provided US$ 300,000 of financial assistance to the Church between July to December 2007 (Guterres 2008).

> Maybe now people say that [the] Church cannot do nothing, because [from the] government [it] gets a lot of money. You see the Cathedral, it's funded by the government. And now also for the new residence of the new bishop of Maliana, a lot of money. They say [the] Catholic Church will not speak [up on] many things (quoted in McGregor et al. 2012: p.1139-1140).

While their policy regarding the veterans and the Church reinforced CNRT's populist support, Gusmao's leadership did not last until the end of administration period due to repeated scandals and allegations of corruption and nepotism against his government officials (McDonnell 2014). This particularly occurred in relation to procurement of goods and services involving multimillion dollar infrastructure contracts which decided through personal judgement and discretion without following approved procedures and legal frameworks. For instance, Gusmao awarded a US$ 14.4 million rice supply contract to a company headed by his friend and fellow party member without an open tender and consultation with Parliament (FRETILIN 2008a). Interestingly, in the case of the National Electrification Projects, when FRETILIN criticised the government on poor tender procedures, Gusmao government reacted and published a media release asserting that FRETILIN's argument was incorrect and misleading because tender information was advertised on the government website (Pereira 2011).

Gusmao's resignation in 2015 signalled a new political cycle in the power relationship between CNRT and FRETILIN elites whereby the two parties worked collaboratively. This started with Gusmao's nomination of Rui Araujo, a FRETILIN figure known for his professionalism, integrity and incorruptible characteristics - although unproven since when he led MoH there was little scope for large scale corruption -, to take the position of Prime Minister. Some argue that this was a political gambit to get FRETILIN support and avoid criminal sanctions from poor financial behaviour of executive government under Gusmao leadership (McDonnell 2016). With the formation of a new government, led by Rui Araújo, political settlements (both in executive and legislative) between elites in the two largest parties began to emerge for the first time since independence. This was evident with the appointment of Gusmao as the Minister of Planning and Strategic Investment with control of major

infrastructure spending. Meanwhile, in 2013, Alkatiri was appointed President of the Authority of the Special Administrative Region of Oecusse (ZEESM) – a grandiose investment project to develop an area covering 170 hectares in the village of Costa in the subdistrict Pante Macassar into special administrative zone which has international standard facilities including hospitals, airport, bridge, hotel, port, etc. Thus, the new political cycle was used to carve up big infrastructure projects between the parties and use the associated opportunities for expanding patronage networks through awarding contracts and other benefits to supporters, while leaving Rui to perform the populist role as Prime Minister. This political romance between the two parties continued in the 2017 elections when Gusmao strongly supported FRETILIN's candidate, Lu Olo, in the presidential election; consequently, Olo became the fourth president of Timor-Leste, indicating, for some, that the "power-sharing combination of CNRT and FRETILIN remain[ed] strongly competitive" (Leach 2017b).

The appointment of Alkatiri as the President of ZEESM projects in 2013 began a new coalition of the two majority parties and led to increased corruption in governance, especially under Rui Araujo's leadership from 2015. Although, previously, FRETILIN had been very critical of the CNRT leadership, after the coalition formed, the CNRT government always received budget support from FRETILIN (Leach 2017a). In exchange for this, FRETILIN got two benefits: a special economic project in Oecusse (led by Alkatiri and worth US$ 1.36 billion) and most of the development budget for Dili, Viqueque, Covalima and Baucau (districts that became the political base of FRETILIN) (Field journal notes, 9 February 2016; Leach 2014; Strating 2016). Meanwhile, Gusmao controlled crucial infrastructures projects like the Tasi Mane south coast petroleum development (worth US$ 1.4 billion) which aimed to build a regional airport, a supply base and port and a 250 kilometre-long highway to transport oil and liquefied natural gas plant (Lao Hamutuk 2016b). Some also argue that veterans became frequent recipients of government infrastructure projects (EU Election Observation Mission 2012; Leach 2017a), for instance, the round of contracts in August 2010 was granted to sixty-eight veterans of the armed struggle for independence (Kammen 2011).

These political practices eventually weakened parliamentary control and increased the abuse of power.[41] Although President Taur Matan Ruak criticised both CNRT and FRETILIN, he had little influence due to their powerful domination (Taur Matan Ruak 2014; Office of the Presidency 2016). As a result, Timor-Leste's rating according to the Worldwide Governance Indicator, commitment to control corruption, dropped to 34.6 in 2016 from 49.5 under FRETILIN in 2002 (World Bank 2018). Data from Transparency International also showed a negative trend regarding protection against corruption. Clearly, the country faced serious issues of domestic corruption, particularly so at various levels of government administration (Bosso 2015). Thus, elites' ownership of development increased as can be seen from the use of patronage politics on the allocation of resources.

A popular influence of CNRT government began in 2009 when Gusmao announced the priorities of developing infrastructures as a way of combating social issues in the country. For the Gusmao-led coalition government, the downfall of FRETILIN government was rooted in the failure to take benefit from the petroleum wealth for maintaining peace post-independence; therefore, the CNRT government would not repeat the same mistake and planned to invest the oil wealth for the current generation – this would also build a base for future development (Barma 2016). However, for Gusmao, the vision would be able to reach if the account of petroleum revenues was unlocked to finance development initiatives. In the 2009 budget proposal, the Government proposed US$ 407.8 million of ESI and an additional US$ 181.2 million to fund mega infrastructures projects throughout districts (MoF Timor-Leste 2009).

Yet, Government emphasises the vision of infrastructure development under NSDP 2011-2030 as way to transform Timorese community into prosperity. This meant that the trend to withdraw money exceeding the ESI was continuing upwards (see Bar chart 6.1 below) – although some projects were financed by hundreds of millions of dollars from foreign loans (Lao Hamutuk 2016c). Although FRETILIN and Lao Hamutuk disagreed with the plan to invest

[41]According to an interview with the Director of CAC Timor-Leste, although the country had anti-corruption institutions, these were only capable of collecting data and submitting it to the court. It was then up to the court to take further control over the legal process. Meanwhile, in other countries, like Indonesia, anti-corruption institution is able to have legal control of the corruptor up to point of going to court. He also noted that, since the presence of oil, money for development corruption cases has been increased significantly, but weak political commitment of elites meant that only a few cases could be investigated further (Field journal notes, 1 March 2016).

a large amount of petroleum revenues on infrastructures development (Lao Hamutuk 2008b; Guterres 2011), their voices were weak compared to the strength of CNRT both in executive and legislative houses. For instance, during the parliamentary vote to approve the 2009 State Budget, Gusmao managed to consolidate the power of its coalition parties and got 40 votes in favour of his development plan – meanwhile, FRETILIN that against the policy received only 20 votes against it (East Timor Law and Justice Bulletin 2009).

For CNRT government, NSDP document "reflects the views and aspirations of the people" (Council of Ministers Republic Democratic Timor-Leste 2011), because it was released after the Prime Minister conducted community consultations in 65 subdistricts across Timor-Leste. In contrast, according to Lao Hamutuk (2010), the role of people was limited to consultation and the Plan needed further scrutiny and analysis. For Lao Hamutuk, the public deserved more access to the Plan and expected to make a bigger contribution rather than just consultations – they would have liked to see the contents and decide which of these was more desirable and achievable in Timor-Leste's current situation and available resources. Thus, they would have had more ownership of development. However, since elites have more power compared to the public, development policies were largely 'owned' by political leaders – not the people.

With the introduction of NSDP and revenues from oil exploration for development, contributions from external development partners have steadily reduced for Timor-Leste. In 2016, donors contributed less than 10 percent from the total development budget (Lao Hamutuk 2016a). Donors also committed to only supporting activities and objectives in NSDP and continuously coordinated their programme implementation with Timorese leaders in the Development Policy Coordination Mechanism Forum, a periodical forum of government and donors to review whether development planning and budgeting are aligned to the goals of NSDP (Respondent 3, RDTL 2014). Although in some areas, elites were able to exercise power to persuade development partners to support their development ownership agendas, in other cases, elites needed the support of development partners to sustain their development ownership. Since the coalition formed between CNRT and FRETILIN, local leaders and international commentators have persistently accused Gusmao and Alkatiri of corrupt practices and wasting funds; for instance, in the implementation of ZEESM

projects which largely enriched both parties and their supporters, rather than the people (Lao Hamutuk 2014; Hutt 2016). However, Gusmao and Alkatiri countered this opinion by requesting the World Bank to conduct an analysis of the economic potential of Oecusse project. The resultant report stated that:

> the ZEESMs project has a significant opportunity to improve the lives, livelihoods, and futures of the people of Oecusse as well as to become an example of a successful development model for the rest of the country and the wider region (World Bank 2016: p.64).

This evidence indicates that, to some extent, elites would let external donors have more influence in development agendas (rather than following their own priorities) – as long as it could secure their patronage and populist politics that maintained their development ownership. For example, the formal intervention of the World Bank in studies and reports about the potential economy of the ZEESM project, allowed the Bank to exercise its visible power and thus affect the values and practice of the local policy-makers.

From the above discussion, it is clear that the presence of oil wealth gave more power to politicians to decide development priorities. Both FRETILIN and CNRT adopted large scale programmes, funded by oil wealth that benefited key sections of the population and were by this means able to secure peace and stability in a way that the Alkatiri government, heavily dependent upon the priorities of aid donors, was not able to do. However, the health sector appears to have remained largely free from patronage politics of elites. Both CNRT and FRETILIN leaders believed access to primary healthcare is important for Timorese people, this makes politisation of health was conducted through populist policy for capturing public support. In the context of Timor-Leste during the oil dependence era, politicisation of healthcare was conducted through developmentalists approach and populist-inspired Cuban solution. These policies, however, did not automatically allow better access and quality of healthcare services due to problems of the elites' political commitment and limited health facilities in rural areas. As a result, the rest of this chapter argues that elites and donor have gained more ownership during the oil dependence era, at the expense of health professionals who have limited influence on policy. The next section discusses in detail the relations between actors in the

country's healthcare, whether Timorese healthcare professionals had a voice in decision-making and how, despite the socialist ideals, the health budget was not prioritised. As a senior member of East Timor Nurses Association explained:

> Then, I also criticize the Government about the amount of health budget they are allocated. As far as I know, in other countries, including developing countries, the budget allocation for health sector is at least 10-15 percent. But in Timor-Leste health budget is not more than 4 percent of total state budget. So, how do we answer the health needs if the budget is not enough? This also makes logistic needs is not able to fulfil. Meanwhile, the Government says they give priority to the health sector [author's personal translation] (Respondent 41).

Having reviewed, the various strategies and alliances involved in development policy, it is hardly surprising that members of the government, citizens, and intellectuals say that the combination of political culture and oil wealth has turned Timor-Leste into a country with high level of endemic corruption and nepotism (Jütersonke et al. 2010; Leach 2014; Guterres 2017).

Ownership in the Health Sector (2007-2017)

The focus of this section is to analyse the dynamics of power relations among actors in directing the health agenda of the MoH Timor-Leste when the budget allocation from the Central Government became available. It highlights the different approaches of prime ministers and examines how the ownership of policies and their implementation, enabled by the oil revenue, continued to be undermined by the politics of elites and the strategies of external donors seeking to fulfil their own agendas. Lastly, it discusses the role of healthcare professionals in decision-making and explains the factors that limit their role in health policies.

With respect to healthcare, specifically, during their respective terms as prime minister, Alkatiri and Araujo used socialist-inspired visions of creating a healthy Timorese society (RDTL 2012c; RDTL 2015a); however, they used different strategies to reach their agendas. Gusmao, on the other hand, focussed on prioritizing development infrastructures as a strategy to achieve

healthcare delivery throughout society. During his speech to National Parliament proposing the 2015 budget, Gusmao stated: “Infrastructure also underpins the delivery of public services. Better roads, for example, allow children to travel to school and patients to more easily visit hospitals” (Gusmao 2015: p.15). Thus, the rationalization of his heavy focus on infrastructure was the primary impetus of Gusmao’s government, rather than a genuine commitment to improving services for the poor. Even if Gusmao had intended that it should do so, somehow the parts that benefited the poor failed to be translated into implemented policy; whereas those which benefited the elites (i.e., the infrastructure developments, themselves) invariably did. A respondent who had been a senior member of the MoH when Gusmao was prime minister explained:

> In the health sector we think about the whole people. Let's say we are talking about health access. If we think too much about infrastructure development, by building massive asphalt roads everywhere to connect districts and capitals; meanwhile, we do not think about how to build roads to connect villages and districts, subdistricts to the city. This is very contradictory and, therefore, it will be difficult to achieve the expected targets in the health sector [author’s personal translation] (Respondent 1).

This suggests that patronage politics became dominant over populism when it came to implementation. Interestingly, this reflects the situation described in Chapter 4, when Timor-Leste was under Indonesian territory. Indonesian elites had also planned to develop infrastructures as a way to open access for healthcare delivery but, in reality, this was used as a tool to support patron-client politics, and this made health infrastructures primarily benefit the army and Indonesian bureaucrats as the power base of Indonesian government. This evidence illustrates how healthcare issues have been continuously politicised by elites and, while improvements have been conducted through populist politics, they have largely benefited political leaders rather than the Timorese people.

A very different approach to healthcare was proposed by Araujo who, influenced by FRETILIN’s ideology to healthcare, introduced the Health in the

Family Programme (*Programa Saude na Familia*),[42] in 2015. In this case, the agenda is that of the Central Government and implementation is imposed on the MoH. In an official document on his leadership programme, Araujo says: "We will be implementing the Community Service Models, such as family health programmes and house visits, as well as developing protocols for treating and promptly detecting diseases" (RDTL 2015a: p.7). Interestingly, the idea behind the programme partially came from the successful implementation in Cuba of the family health project conducted by the Cuban government. If the same programme is implemented in Timor-Leste, Araujo assumed, it would be easy to realise "the responsibility of the State to provide general access to quality healthcare, without out of pocket costs" (RDTL 2015b: p.126). In his speech at the opening session of the second national health conference on health in the family, Araujo says:

> A short while ago I mentioned the Republic of Cuba as an example of a country that has achieved remarkable outcomes, even when compared with developed countries, in what regards health and human development indicators. In a way, Timor-Leste is following on Cuba's footsteps, which is why we are confident of making good progress with the outcome of this "Health in the Family" programme (Araujo 2015).

Some argue that the implementation of the programme faced particular challenges regarding access to emergency services (World Vision 2015), and to some extent, it may also prove problematic *vis-à-vis* the liberal-technocratic approach which became the paradigm of local health professionals, explained in Chapter 3 – as happened during the FRETILIN administration.

According to the discussion above, it can be seen that, although both Gusmao and Araujo applied different political approaches to win ownership of development, Gusmao used a developmentalist approach combining populist

[42]Under this programme, a joint integrated team composed by health professionals (one doctor, one nurse and one midwife) travels to health centres and posts to visit every single household across the 12 municipalities and provide healthcare services. At the time of the field research in Timor-Leste, the programme was just about to be implemented in the districts and it was difficult to get opinions from health workers about the 'challenges' regarding implementation on the ground. A Timorese local doctor, who was interviewed during the research, argued that the Health in the Family is a good programme but he was not sure that it would be maintained in the future; furthermore, he understood it to be continuing the agenda of the FRETILIN leadership which started with Alkatiri (Field journal notes, 9 February 2016).

and patronage politics through infrastructure projects while Araujo consistently applied a populist strategy to healthcare motivated by Cuban-socialist ideology. In the post-crisis era, the MoH leadership recognized primary healthcare as a priority for ensuring better health for rural populations. However, different agendas of the political elites affected its ability to exercise influence regarding delivery. As highlighted above, Gusmao's leadership justified massive infrastructure development as a way to improve delivery of healthcare. Nevertheless, he also acknowledged the achievements of the FRETILIN government and was committed to continuing their agenda; thus, health cooperation with the Cuban government continued. During his inauguration as Prime Minister, Gusmao stated:

> In relation to the health sector, I should congratulate Dr. Antonio Maria de Araújo [former Minister of Health under FRETILIN government] for the magnificent work he has developed in this sector. This Government will pursue a similar policy as previously defined, but will dedicate special attention to the development of a national health system that will guarantee a reliable supply of good health care to our population (Gusmao 2007).

For Nelson Martins, the Minister of Health (2007-2012), however, health access was still limited and waiting for the result of the government infrastructure programme and Cuban-trained doctors. Historically, FRETILIN had promised that all Timorese people, regardless of status, would have access to healthcare. Therefore, he introduced the Integrated Community Health Services (SISCa) aiming to deliver better healthcare access in rural areas. This involved monthly healthcare services in villages – usually outdoors or at local residents' homes, schools, village offices etc. – and a team of health professionals including doctors, midwives, health promotion officers, nurses and/or lab technicians depending on availability (see Martins and Trevena 2014). In interview, a senior member of the MoH, who was directly involved in this project, said:

> We created SISCa programme because of poor health access. During the struggle, we promised the community that no one will be left behind [in terms of healthcare]. But when we came to Timor-Leste [after studying

> abroad], we saw a mother who would like to give birth but there was no maternity clinic in the district. This is one of the problems. People, who live in the villages, sometimes cannot get healthcare at once. That's why we created SISCa. The Government had a plan for it, but it was too long because the Government was waiting for doctors to graduate from Cuba, and they would have graduated in 2012. Imagine if in 2007 we have not established SISCa, then, people have to wait five years. After we conducted an evaluation in 2010, within two years, there were 55,000 people who treated through SISCa. If SISCa was not implemented, then, 55,000 people could not get health service [author's personal translation] (Respondent 22).

Later, under Maria da Costa's (2015-2017) leadership, the MoH focused on the Health in the Family programme which became the agenda of the Araujo executive government.[43] Unlike SISCa, which relied on community attendance, Health in the Family required healthcare teams to conduct home visits and identify steps to prevent illness. Thus, different political leaderships affected MoH opportunities to exercise decision-making. At the same time, donors still had ongoing influence after oil money increases for the ministry and this has been conducted through the language of 'technically assistance' for the MoH, providing a focus for domination through hidden power, making the health agenda favour donor interests. This can be seen from the preparation of the National Health Sector Strategic Plan (NHSSP)[44] 2011-2030 which was formulated by civil servants within the MoH, with the assistance of many parties outside the ministry including foreign 'experts'. In his foreword to the NHSSP document, Martins says:

> I wish to specially thank health directors and head of departments for their technical directions and contributions. My gratitude and appreciation also goes to the dedication and energy of national and international health advisers and specialists who assisted senior health officials in making this Plan a reality (MoH Timor-Leste 2011: p.iii).

[43]Da Costa was sick during most her leadership and, much of time, health programmes were led by the Vice Minister of Health, Ana Isabel Soares.
[44]This document becomes a guide of the next Minister of Health in developing health services although they used different strategy of primary healthcare.

The allocation of budget from Central Government (see Figure 5.1 below) increased the ability of the MoH to achieve some targets of the National Plan. In human resources, for instance, due to demand for specific skills of health workers, the MoH was able to send health staff to study medicine in foreign universities like Indonesia, China, Fiji, etc. According to data collected from the MoH by the researcher in 2016, there were 1,280 students who studied at various levels of education under MoH scholarship (MoH Timor-Leste 2016). The MoH was also able to buy health technologies and facilities to better treat patients with serious health problems and reduce local dependency on international referral treatment services. A Timorese nurse working at the National Hospital said:

> In the fourth government, the state [meaning the MoH] has power to manage the programmes needed by Timor-Leste. For example, the Government has been able to purchase complete health equipment to optimize services to patients. Before, patients who need dialysis should be sent out because we do not have facilities. But since the Government buys dialysis equipment, we can do it in the hospital [author's personal translation] (Respondent 17).

These evidences show that, in the post-crisis era, the MoH was able to decide some priorities of development that was intended to increase the quality of healthcare delivery. The presence of oil money gave power to the MoH to implement such a vision – a different situation to that during aid-dependence where the MoH could only decide some health priorities that fitted to donor agendas (Respondent 7, 19).

Figure 5.1: Percentage of Actual MoH Budget Allocations Compare to National Budget (US$ million)

	MoH Budget (US$ million)	**National budget** (US$ million)	**Health budget** (% of national budget)
2008	27.58	483.66	5.70

2009	28.86	604.42	4.78
2010	34.45	760.33	4.53
2011	38.75	1,097.16	3.53
2012	51.09	1,197.61	4.27
2013	58.14	1,080.23	5.38
2014	59.72	1,339.25	4.46
2015	59.02	1,340.20	4.40
2016	40.26	1,629.95	2.47

Source: (Data were collated from the Timor-Leste Transparency Portal of the MoF, August 2017)

The presence of oil money and the existence of NHSSP became a source of power for the MoH to "encourage stakeholders (including development partners) to work together towards common aims" in improving Timor-Leste health level (MoH Timor-Leste 2011: p.x). Consequently, all donor projects had to be discussed with the MoH before implementation – because their role was supportive. As a Timorese health consultant, who was working at the MoH at the time, said:

> In the past, their programmes were not uniform and they worked with their own standards and their activities were also independent one to each other. Then the Government made its own standard [National Health Plan] and all donors should follow it. If they do not follow this standard, they are not allowed to run the programme in Timor-Leste. Then, at this time, every donor who would like to run programme must get approval from the minister. If not, then the programme should not be implemented. This regulation came into effect after Timor-Leste gained development support from the oil sector [author's personal translation] (Respondent 19).

A foreign worker in an international NGO agreed that the focus of her organization was to support MoH agendas and, therefore, the implementation of health programmes had to be coordinated with the Ministry to ensure it was in accordance with their priorities. Concerning this, she explained:

> First of all, we are not like NGOs doing some work by just informing MoH. It is really a technical assistance project to the Ministry of Health. It is part of a bilateral agreement between the US and the Ministry of Finance here. This project was under the bilateral agreement which aims to support the Government of Timor-Leste. We have to support the implementation of MoH policies. We work with them. We have a common work plan. We implement all interventions together. We don't do anything ourselves (Respondent 30).

This demonstrates that during the oil dependent era there was a shift in relationship between the MoH and donors whereby the MoH has more power to decide health agendas rather than donors. Further evidence of this is provided in Chapter 6 where I discuss the case of the World Bank health programme in which MoH refused to participate in further cooperation because the Bank wanted to lead and implement its health programme. The MoH objected to this because the Bank's attitude would have undermined the Ministry's ownership in development.

Although, in some cases, the MoH has been able to exercise autonomous decision-making, development agencies still deploy strategies that challenge their power, thus raising a question mark over the nature and extent of MoH ownership of health policy. These are conducted in two ways. Firstly, donor agencies are highly active in mobilizing evidence to convince the MoH that their programme is essential to delivering health services to the community and, therefore, it must be implemented in the country. A foreign worker from an international agency described her experience working on a programme that facilitated communication between expectant mothers and health providers using mobile phones:

> The way we convinced the Ministry that [the programme] is beneficial is that we presented it as a research project. We said to the MoH that we will demonstrate to you the utility of it. If you think it doesn't seem to have utility then we know it is not something that we should proceed with. So, at the beginning, we conducted a baseline survey, we presented it to the ethics department of the MoH. Some people were sceptical and some people were on board in the Ministry. At the end, USAID proceeded with

> this intervention. So it took some persuasion. There were some sceptical people particularly at the central level. For instance, Isabel Gomes was very sceptical. One of the reason they were sceptical was, first of all, they didn't think mobile phone ownership will be that high. Secondly, they didn't think that literacy rates of the people will be that high. When we did the baseline survey we demonstrated that actually that was not the case. And then we started to get some results coming in which didn't seem to persuade some people at the Ministry but it suddenly persuaded DFAT [The Australian Department of Foreign Affairs and Trade]. What happened was then DFAT went on and expanded the … project toward districts (Respondent 3).

This point was supported by a foreign respondent whose international NGO received grants to implement the programme. She explained that the role of the base line study was significant in convincing the MoH to implement their programme**:**

> There is definitely better role for data and evidence. I think the baseline survey went a very long way to convince the Ministry that it was at least a project worth trying. There was a lot of resistance during the cell phones project because they didn't think woman had phones. They also didn't think women can read. So when we did this survey and we found the majority of people had phones. If they could not read then family member would read for them. I think providing that evidence based and those results back was vital. If we won't able to show that it wouldn't be able start the programme (Respondent 11).

These examples illustrate the power relationships between donors and the MoH during the aid-dependence era. Thus, although in theory the MoH had sufficient ownership of policy to set priorities, cancel programmes, allocate human resources and execute programmes, in practice, this was undermined in various ways and donors still determined which health agenda should be prioritised by the MoH.

Secondly, when development agencies met difficulties in sharing priorities with MoH,[45] they could simply implement health programmes at the district level rather than national. When I asked a foreign staff at an international NGO about her institution's strategy to solve its differences with the MoH, she said:

> Differences can be solved through meetings. But if they [MoH] still do not accept, it is fine. We can always implement the programme at the municipality level. Very often this is what happens. We found out that at the municipality level they have much more time available to work together with us. Then, at the national level it is very often just the matter of informing them [but they do not give support after permission]. It is very easy to work in the district because they are very easy to accept the project. It is very concrete for them (Respondent 30).

The same strategy was also applied by multilateral agencies when they faced difficulties working with the MoH, as explained by a staff member of one of these:

> In our case we had a quite good relationship with the district municipal health services. So instead of waiting for everything to go through national level, we did it locally and a lot of the things we did implement happen at municipal level. And in some ways there was a delay but we had a better understanding of why it [programme implementation at municipality] makes things happen quickly (Respondent 14).

These two responses indicate that although the MoH has some ownership of development, donors always have the strategy of 'alternative plans'. This is to ensure their project initiative is implemented according to their schedule and intended outcomes (invisible power), even if it has to bypass the power of the MoH (visible power), limiting its ownership of the process.

Although the budget allocation from Central Government meant that the MoH exercised some ownership of health policies, donor contributions were still significant due to poor budget execution and lack of capacity within the ministry.

[45]This includes delays in decision-making due to the change in leaderships, long approval processes and disagreements with the MoH.

Interviews with civil servants and local and international NGO workers indicated that the MoH received a limited budget to fund its health programme. This was to cover free medical treatment, locally and nationally, as well as implementing new programmes, and it consumes its budget (this is discussed in more detail in Chapter 6). This is because, during oil dependence era, healthcare sector continuously becomes subject of populist politics among Timorese elites. In this context, CNRT elites prefer to use oil money for developing infrastructures as a way to gain visible results to attract voters and sustain their power, rather than to channel the money through MoH without political benefits warranty.

Although the MoH received the budget indicated in Table 5.1, above, interviewees from the MoH cited allocation problems, poor budget execution and lack of capacity as reasons that the MoH continuously needed donor support. Due to this, donor projects are able to have unduly significant influence on the overall direction of healthcare because of their ability to fill the gap in the MoH's budget and capacity – thus this increases donors' opportunities to exercise their visible domination practices.

The respondents at the MoH who highlighted the poor execution of the state budget asserted that this affected the implementation of the national health programme. For instance, for the first quarter of 2016 (January-March), the budget for the MoH had not yet been transferred although it was already February. Meanwhile, donor money always comes on time and donors' activities are always implemented according to plan (as agreed with the MoH) (Field journal notes, 15 February and 25 February 2016). According to Basilio Soares, from the MoF, the problem occurs for several reasons including "too much bureaucratic administrative process" and "lack of experienced and skilled employees in both management and technical areas", consequently, this slows down the payment process from the MoF (Soares 2014).

During his term as Prime Minister, however, Gusmao argued that inefficiency in the state budget management occurred because of a few factors, in particular, "weak ministries' financial management due to lack of coordination between ministers, vice ministers and secretaries of state and directors" (MoF Timor-Leste 2011). Some members of the Timorese Parliament argue that widespread corruption was one of the reasons why Gusmao's government had weaknesses in terms of managing procurement, which can be seen from two examples: firstly, the implementation of the Referendum Package Projects

which aimed to improve infrastructures in rural areas but, in reality, the Projects' quality was poor. Secondly, Gusmao government failed to spend the state budget as planned with Parliament. For instance, the Government was not able to spend US$ 116 million from 2008 until the middle of 2009 (FRETILIN 2009).

The lack of capacity to plan and manage programmes also makes the MoH continually rely on donor assistance. Notes from an interview with an international worker at the World Bank shows that the MoH is often unable to explain the baseline argument of their programmes effectively to the MoF and this results in limited budget allocation for MoH programmes (Respondent 5). Data presented in Table 5.1 shows the MoH received the average budget 4.39 percent during nine years (from 2008 to 2016). In line with this argument, a foreign staff member of an international organization based in Timor-Leste explained:

> Budgeting here is done so poorly and it doesn't get actually aligned to priorities. So if the Government said I will focus now on reducing maternal mortality, as already view in the strategic plan, it doesn't get budget support to do that. That is disconnecting between the MoF and the MoH. And MoH is not very good at presenting its case to the MoF. It works from historical budgeting. When you work on historical budgeting on a line-item budget…I cannot tell the priorities in the health sector but in my opinion it is just about getting services done in the districts and each district is allocated a budget, the hospitals are allocated a budget, how that budget is end divided up toward the priorities (Respondent 3).

One civil servant at the MoH had different point a view, arguing that difficulties in explaining the rationale of MoH programmes are rooted in the current budget system of the MoF which does not allow his ministry to articulate its policies. He says:

> Actually, if we are really able to manage and coordinate the budget well then we will be able to see how much the budget needs for the MoH. But because the budget rationalization is not good then the budget given by the MoF is not too large for the MoH. Actually, this is also a mistake of MoF which still uses traditional model budgeting (line item based

> budgeting). If only they use the program-based budgeting then we are able to explain how much funding is needed [author's personal translation] (Respondent 29).

Clearly, the politisation of health by elites combined with lack of capacity within health institutions has limited MoH's ownership in development. Meanwhile, this will have helped to sustain Gusmao's patron-client relationships with the ministries who controlled procurement contracts and tendering processes under the CNRT government, while continuing to give external donors an influential role in the health sector.

The discussion above on budget execution and human capacity indicate that donor contributions are still an important factor to implement the healthcare system in the country. In the context of Timor-Leste, donor influence was manifest both in the MoH and in the National Hospital. At national level, donors are still invited to periodic MoH meetings and continue to give money, advice, trainings and workshops for the health sector. In short, whenever the MoH has problems and needs additional assistance, donors will always be contacted and they are ready to help (Field journal notes, 12 February 2017). In an interview, a civil servant at the MoH made specific reference to the situation, saying:

> I think there is a big difference [between aid-dependence to oil-dependence]. Although we still need some help from donors, for example there is a government budget every year that does not cover all our planning. This is where donor support is needed. Like now we get AusAID [Australian Agency for International Development] assistance, especially for maintenance of the ambulance. Then there is also a car we call multifunctional – the function is to help the healthcare workers to provide services through family visits, doctor visits to villages and can also be used to transport patients. Therefore we call it a multifunctional car. These are covered by AusAID, starting from maintenance and all are financed by them. This programme has been running from 2014 until now [author's personal translation] (Respondent 4).

In the National Hospital, donors also provide assistance to improve the quality of health services and this is mostly conducted through training and/or sending foreign health workers to assist medical services. A Timorese nurse pointed out that there was still a large amount of cooperation with external donors:

> For nursing, we work with health workers from Australia; the organization's name is St. John of God. The form of cooperation is on the development of nursing and pathology. Furthermore, in the field of medical services, we work with health workers from various countries. For postgraduate training most of the cooperation with RACS [Royal Australasian College of Surgeons]. This is a new programme in the form of providing training to nurses who will work in the hospital before plunging to handle patients. But there are also from Cuban brigade, Chinese Medical Brigade and we also have contracts from various countries, such as Nepal, Indonesia etc. [author's personal translation] (Respondent 17).

This suggests that although MoH control over policy agendas has increased during the oil dependence era, donors still have great influence over development practices and this is conducted using the four domination practices which were discussed in Section B, Chapter 2: visible, invisible, hidden power and governmentality. Thus, while the MoH's ability to negotiate with the World Bank (see Chapter 6) and insist on its own priorities has increased, yet, we still need to know who set those priorities and who took the decisions within the MoH itself. A senior member of the Faculty of Medicine and Health Sciences, University National Timor-Leste, whose institution cooperates with different foreign agencies to provide medical education for Timorese students, admitted that each Minister of Health had different priorities, making it difficult for his institution to sustain cooperation because it depended on whether or not the MoH leadership thought the programme was his/hers. He provided a specific example:

> We [Faculty of Medicine and Health Sciences] cooperated within the postgraduate programme. The participants of this programme are Cuban-trained doctors. The study period is 18-24 months. This programme actually started in Nelson Martin's time [Minister of Health 2002-2007]. The

> focus was on areas such as midwifery, surgery, internal disease and Internal Medicine. But during the leadership of the doctor Sergio Lobo [Minister of Health 2012-2015], he was disagree with the programme. Finally the postgraduate programme stopped, family medicine is still running [author's personal translation](Respondent 16).

Interestingly, in some areas, there has been a shift towards evidence-based policy-making, which was introduced by leadership in the MoH. For instance, a policy to have maternity clinics and community-based antenatal and postnatal services was enacted through SISCa activities. This was decided by the Minister of Health, Nelson Martins, based on his experience that maternity clinics in subdistricts were important to improve healthcare access for pregnant women in remote areas. A project officer at an international NGO said: "He [a senior decision-maker] has been working in academia for a long time and he was probably exposed to the evidence, or the lack of, on maternity waiting homes. And he was just like 'take it out'" [bracketed phrase is in the text] (quoted in Wild et al. 2015: p.6). This evidence suggests that, during the oil dependence era, the MoH also used a liberal-technocratic approach for implementing its health agenda.

Lastly, having discussed the different approaches of health ministers and their various ideas regarding healthcare, it is the health professionals who are the actors most aware of how this plays out in practice. In this case, health professionals lacked structural opportunities and continued to have a limited 'voice' to influence development agendas and health policy priorities. For instance, during the informal interview, a Timorese nurse who became an activist in the East Timor Nurses Association expressed his dissatisfaction over the poor commitment of the MoH in addressing the aspirations of local health professionals to improve the national standard of healthcare both in public and private care facilities. However, in response to this dissatisfaction, in 2015, the healthcare associations (mainly involving doctors, nurses and midwives) formulated three draft documents based on regional and national consultations which had started in 2013, which they sent to the MoH for further approval,

intending that these should become law.[46] The aim of these was to ensure that Timor-Leste would have standard national health documents for healthcare professionals in any healthcare facilities (both private and public). However, despite the leadership change in the MoH in 2017 elections, the three documents have not yet been approved. The respondent stated:

> The three draft documents have already been proposed to become law to the Government [MoH] since 2015. However, until 2017, the documents have not been approved, even until the Minister of Health [Maria da Costa, 2015-2017] stepped down. According to the associations, the three documents may not be government priorities, so they have not been legalized. And now, we have to present again the documents with the new Minister of Health Rui de Araujo [2017-2022] [author's personal translation] (Informal Interview with Respondent 41).

The work on these three documents demonstrates that healthcare professionals worked together effectively to formulate the three documents and present it to the MoH for approval. And indeed, this research did not find any significant evidence of political pressures and conflicting dynamics among healthcare professionals in policy-making. This is because the healthcare associations are still organizing themselves post-independence. Even so, according nurses and doctors, contestations among them largely occur in service delivery – for instance, which drugs should be given to patients and which treatments to use in some clinical case (Respondent 36, 41).

Meanwhile, a further effect of the dominant role of the MoH in decision-making is that although the number of doctors has been increased, other healthcare professionals, who also have important roles in service delivery, continue to be in short supply. This reflects the inadequacy of policy that lacks input, let alone ownership, from those working directly in healthcare. As the same respondent stated:

[46]These included documents on ethical codes of practice (for doctors, nurses, midwives, etc.), practical standards (for doctors, nurses, midwives, etc.) and competency standards (for doctors, nurses, midwives, etc.).

> Until now, I have not seen a definite policy on human resource development, particularly in the health field. For example, we don't have policy to target how many nurse specialists who must work in intensive care unit, paediatrics, neonatology, and in the field of emergency care. Up to the moment, I haven't seen government attention in this field [author's personal translation] (Informal interview with Respondent 41).

Thus, ownership of healthcare once oil revenues became available continues to be contested. Although healthcare is based on populist policy, patron-client relationships continue to be significant in implementation, external donors still find ways to impose their own ideals, and, consequently, the MoH's ownership is limited to some areas of policy-making. Meanwhile the health professionals, who have had little say in the direction of development of healthcare, are beginning to assert their expert view of what is needed, but remain far from having any ownership of policy.

D. Conclusion

This chapter examined the dynamics of power relationships among elites during the aid and oil dependent eras and demonstrated how elites applied development strategies to sustain their power under FRETILIN and CNRT leaderships. During the Alkatiri government era, political leaders allocated state resources using patronage-based policy-making which benefited FRETILIN supporters in the appointment of many public service positions, a pattern that had become entrenched in Timor, as indicated by repeated corruption scandals featuring elite networks. Moreover, the crisis in the armed forces that brought down the Alkatiri leadership was symptomatic of the way that elite rivalries affected state-building policies, as different groups claimed that public resources and policies were deliberately used to benefit other figures' key supporters. It also reflected the increasing power of the Church and the veteran groups. As a consequence, Alkatiri's resignation came amid mutiny by some sections of the armed forces and violence in Dili.

Interestingly, the situation was different in the field of healthcare. The creation of a 'modern' healthcare system that would benefit future Timorese generations was central to FRETILIN's ideology and consequently healthcare

became subject to populist rather than patronage-based politics. However, the MoH was only able to secure very limited ownership of health development because it lacked funds and capacity to implement programmes and so became reliant upon donor support. Consequently, while donors supported the MoH in implementing programmes based on a rationalist approach, this also meant that donors' agendas came to dominate MoH priorities. Meanwhile, health professionals had even less ownership in healthcare development because of their limited role in decision-making regarding health policies. Thus, under FRETILIN leadership, elites, donors and the MoH had some ownership of healthcare development compared to health professionals.

Under CNRT leadership, due to revenue from oil exploitation, elites were able to exercise greater autonomy over development and empowered them to maintain peace and security by allocating development resources to important groups and so sustain their power. The introduction of pension schemes and infrastructure developments as key items in the policy agenda post-crisis represent examples of Timorese political elites' greater ownership over decision-making. These policies were presented to gain populist appeal and served to expand political networks and to provide 'political compensation' for both the CNRT power base and the opposition to ensure their support. It also meant that peace and stability were successfully sustained in Timor-Leste.

The change of leadership in government after the corruption scandals and allegations against Gusmao's government did not really change the situation. Populism and neopatrimonialism were still used by the elites' as tools to secure ownership of development. The only difference was in political approach: Gusmao's developmentalist approach, combining populist and patronage politics compared to Araujo's consistently populist strategy regarding healthcare based on Cuban-socialist ideology.

As in the FRETILIN period, elite ideas on 'modern' healthcare post-crisis continued to politicise healthcare through populist policy rather than patronage politics. Although, under CNRT leadership, the MoH was able to exercise some decision-making for development, it had limited ownership of development due to poor budget execution, lack of capacity, the politics of an 'alternative plan' conducted by foreign donors and lack of budget allocation from National Government. This latter factor occurs because CNRT elites have been using infrastructures projects as an 'idea' to improve access and quality of healthcare

delivery. This then provided them with more political justifications to control oil money and let MoH run their programme with limited budget. In the end, these constraints have meant that the Ministry has continued to be dependent on development partners' support, both nationally and in hospitals. Furthermore, elites, donors and the MoH still have significantly more ownership of health development compared to health professionals.

This research did not find a great deal of political pressure from healthcare professionals in policy-making, nor of internal dynamics between groups: rather, healthcare professionals focused on formulating the three healthcare documents, before asking the MoH to approve it. However, based on interviews with some nurse and doctor respondents, contestation among them largely occurs in service delivery. This can be related to the fact that, until recently, healthcare associations have still been organising themselves post-independence.

The analysis of this chapter found that although, during the oil dependent era, leadership in the MoH has been able to exercise some decision-making, healthcare priorities has been different for each Minister of Health and this has meant that health programmes are, in part, dependent on who takes 'ownership' in the ministry. Even so, the data above also shows that there is some evidence indicating that decisions within the MoH have become more based on a liberal-technocrat approach. Also, although the dominance of elites and the MoH in decision-making has meant that health professionals do not have much voice in healthcare policies, there are signs that this is changing in a very limited way. Thus, while ownership has shifted slightly towards the MoH, and the dynamics of contestation have also shifted, the ideal of national ownership remains an unrealised and complex notion. The next chapter looks at four specific projects, each enabled by different agencies – the World Bank, the Cuban government, WHO, and USAID – and considers the different ways in which the politics of ownership is negotiated and challenged in these, as a means to understanding the dynamics involved in detail.

Chapter 6: The Politics of MoH-Donor Relations in Timor-Leste

This chapter examines how changing attitudes to 'ownership' of health policy are reflected in the government's relations with donors. It focuses specifically on four key programmes: the World Bank health programme; the Cuban medical programme; the WHO programme; and the USAID family planning programme. Two of these programmes were successful in terms of meeting the Ministry's expectations about ownership; two eventually failed to achieve their goals because of problems to do with ownership. In each case, the discussion focuses how the relationships between political elites, the MoH, healthcare professionals and key constituencies, such as veterans and the Church, affected the way that donor-government relationships developed and the conception of 'ownership' that the MoH attempted to promote.

The World Bank programme demonstrates that the shift from dependence on aid to oil made only a small difference to the MoH's highly limited ownership in deciding health agendas. This was due to its restricted budget from Central Government; however, the introduction of the NHSSP document in 2010 significantly enhanced ownership, albeit to a still to a limited extent because of the small budget. This affected the MoH-relationship with the donor and highlighted the Bank's lack of respect for MoH priorities – with the outcome being the cancellation of the Bank's support for the SISCa healthcare programme. Despite this, the grounding of the NHSSP document, the increased budget and the availability of other donors more concerned to respect MoH ownership of policy priorities were able to empower the MoH to stand up to the Bank and continue the programme without its support. Meanwhile, the Cuban programme represented very different political influences, being the result of a political decision by Timorese elites based on populist socialist ideologies surrounding healthcare and initiated and implemented with strong Cuban support; aiming to build a 'modern' healthcare system for future Timorese generations. However, it produced unclear results regarding ownership. In particular, it further reduced healthcare professionals' ownership since they became divided nationally and in hospitals between those supported the Cuban ideals and those who considered the neoliberal approach introduced under Indonesian administration was more productive for the healthcare system. In the WHO programme the MoH and donors developed a productive relationship

and the WHO designed its projects, which were focussed on maternal and child health, to fit the NHSSP framework. The WHO listened to the Ministry priorities and decision-making was shared between the two actors. However, although the project was (and continues to be) successful, again, healthcare professionals had little voice in the proceedings. Similarly, the USAID health programme, focussed on family planning, also provided a case of successful collaboration between the MoH and donors; however, this case also demonstrates the dynamics involved in the increasing power of the Church, as a non-medical actor whose interventions strongly influenced priorities and made the design and implementation significantly more problematic.

Based on the field research and published documents and literature, the next four sections present the details of the four cases, and explore how the dynamics of relations between all actors were played out and how this affected issues relating to 'ownership' of the programmes. The final section then provides a summary and discussion of insights provided by the analyses of these examples of donor-MoH cooperation.

A. World Bank Health Programme (2000-2015)

The course of this World Bank health programme demonstrates how the independence gained through the shift from aid to oil dependence affected ownership of health development. At the beginning of implementation, the Bank was able to exercise more control over the programme than the MoH, which had very limited role in policy-making. This situation changed to some extent immediately after the MoH started receiving the development budget from the Central Government in 2007. However, when the NHSSP had been established as a long term vision of healthcare, this gave it significant ownership of some health priorities and the ability to require all donor supports (including the World Bank) to align with local priorities. However, under pressure from its donor communities to produce greater achievements, the Bank refused to accept this, insisting that implementation should be conducted according to its priorities. The MoH resisted this and, as a result, cooperation between the MoH and the World Bank was limited to programmes that suited local agendas. This indicates a significant shift in attitude to ownership that affected donor-MoH power relationships in development efforts.

The World Bank designed and implemented four health projects to assist the rehabilitation of the healthcare system post-independence in Timor-Leste during the period 2000-2015. These interventions mainly focused on improving access and quality of primary healthcare by building infrastructures and increasing the capacity of the MoH (as policy maker) and health professionals (as healthcare providers). The first two projects were implemented between 2000 and 2008: the Health Sector Rehabilitation and Development programme I (HSRDP I) and Health Sector Rehabilitation and Development Programme II (HSRDP II). These included short and long term projects. The objective of the short-term projects focused on restoring access to basic health services, while the medium-term projects focussed on developing an appropriate health system and policies for the long-term benefit of public health services (World Bank 2005b). The HSRDP II represented a second phase in this programme, which aimed to extend the work done under HSRDP I.

Unlike HSRDP I, which emphasized rebuilding and re-equipping health facilities and ensuring the access to healthcare services, HSRDP II was focused more on medium- to long-term health sector development and, therefore, the programme had the general objective of assisting "in rehabilitating and developing a cost-effective and financially sustainable health system in East Timor to be responsive to the immediate basic health needs of the population and, within a well-integrated and sustainable health policy framework, to prepare the health system to meet future needs" (World Bank 2009b). The central agenda of the third and fourth projects, the Health Sector Support Programme (funded by European Commission) (2006-2008) and the Health Sector Strategic Plan Support (HSSPS) (2008-2015), also focussed on improving coverage and quality of primary healthcare services but with an emphasis on women and children. In total, the four projects involved US$ 58 million. This money was largely sourced from the Trust Fund for East Timor (TFET),[47] with a small portion coming from the International Development Association[48] and the European Union (World Bank 2005a; 2009a; Independent Evaluation Group 2011; World Bank 2015).

[47]These funds came from bilateral (such as Australia, Finland, Ireland, Italy, Japan, New Zealand, Norway, Portugal, the UK, and the United States) and multilateral donors (like the European Commission and the World Bank).
[48]This institution is a member of the World Bank Groups and offers loans and grants to developing countries.

The implementation of these projects contributed to some positive improvements in the health sector. Firstly, according to the World Bank's public expenditure review document, with the support of the Bank (and other foreign agencies) the MoH (initially the DHS) was able to increase the coverage and quality of access to basic healthcare services. For instance, by mid-2004, Timor-Leste had opened 65 community health centres, 174 health posts, 5 regional hospitals and a National Hospital (World Bank 2004) compared to situation post-conflict although this research could find little data to confirm how many facilities existed following the violence in 1999. Some of these health facilities were equipped with radio communications and mobile services to link them with the higher levels of health facilities. A central medical supplies system, tasked to manage the procurement and distribution of pharmaceuticals was also successfully established.

These positive contributions resulted in improved health service delivery, which can be seen from the following: the percentage of population able to access health facilities within a two-hour traveling distance (by walking or driving) increased from 75 percent in 2001 to 86 percent in 2004; vaccination coverage for child and maternal health increased; the number of births attended by a skilled health worker was also increased from 26 percent in 2002 to 37.3 percent by end 2007 (World Bank 2007b; Independent Evaluation Group 2011). Secondly, progress was also made in strengthening health sector institutions. At national level, for instance, the projects assisted the MoH in developing local capacity for formulating strategic plans for the health sector (Independent Evaluation Group 2011). Based on these substantial achievements, some projects were rated with good results; for example, HSRDP II received an outcome rating of "Moderately Satisfactory" (World Bank 2009a).

Interestingly, for the World Bank, the key success of their first three programmes was the high degree of local ownership in controlling health design, implementation and evaluation and this was emphasized in one of its programme reports:

> With regard to health policy and systems development, as detailed below, the Project contributed greatly to the development of a health policy framework within which a strong health system could be developed. In particular, the Project fostered strong Timorese ownership of this policy

framework supported by all development partners (World Bank 2005a: p.5).

However, some (including Timorese political leaders like Xanana Gusmao and Jose Ramos Horta) had the opposite view asserting that the Bank's health projects had actually subordinated and marginalised the position of the government. In an online publication, Guteriano Neves, a Timorese activist at Lao Hamutuk, wrote:

> Even though the Bank argues that its presence has reinforced the position of the government, the reality is that is has subordinated and marginalised it. Most of the Bank's programme [including health projects] does not involve the Government in the decision-making process, undermining the accountability of democratically elected representatives. In the end, the Bank's presence has created problems rather than solving them (Neves 2007; see Davis 2010).

The reasoning behind Neves' argument was that TFET management was centrally controlled by the World Bank and the participating donors, and that it had no coordination mechanism with local stakeholders. In fact, local government civil servants reported that, in the early days under UNTAET, the Timorese government thought TFET included a mechanism which would allow them to have a say in the allocation of resources (Phung and Bauer 2004). However, according to a senior Timorese official involved in all high level discussions and work related to TFET, although during the early reconstruction period the Bank made some effort to involve Timorese leaders on programme consultations, in reality, it was just a populist motive which advantaged the Bank rather more than the local Timorese:

> these consultations were often done at the last minute and did not give them [Timorese leaders] enough time to comment on the documents to be presented to the Donors' Council and suspected that one of the motives for the consultations (at least during the UNTAET period) was to gain their support against UNTAET (quoted in Phung and Bauer 2004: p.76).

Under the FRETILIN leadership, the integration of TFET-funded projects into the newly established Timorese ministries (including the MoH) was generally difficult because of the dominating influence of the World Bank and donor communities. For instance, although Government had the power to decide the allocation of funds between sectors and the prioritization of TFET projects, all proposals had to be approved by the Bank and the TFET donors' council to ensure that the programme costing and implementation arrangements aligned with donor priorities (Neves 2006a; Scanteam/Norway 2007; Davis 2010). Thus, this evidence links to the point made previously that under the UN transitional government, some donors have consistently dominated aid implementation using visible power so that development agendas favour their interests. When I asked a former senior official at the MoH (2007-2012) about his experience working with different donors, he immediately responded by dividing donors into two groups: donors who had been easy to cooperate with or and those who were not. He included the Bank as the latter for the following reason:

> But the World Bank is a bit different; it does not give funds [but] only plays a management role. Since the public finance management system in every government department [including the MoH] is still weak, they need a third institution to manage the fund ... If we contract a third party to manage the funds, such as the World Bank, at that point, there is a problem – because their priorities are focussed on finishing funding rather than achievements. They do not consider how best to achieve the programme. This is an experience that [the MoH] once had while working with the World Bank [author's personal translation] (Respondent 22).

Thus, rather than focusing on local priorities, TFET-funded projects were dominated by the Bank's institutional agenda. This was done through the Community Empowerment and Local Governance Programme (CEP) (which included three projects running from 2000 to 2004). Through this, the Bank promoted a market economy by building and reconstructing the economic infrastructure as a way "to build institutions that reduce poverty and support inclusive patterns of growth" (World Bank 2000: p.2). Thus, the language of the neoliberal agenda, was clearly apparent in the first project appraisal document

(World Bank 2000). Later on, this changed and a more general language use was used in subsequent documents (see World Bank 2006a). The issue here is that although, in its NDP document, the FRETILIN government identified health as one of its top priorities, the CEP projects barely allowed funding for health clinics (World Bank 2003b). This illustrates a main argument of Chapter 5 that, under Araujo's leadership (2002-2007), the MoH only had limited power over healthcare development because it was dependent on donors' funding which enables donors' to become dominant in decision-making. Thus, the development programme largely served donors' agendas rather than being led by the MoH ownership.

Some argue that it was the lack of capacity within the local health staff that created problems in the implementation of health programmes (Tulloch et al. 2003; World Bank 2005a). For instance, according to Norris et al. (2007), difficulties in medicine procurement was mainly caused by inaccurate information regarding estimates of drug needs due to lack of skilled people to operate the computer system (Norris et al. 2007). However, it is clear from a World Bank evaluation document that the heavy influence of the Bank created an issue of knowledge transfer which limited the local capacity to administer development post-independence:

> project finances were not fully incorporated into the finance division within the MoH; therefore the result has been a lack of capacity building or knowledge transfer from internationals to nationals on the financial management requirements of World Bank Projects. Only international finance staff were employed under the project, no nationals were employed by the project, nor were the current Government Finance Staff within the MoH involved in the financial management of the project (World Bank 2005a: p.15).

The document does not further discuss the reason behind this decision, but according to lessons learned on the failure to pass procurement capacity skills on to national staff within other World Bank-MoH collaborative projects, the Bank did not recruit local staff due to lack of English language capabilities among Timorese civil servants (World Bank 2005a). This evidence, again, exemplifies the argument in Chapter 5 that part of the problem for the MoH was

that, even though it could set priorities, it could not allocate financial resources and the Bank continued to dominate in aid implementation. Also, the implications of devolving service implementation but not financial management to local staff meant that Timorese health staff had some ownership in healthcare delivery, while the real power remained with financial managers who owned the monetary resources which could be used to achieve its purposes – linking to the discussion about power in Chapter 2 which argues that donors would be able to use their 'abilities' (including with their financial resources) as a source of power to impose interests in aid recipient countries.

Moreover, the World Bank was under the pressure to spend and show results to the funders who had created the pool of financial resources under TFET. Under the UNTAET administration (2000-2002), the establishment of the Project Management Unit, an institution designed to help implementation of TFET's projects, was based on a strategy to increase the accountability of spending and to ensure the greater satisfaction of the programme according to the Bank's procurement rules (World Bank 2001a). Therefore, although the Project Management Unit was located within the structure of IHA and later supported the MoH programme through SWAP, the Bank still had a strong influence on decision-making (Tulloch et al. 2003), and was able to contract international experts to train Timorese people on the Bank's procurement approach (Fonseca and Almeida 2014). This meant that, with the significant financial resources to hand, donors are able to use visible and/or hidden power as a way to sustain their interests. Meanwhile, the practice means that local leaders can only enjoy limited control of health budget allocation and, consequently, many health programmes had difficulty in reaching their targets. For instance, according to the Independent Evaluation Group (an independent unit within the World Bank Group), under the FRETILIN government, the Bank financed a significant amount of capacity-building and some training activities rather than paying sufficient attention to mitigating the shortage of qualified medical personnel that was an issue, especially in rural areas (Independent Evaluation Group 2011).

Meanwhile, for the Alkatiri leadership (as stated in NDP and further emphasised in the Health Sector Plans under Rui Araujo as Minister of Health (2002-2007)) improving the availability of health professionals became a priority of the government (see MoH Timor-Leste 2002; RDTL 2002b).

The senior official in the MoH (2007-2012) quoted above, who explained the motivation behind the SISCa project (introduced in 2007) in Chapter 5, also described how the Ministry under the CNRT government had a different approach to the FRETILIN government, preferring to focus more on expanding primary access to healthcare for the rural population. Nevertheless, he had the same experience in which the Bank's governmentality practice, which aimed to guide and shape the conduct of local leaders through indirect operational activities, meant that the MoH could not really execute their programme:

> For example [in] the SISCa programme, we had no funds at all to support the service in health posts. And the funds from the Central Government could not much help. [Then] we were able to get funding from the World Bank, at that time it was worth around US$ 27 million. Then we asked that the funds be immediately sent to the health posts. But the World Bank had ruled before the funds were made liquid certain regulations must be followed, which required that a system for this must be created before the money can go. While our philosophy was different, the money must go to form the system. If not, when would the system exist if we did not send money there [author's personal translation] (Respondent 22).

This, again, illustrates how ownership is contested and problematic because different actors of development have different approaches, making national ownership difficult to achieve. As a result of the Bank's dominating the situation with its focus on 'accountability' of spending rather than responding to the immediate and emerging needs of the people, physical reconstruction of health infrastructure was delayed and this was evidenced by a study conducted by the Independent Evaluation Group:

> [although] at least four district hospitals and the central referral hospital in Dili were rehabilitated and reconstructed. However, the strict application of the Bank's procurement rules delayed the equipping of those hospitals for over a year after their construction was over (Independent Evaluation Group 2011: p.31).

This was because the Bank's procurement rules and procedures were too complicated, and the Timor government did not have enough national capacity to handle them.

As discussed in Chapter 5, the presentation of the NHSSP document in 2010 demonstrated the shift in ownership that was contingent on the allocation of budget from oil exploration from Central Government to the MoH. For instance, in 2008, the MoH received more than US$ 27 million and this amount was increased to over US$ 40 million in 2016, which allowed it to become the main player in health development. The presence of donor projects was meant to function as additional support and therefore these should fit into the local agenda – if donors suggested ideas which were not aligned to the priority of the country, the MoH could refuse to approve it (Respondent 4, 7, 19, 29).

Interestingly, in the context of TFET projects supporting SISCa implementation, relationships between the MoH and the World Bank can be classified into two periods. The first being when the SISCa programme was initiated in 2007 during which, according to civil servant respondents (and supported by local and international aid workers), the MoH budget from Central Government to fund its health programme implementation was continually limited (as highlighted in Chapter 5). To remedy this, the Bank committed to allocating funds to support the implementation of SISCa in the districts, allocating US$ 120 per month per health post. This commitment became one of the objectives of the Bank's HSSPS project which allocated US$ 27.3 million from TFET and a US$ 1 million grant for funding activities that would improve the coverage and quality of curative and preventive health services, with an emphasis on those for women and children during the period 2008 to 2015 (World Bank 2015). In the first phase of this programme (from 2008 to mid-2013), the MoH was responsible for the overall implementation, including procurement, disbursement, and financial management, although the Bank was concerned that the capacity and knowhow of the MoH staff was too limited for project implementation (World Bank 2015).

However, during the execution of the programme, problems emerged. According to an interview with a senior civil servant (Respondent 28), the MoH encountered two specific problems in collaborating with the World Bank: although the MoH and the Bank had agreed some priorities since the outset, during implementation the Bank still required the MoH to seek their approval

before a project was implemented. For the Bank, this process was important to 'ensure' the MoH was using TFET funds for eligible expenditures and according to procurement standards and procedures, meaning that, according to the Bank's priorities, the project was implemented effectively.[49] This affected the MoH's power over decision-making because it could only decide priorities, execute programmes, cancel programmes and allocate human resources. Meanwhile, the allocation of money still fell under control of the Bank and this meant that the donor's visible power play overrode MoH priorities, the project still needed the approval of the Bank.

Another problem emerged during implementation of the second phase of the programme (2013-2015), especially when it was operated through a Project Management Team which put donors as dominant actors managing the programme and procurements. Towards the end of the SISCa programme, in 2015, the Bank tried to intervene in a MoH decision to redeploy a civil servant who had been managing it. Although the MoH claimed that this was a routine rotation from centre to district and there were directors and other experienced civil servants that could replace his roles, for the Bank, this change was unacceptable because it claimed it would affect future programme implementation (Respondent 28).

In the evaluation of the programme's implementation, as well as being concerned about the highly centralized nature of decision making in the Timorese government, the Bank highlighted its lack of institutional stability, in particular, its high staff turnover as a key challenge to cooperation. During the eight years the programme had been running, there were three re-organizations at the MoH and four different Ministers for Health, and each change slowed down decision making process. For the Bank, "each re-organization meant that about 5 to 6 months of implementation time would be lost, as new positions took time to fill and another round of 'socialization' would be needed to familiarize new directors and staff with the project" (World Bank 2015: p.29).The challenges in implementing programmes caused by leadership change in the

[49]To improve project management in the second phase (mid-2013 to 2015), the Bank established a Project Manager Team, which was separate from the MoH structure and included an international accountant, an MoH procurement specialist, and an MoH project accountant. This had a duty to coordinate the project and its implementation, particularly in procurement and financial management.

Timorese government (which also involved change in leadership in the MoH) was also experienced by a respondent working in international organizations:

> But often working with the MoH takes a lot longer. For instance last year there was one Head Principal Minister and Health Minister changed as a result of the change in the cabinet, there was a change of the minister. This caused delay in the program and makes it difficult [to implement the program]. So these things [the change of leaderships] always cause delays and make it difficult in term of getting approval and getting agreement to run things (Respondent 14).

While such changes were unacceptable to the Bank, the MoH insisted that recruitment and placement of civil servants were part of their institutional power which could not be influenced by other parties, including donors. Despite some negotiation, both parties remained intransigent and their differences could not be resolved. As a result, the Bank stopped its funding commitment and the MoH funded the final year (2015) budget for the SISCa programme, itself (informal interview with Respondent 28). After this, the MoH became more careful in its cooperation with the Bank and made rules that aimed to avoid the same thing happening again. In particular, it insisted that the programme budget should be provided via the MoH so that the Ministry could control the allocation of money and the implementation of activities. Through this, it hoped that the Bank (and also the other aid agencies) would not be able to make programmes stop in the middle of implementation by withholding funds (informal interview with Respondent 28).

Meanwhile, according to interviews with a World Bank official, in general, the MoH still had weak capacity and was unable to present how they intended to conduct procurement planning and programme costing effectively; presumably this was based on the evaluation report. Therefore, the interviewee considered it difficult for donors to trust it to manage programmes. Consequently, other donors continued to provide assistance such as money, training, workshops, and capacity-building for the health sector. This also included helping the MoH to make a better case for getting funds from Central Government and National Parliament (Respondent 5). This also demonstrates how the lack of capacity and experience in managing development has given

more opportunities for donors to exercise their various tools of power and influence (visible, invisible, hidden and governmentality) – as discussed in Chapter 2. Arguably, the weak management capacity, as well as the lack of a dedicated project management team resulting from the changes in government, made the SISCa programme (and other projects funded by TFET) unlikely to reach donor expectations. For instance, a World Bank review of the implementation of the HSSPS project – which provided financial support for SISCa (US$ 120 per health post) – indicated that, besides some positive contributions, finalizing the revised guidelines on financial management and monitoring, which aimed to enable the MoH to send more funds for SISCa's operating costs in the districts, was making "limited progress". Although the MoH had started some relevant activities many of them had not been fully completed "due mainly to sub-optimal internal communications and a dedicated project team to follow up and facilitate the process" (World Bank 2012). Due to this, the rating for the HSSPS projects was "Moderately Unsatisfactory" (World Bank 2015). The Bank was unhappy with the poor performance of the MoH and planned to run the programme again this time under the full control of the Bank. This caused another stalemate in SISCa and other projects supported by the Strategic Plan because the MoH, then under the leadership of Minister of Health, Maria da Costa (2015-2017), insisted that the funds should be sent via the ministry so that it could control the allocation according to local priorities – if donors take the lead, there is no guarantee that the implementation suits the MoH agenda (Respondent 4, 29).

Because of this deep disagreement over ownership of the programme, the MoH (i.e., the relevant ministers and the Minister of Finance) stopped their collaboration with the World Bank in 2015. In an interview, a senior civil servant at the MoH explained how this happened:

> On one occasion, the Minister of Health had a discussion with the World Bank on programme objectives. This was conducted for half a day. In the end, the Minister said: "I do not agree". We decided not to continue the programme with the World Bank. This decision was taken after the Minister has heard suggestions and inputs from all levels of the MoH officials that attended the meeting. Finally they [the Bank] looked for another way, maybe meet with the Prime Minister to conduct a lobby but

this was not successful (Respondent 28).[50] The Minister also said this: "I can accept the aid as long as it is in accordance with our wishes, if it is imposed and is not in accordance with the needs of the community it's better if it's not implemented". In the end, some programmes may still be implemented according to what we [the MoH and the World Bank] have agreed upon. As for programmes that are not approved, these cannot be continued [author's personal translation] (Respondent 28).

Another civil servant explained how the Timorese government came to finance continuing projects, including the operating costs of the SISCa project:

> We want donor money to come into the MoH, so we can manage it to fit our needs. We don't want the MoH to prioritize this, while donors want that. Later on, people will assume a lot aid has been poured into Timor-Leste, whereas the implementation is not in accordance with health priorities. This is what happened last year, which in the end, Timor-Leste felt it did not need the World Bank and has tried to work independently on the project that has been planned. [In fact] We still have projects with European Commissions in nutrition programs [author's personal translation] (Respondent 4).

Since the amount involved was so small (about US$ 20,000 per month in total), this action on the part of the Bank was clearly more concerned with issues of ideology and ownership than careful budgeting.

Yet, another senior civil servant criticized the Bank's attitude by comparing it with the way other donors' programme implementations were conducted, which awarded more ownership to leadership in the MoH:

> But if all goes clearly like with the Global Fund, it's so good. There is base performance. [For instance] if you [the MoH] were given money like this in three months what you can give us [donor], in six months what can you

[50]During the interviews, the author asked the same respondent about evidence regarding the Bank's attempt to lobby Prime Minister Araujo on the implementation of their programme, but he just answered 'maybe'. He also claimed, although if it was true that the Bank lobbied the Prime Minister, he believed that the Prime Minister would let decision be made by MoH (Respondent 28).

> give us, in a year what can you give us. This is obvious. But, assistance from other donors [like World Bank] was grey. They can brain-tweak the programme at their will [author's personal translation] (Respondent 29).

As noted in Chapter 5, before the oil revenue became available, although the MoH had control over decision-making, being able to decide priorities, execute programs, cancel programmes and allocate human resources, due to its limited budget allocation and weak budget transfer execution, it remained dependent on donor funding to implement its programme activities. Thus, the decision to stop collaboration with the World Bank was partially due to the availability of oil money which allowed the MoH to take a more assertive stance. It was also due to the availability of other donors who were more aligned with MoH 'expectations' - like the Global Fund, WHO, the European Commission, the Korean International Cooperation Agency, and AusAID (Respondent, 4, 7, 19, 29). Moreover, through development of NHSSP document since it was introduced in 2010, the MoH had learnt a 'language' to speak with donors and so was more able to ask them to implement health programmes according to MoH targets (Respondent 2, 7, 19). Meanwhile, after its experience where the Bank stopped its commitment before the programme ended, the MoH asked donors to provide additional support through sending their money to the MoH so that the Ministry could control the allocation of resources in line with NHSSP indicators (Respondent 4, 29).

The discussion above explored the significant change in power relationships among donors and the MoH, which meant that the Ministry had a dominant voice to say which programme was appropriate for the country and which could be run by development partners. This shows an increase in health ownership within the MoH and a reduction of donor domination. The following quote from a local Timorese, who previously worked in the World Bank and now has a contract at an international NGO and is in charge of two health projects for the MoH, illustrates the shift in its level of ownership between the past and the current period:

> Even regarding decision-making, the Government is more independent. This is in contrast with the past where programmes were decided by the donor. This difference is very strong. Now, the Government designs the

> programmes. Donors support and plan programmes according to government priorities. I used to work at the World Bank, and there was a friend of mine who worked as a staff at the World Bank office in South America. My friend said that in South America, at the time of our meeting, the World Bank had a full control of programmes, while the Government only submitted and obeyed the planned programme. Here [Timor-Leste], the government is not subject to donors, but rather, donors have to follow government plans. And this has happened since 2010 [author's personal translation] (Respondent 2).

Another senior civil servant at the MoH argued that the existence of SISCa (under Nelson Martins) and Saude na Familia (under Maria da Costa) indicated that the MoH had been able to design programmes according to local needs and it was partially empowered by the availability of development budget from Central Government; whereas during the aid-dependence era, the MoH followed programmes which were designed by donors and did not have power to revise the programme standard (Respondent 19). When asked if revenues from oil exploration had increased MoH's sense of ownership in development, the respondent answered: "Yes [it is bigger]. In fact, it was not only in the sense of ownership, in decision-making the Government was also more independent..." (Respondent 19). Thus, the informant's responses confirm that the existence of oil money and the formulation of the plan allowed greater ownership on the part of the MoH. Moreover, under Maria da Costa's leadership, the MoH could refuse donor programmes for a combination of factors: the budget from oil money, hindsight from the experience when the Bank stopped supporting the SISCa programme, and the existence of other donors who provided support more in line with their priorities. In particular, empowered by oil resources, the Government had been able to formulate NSDP document (including priorities in health sector). They introduced a summary of this to donors in 2010 to enable donors to be more aware of government priorities and so programmes could be designed more in line with these. The Plan itself was then launched the following year.

The nature of the negotiations between the World Bank and the MoH over healthcare programmes, and the eventual ending of cooperation, suggests that the power of the MoH to take decisions against the advice of key development

partners significantly increased from 2010. This change has been linked to the emergence of a new leadership in the ministry, Nelson Martins (2007-2012) (Wild et al. 2015). It also coincides with the beginning of significant flows of oil money to government and a sharp reduction in the level of the country's aid-dependence (see in Chapter 1). However, although ownership increased within the MoH, this raised further issues regarding the nature of 'ownership' since, although the MoH was setting priorities, each successive leadership in the Ministry had different programme priorities and claimed ownership of the health programmes introduced during their leadership period (see Chapter 5). Thus, once again, even within the MoH itself there are political contests that make national ownership difficult to achieve. Moreover, although Martin introduced his reforms on the basis of his medical experience, health professionals were not consulted in the programme and this meant they had limited ownership in the implementation of World Bank health programmes.

B. The Cuban Health Programme (2003-the present day)

The discussion above regarding the negotiations between the MoH and the World Bank over the SISCa programme demonstrates the increasing capacity and determination of the MoH to insist on its own priorities. The next case study – of the Cuban health programme in Timor since 2003 – demonstrates the extent to which 'local ownership' of health policy in Timor in fact implied 'elite ownership' and reflected the populist approach to healthcare policy discussed in Chapter 5. This approach limited the input of healthcare professionals who were doing the job on the ground and, arguably, the programme disempowered them further; moreover, it has created significant divisions within Timor's relatively small number of health workers, which could potentially disempower them even more vis-à-vis the political leadership in future.

Cuba has long been known for the reputed success of its socialist medical care system. For instance, Cuba has the highest life expectancy and lowest infant mortality rate in Latin America (Mesa-Lago and Roca 2016). Consequently, the natural disasters which affected many people in Central America and the Caribbean in 1998 opened a door to Cuba's socialist internationalism. Fidel Castro understood that the Cuban government's socialist medical system was of high capacity and that this could be used to assist other

countries throughout their worst times, while at the same time, providing a way of enhancing the revolutionary struggle against the United States liberal domination (Gold 2015). As a result, hundreds of Cuban doctors were sent to disaster-affected states as a quick response to medical emergencies. For more long-term support, Castro established the Latin American School of Medicine in Cuba, with the purpose of training students from developing countries in primary healthcare. This education was and still is free but, in exchange, recipient governments, with the support of Cuban doctors, are required to implement a 'health system' of equal quality with the ability to respond to any health issues in their own country – a condition that would enable Cuban doctors to return home and be substituted by local health professionals (Evert et al. 2011; Fiddian-Qasmiyeh 2015). This pattern – which involved bilateral agreement between governments on the number of Cuban doctors to assist this development and the numbers of medical scholarships offered to students from the recipient country – became a common pattern of Cuban socialist health cooperation.

In an earlier discussion, this thesis showed that improving the healthcare of the population was high on the FRETILIN elites' agenda. However, problems concerning infrastructure, capacity and lack of medical personnel had undermined the ability of the Timorese government to implement a basic service package of programmes. Therefore, in 2003, Timorese leaders (represented by Mari Alkatiri as Prime Minister, and supported by Xanana Gusmao as President and Jose Ramos-Horta as Foreign Minister) met with Fidel Castro during a conference in Malaysia 2003. Here, they agreed to start cooperation regarding healthcare through the Cuban aid programme.[51] The FRETILIN elites were extremely pleased with this decision because it gave

[51]This cooperation involves Cuba providing medical assistance through sending Cuban health workers to support healthcare delivery in rural areas of Timor-Leste – according to Lao Hamutuk (2008a), from 2007-2009, there were 235 Cuban health workers (mostly doctors) supporting health delivery system in the country. Cuba also provides capacity-building for Timorese health workers in two ways: firstly, almost 700 Timorese students have received scholarships from the Cuban government to study in Cuba in seven waves of admissions (Lao Hamutuk 2008a). Secondly, by allocating fund and trainers, Cuba also supported the establishment of the Faculty of Medicine at the National University of Timor-Leste in 2005 to provide training for local medical students (Hickling-Hudson et al. 2012). However, according to an interview with a member of the faculty's teaching staff, since 2008 Cuban capacity training has only been conducted in Timor-Leste, particularly in 13 district health facilities (Respondent 16).This medical cooperation between the Cuban and Timor-Leste governments is renewed every year by the two parties and therefore, to date, the programmes are still running (Asante et al. 2014).

them a chance to fill the gap in health sector and also learn about a successful socialist medical system in accordance with their ideology (FRETILIN 2007a).

It is worth noting that the Cuban assistance programme has been explicitly linked by Timorese political leaders with a broader foreign policy stance of non-alignment with particular powers. For example, during the political crisis of 2006, Prime Minister Ramos-Horta used the Cuban programme to obliquely criticise what had been seen by Alkatiri's opponents as the United States and Australian over-reaction to the breakdown of discipline in the Timorese armed forces, asserting*:* "During the worst of the crisis in May, June and July our Cuban doctors stayed unconditionally in the villages and hospitals with the patients and the people, providing the much-needed moral, medical and psychological support" (RDTL 2006). He also contrasted the dedication of Cuban health workers with the Western medical approach:

> This [the Cuban commitment and courage] is in contrast with American Peace Corp volunteers, who, even though there was not the slightest threat to their safety and well-being in rural areas, were given orders by the US administration to leave our country (RDTL 2006).

Such comments link into broader concern in Timorese foreign policy to link SSC[52] in aid and development with an anti-imperialist populist rhetoric designed to maximise freedom of action from neighbouring Australia; and, in particular, to remind the population of the lack of support provided by countries like the United States and Australia for the independence struggle. The linking of the Cuban health programme to this rhetoric suggests that part of the attractiveness of the programme for FRETILIN elites was precisely its 'South-South' nature and the way that it demonstrated Timor's freedom of action from traditional DAC donors. This suggests that the motivation for the programme may have been linked to elite populist politics rather than to specific healthcare policy priorities. Moreover, the research carried out in 2016 for this thesis suggests that, nationally, the decision to bring in Cuban aid to the health sector divided Timorese population, and in particular the health professionals, into two groups. The first group consists of those who responded positively to the decision to cooperate with the Cuban government. As a civil servant at the MoH argued:

[52] Details about SSC can be found in Chapter 2.

> So cooperation with the Cuban government has successfully educated 800 Timorese doctors. This was to achieve the target of the MoH in which every Suku [subdistrict] should have one doctor, two nurses and two midwives. To the present, we have reached this target. Although there are some Suku where doctors could not be placed due to infrastructure problems [author's personal translation] (Respondent 4).

In an interview with a member of the Sydney branch of the Australia-Cuba Friendship Society, a Timorese doctor described her valuable experience after studying in Cuba:

> the Cubans taught me many things. They taught me to be independent; they taught me to love people more than simply as human beings; they taught me to embody this great love and to express it in the treatment of my patients; they taught me how to live among the people; and they taught me how to make the most of the scarce resources available to them (quoted in Cameron 2011).

This viewpoint is supported by research that indicates that due to the presence of the Cuban medical team, health delivery services have improved in rural areas and more than 11,400 lives have been saved (Anderson 2008; 2010).

However, the second group questions how well the Cuban programme really linked to specific Timorese health policy priorities. They argue that Cuba and Timor have different health facilities, different types of diseases and treatment procedures and it is difficult to apply the Cuban approach to Timor-Leste. This is supported by local patients' complaints about treatment given by Cuban doctors. For instance, one patient explained: "…maybe they don't know about the problems here for East Timor. Because here everyone knows about malaria but in Cuba they don't have this so they don't know how to treat it. They have no experience" (quoted in Zwi et al. 2007: p.38). Cuban doctors who worked at the regional hospital admitted that they were unfamiliar with malaria and argued: "Well, one experience we have here is to do with treating malaria because in Cuba, it is not an illness frequently found, we do not have malaria cases in Cuba. The first time treating malaria is here in Timor" (quoted in

Martins et al. 2012: p.681). In addition, a foreign international agency staff member responsible for the family planning programme doubted that Cuban doctors were able to contribute to the delivery programme due to difference in the health systems and facilities of the two countries:

> The Cuban doctors don't have health posts/community health centres and don't deliver babies. The Cuban system is they basically collect all the pregnant women and they drive them to the hospital and they have maternity wards and maternity houses. So near their delivery time [women] go to the referral hospital and deliver there. So if I am a general practitioner in Cuba I will not see actual deliveries (Respondent 21).

This is the reason why Cuba has achieved an almost 100 percent in-hospital birth rate (Gorry 2011). The conditions, however, are different to those existing in Timor-Leste where hospitals and transport are limited so doctors have to deal with complex and serious health treatment in rural areas.

Cuba and Timor-Leste also have different educational curricula and this made some respondents question the capacity of Cuban-trained medical workers to give medical treatment to the Timorese population. A foreign worker working at an international agency argued:

> Timor-Leste is also unique because it has 800 doctors who graduated abroad. Now every health post can have a doctor but these doctors do not have [relevant] skills. We are still questioning what kind of skills they have? A perfect example is around the emergency and maternity service…All these doctors who have trained and now they are back they will not have been exposed to deliveries and they were placed there and said they can do deliveries and now we are supposed to have medical cover. I said no you don't. The system is very different and it is just they were not exposed to [this situation]. There are lots of good things about the Cuban heath system and some things are not so good. Some things are not ready yet. Cuba and Timor have very different settings even though the both are islands. Beyond that the infrastructure and how health care is provided is very different. The gap was the assumption that they will come back and be able to drop in and to do certain things. I think it has

> taken time for the realization of the implications of the gap in knowledge. These doctors still need pre-natal care training, etc. (Respondent 21).

A senior official in the MoH under CNRT from 2012-2015, said that the Ministry even got complaints from many parties about the lack of capacities of the Cuban-trained doctors. Regarding these, he stated: “I continually received complaints [from health users and stakeholders] that Cuban-graduated Timorese doctors were not ready to work” [author’s personal translation] (Respondent 1). As a result, even when hundreds of medical students who had been trained in Cuba returned, Timor-Leste still faced a shortage of professional birth attendants – a reason that makes reproductive care and delivery of care continuously rely on traditional doctors (see Sarmento 2014). The lack of congruence between Cuban and Timorese medical systems illustrates the diversity in conditions across the Global South. Consequently, local ownership becomes an important issue even in the context of South-South cooperation where power differentials between donor and recipient are supposedly reduced and interactions animated by a spirit of solidarity (Morvaridi and Hughes 2018).

Indonesian doctors interviewed during this research said that they still make regular visits to Timor under invitation of the MoH Timor-Leste to give medical trainings for civil servants and Timorese health professionals – some the participants and organizers were their employees or students during the Indonesian period. Under the Indonesian system, a new doctor must serve an internship before they are considered qualified to give medical treatment on his/her own. Therefore, these respondents were concerned that letting new doctors give medical services without supervision immediately after completing their studies, as was the case under the Cuban intervention, may affect the quality of services. One Indonesian doctor argued: “Cuban-trained medical personnel did not have the skill when they returned to Timor. This often created conflict with the local health staff because they were caught conducting malpractice [due to unprofessionalism]” [author’s personal translation] (Respondent 37). To remedy this, she suggested “that the MoH Timor-Leste should cooperate with the Indonesian Medical Association so that they can share information and technology” [author’s personal translation] (Respondent 37). It seems possible that cooperation with Indonesia might offer some solutions to problems that the Cuban programme failed to resolve. This idea

would build on some existing foundations because some Timorese doctors, many of whom now work in the MoH, were educated in Indonesia and so share the same approach to health as Indonesian doctors. However, more than fifteen years after independence, political sensitivities over Indonesian aid remain and after over ten years of the Cuban programme, the Timorese medical profession is divided between the two approaches. This further complicates the question of 'ownership' since the medical profession itself is divided between those familiar with the Cuban socialist medicine model and Indonesia's more neoliberal approach to healthcare.

The senior official in the MoH quoted above was critical of the socialist approach of FRETILIN elites which encouraged doctors to work in poorly paid conditions and with a policy of free healthcare for everybody – which he asserted is similar to Cuba (Respondent 1). However, the respondent argued that low-paid health professionals in Cuba are operating in a particular ideological context, in which the spirit of social service is highly valued and inequality has historically been relatively low. This contrasts sharply with Timor-Leste's free market economic system in which white-collar professionals expect to receive pay commensurate to status. In the view of this respondent, Timor's health care system would be more successful if medical expertise was rewarded through the kind of salaries that a partially privatised healthcare system could better offer.

The promotion of free healthcare was driven largely by the veterans' groups claiming social services commensurate with their sacrifice during the war, and by FRETILIN's continued commitment to socialist models of welfare and modernization. Middle class professionals, on the other hand, many of whom had been trained in the very different Indonesian system, preferred a model in which healthcare professionals themselves were privileged through the ability to charge fees for services. The senior member of the MoH was clearly sympathetic to the interests of middle class healthcare professionals. He pointed out: "Because [in Timor] there are many influential groups, in a sense, groups who have championed independence. And now they wanted to reap the fruits of their struggle by wanting to be treated in special manner" [author's personal translation] (Respondent 1). For him although Cuban education aims to train healthcare professionals according to a moral vision similar to that underpinning Cuban healthcare, Timorese doctors are already oriented towards

a capitalist model and are unwilling to accept socialist working conditions.[53] He stated:

> In Cuba, the students were educated according to local social and political conditions. Then, encouraged by the teaching and curriculum, Timorese doctors said that they would dedicate the entire of their life to serving the health sector. In reality, when they returned to Timor, their mentality changed to capitalism. They would say: "I am a doctor and I have to have a better life than the local people". Moreover the level of salary in Cuba and Timor is different. In Cuba, a specialist would earn maximum US$ 29 per month, for a Timorese specialist this amount is very small [author's personal translation] (Respondent 1).

A study conducted by Ferrinho and others concluded that the main motive of the Timorese students who participated in the Cuban medical school was to improve their career opportunities (Ferrinho et al. 2015). However, one rural health worker, interviewed for a World Bank survey, said he had been satisfied with his salary during the Indonesian period and contrasted this with his current dissatisfaction. He argued that, if the policy of low payment continued, many Timorese doctors would seek other ways of making money or look for jobs in foreign countries:

> Now the salary of government workers is not enough [compared to the Indonesian era]. If people don't earn enough they will have to do some other business. After they finish work they might sell drugs. We cannot stop people from doing this because they don't have money for living. Now there are also a lot of people who have left East Timor to work, for example, in Ireland, Japan, and Malaysia (quoted in World Bank 2006c: p.27).

During the fieldwork, some civil servants and doctors expressed dissatisfaction with the policy of free medical treatment because it creates a

[53]According to rumours spread in Timor, Cuban doctors themselves find it difficult to accept living in socialist conditions (with restrictive rules and low salaries). This was said to be the reason why a Cuban doctor posted to Timor-Leste ran away by crossing the Timor-Indonesian border and then flew to the US looking for a better life (Field notes journal, 7 February 2016).

burden on the MoH budget and does not educate people to take personal responsibility for their health. On the contrary, free healthcare, they argued, encourages a 'hospital mindset'. A senior worker at the MoH argued that the free healthcare system had caused the MoH to lose opportunities for generating income which could have been used to implement sectoral programmes:

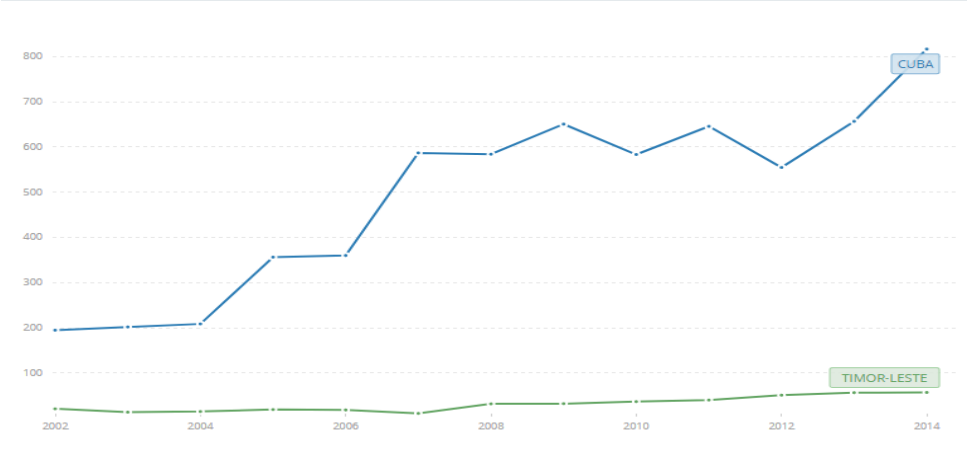
> Ranging from ordinary people to entrepreneurs and officials all [treatment] is free, financed by the government. Even referral abroad is financed by the government. This is one of the things that may bring down the Government someday. The Government should be selective as to what is free and what is not. If this system is continued the MoH will spend more money, while it has no source of income - for example every year the MoH spends about US$ 3,000,000 for international treatment. So the patients we cannot handle here will be referred abroad. Meanwhile investment in the MoH is very small, about 3 – 4 percent [of the annual state budget]. The budget for the MoH is supposed to be above 5 percent. This way, we can invest in human resources, infrastructures and health equipment that can support health services [author's personal translation] (Respondent 4).

A significant part of the MoH budget was spent on referring patients for treatment abroad. According to a civil servant in charge of budgeting for this, this amounted to over US$ 4 million annually from 2013 to 2015, with about 200 patients travelling abroad each year, mainly to Indonesia (informal interview with a MoH civil servant, 8 March 2016). If this number is compared with actual budget received by the MoH (see Figure 5.1 in Chapter 5), the results show that around seven percent of health budget goes for international referral medication – this does not include expenses to finance free medical care in subdistrict, district and national health facilities. One argument put forward by the healthcare professionals interviewed was that by having free medical services people would not really think about how to protect their health because they are guaranteed free medical care. One nurse respondent focused on public health and value for money:

> Currently healthcare is free. But there is a bad side to this policy. We should educate people to pay a little, for example US$ 1 or 50 cents. So

that he/she can keep himself. Don't let the people think because health is free people could eat whatever they want, regardless of the aspects of hygiene, etc. If they are poor, I think he/she does not need to pay, but if the person is working he/she should be charged for treatment. So there is a classification among patients. At this time health treatment is free in Timor and even for referral abroad is free [either rich or poor all are covered by the government]. In fact the MoH gets only a small budget [author's personal translation] (Respondent 17).

Figure 6.1: Comparison of Health Expenditure Per Capita between Cuba and Timor-Leste 2002-2014 (US$)



Source: (World Bank 2007a)

Moreover, the senior member of MoH referred to above argued that the health systems of Cuba and Timor cannot be compared. The Cuban government has a bigger political commitment to social equality than the Timorese government and this can be seen from budget allocation to the health sector in each country (see Figure 6.1). He explained: "Cuba had that system [free healthcare] because their investment in health sector is high enough. For almost 30 years, health budget was 50 percent of the state budget. While, here, the health budget is only 4 percent" [author's personal translation] (Respondent 1). Data from the World Bank in Line Chart 6 below illustrates that Cuba spent more funds on individual health compared Timor-Leste. Since 2002, Cuba continuously increased the budget for heath (from US$ 194 per person in 2002 to US$ 816 in 2014), but Timor-Leste health budget per capita remained under

US$ 60. This evidence suggests why the free healthcare/low salary model of the Cuban system was much more attractive to Timorese political elites than to healthcare professionals, raising questions as to who, within Timor, actually 'owns' the direction of travel of the healthcare system.

Criticism also focused on the cost of the programme: although ostensibly students were financed through 'Cuban scholarships' the Timorese government had to allocate US$ 50 per month for each student as an allowance during their study (Lao Hamutuk 2008a). However, a Cuban-trained Timorese doctor said the amount was higher than this – varying between US$ 90-110 per month depending on the number of students and the availability of government budget (informal interview with Respondent 36). In addition, the Timorese government had to provide the following expenses: a place to stay; transportation; basic facilities such as a mattress, TV, DVD, including maintenance costs; and an expense allocation of US$ 100 per month (for phone card, internet, gas and other costs). On top of this it had to finance one month's vacation every year. Meanwhile, the Cuban government only provided other expenses, such as tickets and food, and a small salary to their families when the students were in Cuba, while the doctors in Timor-Leste only received living expenses (Lao Hamutuk 2008a). However, the Timorese government was only required to provide expenses for Timorese doctors who were studying in Cuba but they were also required to allocate money for all Cuban doctors working in Timor (Respondent 36; Lao Hamutuk 2008a).

Critics of Cuban aid were also concerned about the limited input of the Timorese government on key decisions regarding the programme. This included determining the curriculum on medical education. Although the capacity building programme was signed by both governments, the health training followed the Cuban curriculum, and Timorese decision-makers had limited power to amend it. In some areas, the Timorese government had ownership in decision-making, for instance, they could decide the placement of Cuban doctors and how long they can stay without consultation with district health stakeholders. However, the Cuban government had the power to decide which doctors would be sent to Timor (with limited consultation with Timorese government), the language used and the approach to healthcare used.

While, the MoH had the power to select which Timorese would get scholarships, it was required to pay the cost of visas, airplane tickets and

monthly allowances (Respondent 36; Lao Hamutuk 2008a). The Cuban government selected which Cuban doctors were deployed to Timor. A senior doctor working at the National Hospital argued it was important that the MoH should develop its own mechanism to verify the capacity of foreign doctors because this relates to the quality of the medical service. He said:

> [W]e do not have an effective standard for selecting international health workers. In the end, we accept all the health workers who come, although we don't know if they have enough experience in the field they offer. Also, we do not have parameters by which to measure whether they really have the qualifications to work as a health worker in the hospital. There should be a special team to select and check them. At the moment the MoH only checks the documents of foreign health workers, without checking whether their capabilities equal the expertise mentioned in the document. We ourselves also do not have a field team to monitor the performance of international health personnel. This supervisory team should be available to report to the MoH [author's personal translation] (Respondent 31).

Meanwhile, many health stakeholders at district level were also dissatisfied with the National Government. This was because the details of the policy of having Cuban health workers – where to post them and for how long – was decided at the central level without consulting the local, district and hospital managers (Zwi et al. 2007). The above evidence suggests that, although the programme was decided by political leaders for ideological reasons, the implementation of Cuban aid empowered the foreign partner more than local leaders. This has been conducted in ways based on visible power that make the priorities of the programme answerable to the particular conditionality imposed by external actors, while national elites had only limited power to tailor the programme to their political agenda.

Thus, the presence of Cuban aid has, arguably, divided health professionals in Timorese hospitals. The first argues that the presence of foreign doctors is important and did make some difference in improving healthcare delivery in hospital post-independence. For instance, a nurse respondent was grateful for the existence of the foreign medical team:

> Their contributions [foreign doctors] are extensive. We can see from the data last year, before the presence of foreign doctors in Timor-Leste we only had a few health workers. This [the presence of foreign doctors] is very influential regarding health service delivery. So [before the present of foreign doctors] there was a lack of human resources, while we got many patients. So if we see from the death rate of patients between the past and the present it is very different. So this foreign workforce has made a large contribution to the improvement of our health services [author's personal translation] (Respondent 26).

Some local doctors also learnt positive attitudes from Cuban doctors while working at the National Hospital and it gave them inspiration as to how to better treat patients. When asked about the contributions of foreign doctors in healthcare delivery, a Timorese doctor expressed her positive experience but emphasised the significant role of the Cuban medical personnel compared to others:

> In my opinion their [the foreign doctors] contribution is positive. They all never give up working hard, they are responsible and they are patient with the patients. Even after they have gone home after working in the hospital they still communicate with patients [while they are at home]. Even during the weekends they still come to the hospital to check the patient. Even if it was a weekend [holiday]. Especially the doctors from Cuba, they always want to ensure that the patients are in good condition. This attention is given especially to patients who are in a critical condition [author's personal translation] (Respondent 35).

However, in addition, this respondent provided an example of a Cuban doctor so dedicated to healthcare that he forgot to look after himself and, as a result, died in a National Hospital:

> Some time ago there was a doctor from Cuba who died because he forced his energy too much in providing the health service. Although this doctor had a history of hypertension and was in ongoing medical treatment, perhaps, he also had more sad thoughts because of the distance from his

> family and the children. But, because he had been working too much and was also a workaholic. As I mentioned before, during the weekend he kept coming [to hospital] and checked the patients. Even during holiday time, he still worked and also gave a lecture at University National Timor-Leste. Thus, he took on too much work, so he was really tired [author's personal translation] (Respondent 35).

Local media also published the case (see Quintão 2016c).

It is important to note, those who expressed positive comments on the attitude of Cuban doctors largely come from local doctors who graduated from Cuba. The evidence above reflects two distinct approaches emerging within the Timorese healthcare system as a result of the mix of Western aid and Cuban support: liberal versus populist-socialist approaches.

Some health workers also complained about the presence of foreign health workers, due to language difficulties and different approaches to healthcare. A doctor respondent provides an example the barrier to communicate with Cuban doctors. She explained:

> [T]he main challenge of delivering healthcare that cooperates with foreign doctors is the language barrier. For instance, when we provide health services with Cuban doctors, we can't speak Spanish and this makes us difficult to understand each other. We don't know what the Cuban doctors convey [author's personal translation] (Respondent 23).

Another respondent argued that she should not have to deal with a different language but, due to her lack of opportunity to take part in decision-making regarding the presence of foreign workers, she has to do so. She explained: "sometimes we have to speak Spanish with the Cuban doctors – because some of them can't speak Bahasa Indonesia, English or Tetum. Therefore, we are required to understand Spanish" [author's personal translation] (Respondent 26). Therefore, Lao Hamutuk suggests that "Cuban doctors learn Tetum before they come to Timor-Leste" (Lao Hamutuk 2008a: p.7). The former head of the Cuban medical doctors in Timor-Leste admitted that language barriers became a significant challenge when giving medical treatment. He said: "It's very difficult for our doctors to communicate with patients in Tetum or Portuguese – then

there are over 30 dialects, too. In practice, the doctors receive language training, but in reality they speak Portunhol [a mix of Spanish and Portuguese]" (quoted in Hodal 2012). A study by the University of New South Wales, supported by funding from AusAID, also indicated that the relationship between local and foreign doctors in hospital involves power and domination which often reduces Timorese workers ownership of treatment procedures. As one Timorese staff member working at an international NGO argued:

> The language gap was a huge issue. They spent a lot of time adhering to Cuban protocols without adhering to national protocols which led to a problem. They kept their medical notes in a different language so Timorese doctors and staff couldn't read them. They would prescribe medicines that we didn't have. There was a lot of assimilation issues about how they fit in and I assume they worked through a lot of them but it was certainly an interesting situation for a very long time (quoted in Zwi et al. 2007: p.44).

The above discussions show that the decision to have Cuban aid to create a 'modern' healthcare system in Timor-Leste for future generations was based on populist politics. While to some extent this was motivated by concern to improve the healthcare system, this concern proved to be much less unimportant than maintaining 'solidarity' as the basic nature of the relationship. Thus, this decision was made opportunistically by FRETILIN elites, and the implementation process was imposed on the MoH. The underlying problem is that, although the Cuban deal had some technical advantages, it was significantly motivated by populist concerns – rather than by a liberal-technocrat approach, as described in Chapter 3. Thus, two divergent sets of societal interests emerged with respect to Cuban cooperation in healthcare. One section of Timorese healthcare professionals, who were more attracted to a neoliberal approach to development, felt alienated by it as an imposition while the returning Cuban graduates were more sympathetic to the Cuban approach. This has created divisions in the health service and therefore exacerbated problems of aid fragmentation. A further ramification of this has been to make 'national ownership' more complex and difficult to achieve.

C. The WHO Health Programme (1999-the present day)

While the populist politics motivating elites to welcome Cuban aid limited MoH ownership while causing fragmentation among healthcare professionals in the hospitals, under the MoH health programme funded by WHO, ownership increased within the MoH. This programme applied an approach to development which allowed ministry officials to be in driving seat of development and the donors always listened to the needs of the MoH and were generally able to fulfil these. Consequently, the MoH was very satisfied with their interventions. This case study examines how this worked out in practice, in particular, considering how control over decision-making and implementation of health programmes increased the level of ownership on the side of local health authorities. It was also a significant factor in determining the success of the relationship and cooperation between donors and the MoH in health development. However, in this investigation, the researcher also show that although the MoH already had some power to decide priorities in implementation, healthcare professionals continued to lack roles in policy-making and, thus, continued to have limited ownership in development.

The WHO's intervention in Timor-Leste began with the country's independence and involved two distinct approaches in its working partnership with Timorese health officials. During the initial, emergency phase, it played an important role in implementing health programmes and coordinating health services for children, maternal health and clinical nursing care (see WHO 2001). The presence of the DHS as an official local health authority in 2000 marked a new mode of intervention carried out by WHO which focused largely on long-term development assistance, especially through assisting the national health officials to build their capacity for formulating policies and plans to strengthen the health system for effective delivery of public health services. To achieve this purpose, WHO introduced a five-year strategic agenda which became the focus of its intervention in Timor-Leste. To date, three country agendas have already been published and these documents share similar programme priorities: providing advice and technical capacity-building programmes based on the NHSSP framework and also supporting local capacity to conduct promotive and preventive activities pertaining to priority issues such as maternal and child health, communicable and non-communicable diseases and environmental health (WHO 2004; 2006; 2016). According to one report, during the period

between 2007 and 2011, WHO spent US$ 11.56 million on funding health projects in the country – while a further US$ 12 million was to be allocated for the period 2012-2016 to continuously support development in the health sector (RDTL 2012a). As a result of WHO assistance Timor-Leste had a significant reduction in malaria incidences in 2014 (see Chapter 4).

In the first phase, it applied centralised control over the programme and implementation and this resulted in the national health authority having a limited role in health sector development. An evaluation study conducted by WHO and involving participants from DHS admits that its response would have been more effective "a wider appreciation of and respect for the roles and functioning of national stakeholders and NGOs" (Van der Heijden and Thomas 2001: p.25-26). In particular, it cited the following issues as undermining the process:

> a commonly held conception that 'we are building the health system from scratch' (which may be true in some senses but certainly not all); in a lack of early recognition of capacities that did survive the crisis (e.g., the Caritas TB program, and the health plans developed by the East Timorese Health Professionals Working Group prior to the crisis and which eventually did provide a basis for work undertaken by the IHA); an inability to influence and/or co-ordinate development of policies re employment of health workers across the NGO and government sectors; and inadequate attention to the language issue (Van der Heijden and Thomas 2001: p.25-26).

Following from this, the quality and coherence of some technical assistance was, as already mentioned, disappointing. Concerns particularly exist regarding assistance that was not adequately contextualised and/or adapted to the local socio-cultural and political situation, or paid due regard to the ultimate realities of ensuring sustainability. In some cases, the manner in which the assistance was provided was not appropriate to enabling collaborative relationships or building national capacity. This is as a result of donors' control and direct intervention (visible power). It is interesting to note that most of the WHO advisers to the DHS continued to be based at the WHO office rather than within the DHS. While space was certainly incredibly limited at the DHS, others – including UNTAET, UN Volunteers, and NGOs and donors (e.g., the World

Bank) – have been successful in positioning advisers within the Division (Van der Heijden and Thomas 2001).

To ensure greater local ownership, the report recommended that WHO personnel should appreciate the political context, work closely and collaboratively with local health leaders and deploy WHO key advisers within the DHS (Van der Heijden and Thomas 2001). In response, WHO shifted the focus of its partnership approach, aiming to: "cooperate and collaborate with the Government of the Democratic Republic of Timor-Leste, and other development partners in Timor-Leste to provide the greatest possible contribution to improving the health of the people of Timor-Leste" (WHO 2004: p.25). With this mission, WHO's central role was to become a technical partner of the MoH, especially in meeting the demands and requests of the ministry in implementing the national strategic agenda. A Timorese research participant who works for an international NGO and is responsible for a health programme in Timor-Leste explained the difference between the two WHO approaches: "For example, in the past, health ministers listened more to WHO. But now, WHO listened to the Minister. Although indeed on several occasions the Minister also listened to input from WHO" [author's personal translation] (Respondent 2).

The WHO's later partnership approach which let local leaders function as the main players in development with WHO assistance was welcomed by the MoH. Currently, some of the support given includes advice, capacity-building activities and money. For instance, the immunization programme was initiated and managed by the MoH while WHO supports the implementation. A Timorese civil servant at the MoH, who is currently employed by an international health agency to give technical support in immunization areas, explained the support given:

> WHO work very closely and continuously give technical support to the MoH particularly in immunisation. For example, WHO develops immunisation strategy, provide guideline in practice, guideline in effective action management, so everything. Every guideline which related to immunisation WHO supports the MoH (Respondent 18).

Further, he also explained how they did this:

> Every year WHO always send their staff for training, workshop and meeting. This is all part of capacity-building activity for the government [the MoH]. Usually before a programme started there is always training beforehand. Or sometimes WHO send also some Timorese staffs to outside the country to join training or just having ToT [Training of Trainers] in the country (Respondent 18).

Meanwhile, WHO with the support of other donors allocate money to support the Ministry in implementing their immunization activities. As an international health staff at WHO said:

> This year we supported Timor-Leste to develop the Second Five Year Immunization Plan 2016-2020. It is brought after consultation with the MoH and all the other related partners. This Multiyear Plan uses to reach global and national objectives. Then under discussion the MoH will allocate some amount of money to support the Plan. WHO will say we can provide this amount of money (Respondent 6).

As a result, from the perspective of the MoH, WHO becomes a very close partner. It always responded to the needs of health officials as evidenced by a comment from a senior civil servant at the MoH:

> According to my experience after 16 years working in the MoH, WHO is one of the best donors to work with and always support government programs. Moreover, in general, the assistance they provided was more on technical assistances and trainings etc. [Also] supplies such as medicines and vaccines would be provided according to government needs [only when it is requested] [author's personal translation] (Respondent 7).

Another local civil servant supported this, explain that, due to the very good relationship with donors [particularly WHO], the MoH can easily contact them whenever the Ministry needs money to fund their programme out of agreed activities (Field journal notes, 25 February 2016). Therefore, health officials feel more comfortable to continue cooperation with WHO.

This case illustrates how the core functions of WHO being focused on providing 'back up' to MoH agendas has increased local authority ownership in development efforts, and therefore, the Ministry officials are very happy to welcome the WHO intervention. At the same time, however, the development agency has been able to successfully maintain its power and interests through direct intervention and control (visible power), agenda-setting and project initiatives (invisible power) and secretly taking over decision-making of development (hidden power). However, in contrast, many health workers asserted that decision-making is still dominated by the MoH and their own roles as professionals were still limited in development policy. A good example can be seen from the process of formulating new guidelines on the Malaria Treatment Protocol (MTP) which involved many actors and was led by the MoH and WHO. On one hand, a WHO staff member gave a positive response regarding the method undertaken to formulate the Protocol, explaining that it successfully involved a wide range of actors including local health professionals: "It's good because it's not only one person's work, it is team work. We compare it with other guidelines and protocol [developed], this is the first time getting Timorese doctors involved" (quoted in Martins et al. 2013: p.5). Meanwhile, on the other hand, some criticise the power play conducted by the MoH that meant that the technical committee (which includes the Medical Associations) was not fully engaged in the policy process. Their involvement was just a legitimation to show that the MoH had collaborated with different actors to formulate a new document on MTP, while the MoH and donors had initiated the change. This viewpoint was further reinforced when the Minister gave instructions not to conduct a drug resistance study before moving ahead with the change to the Protocol, although Timorese healthcare professionals had already requested it. From the Minister's viewpoint, it was not necessary for the MoH to spend time and resources in conducting a study that had already been conducted in other countries because it would produce the same results:

> One of my concerns was the proliferation of studies without any significant need. What I mean by any significant need [is that] if there is evidence out there about effectiveness or ineffectiveness of X Y and Z medicine, why should we do it in our country again, why should we lose time going through studies...that was the main consideration at that time, that was the

> reason why I said okay because some would say we should do some study first and I said why, why should we do a study in Timor-Leste, isn't there a body of evidence out there that suggests that it is important to start now? Why should we wait until the study shows that we need to do it? (quoted in Martins 2010: p.253-254)

Consequently, some healthcare providers who were members of the technical committee and had roles giving input, reviewing and approving the final draft protocol, argued that their involvement was just formality and the Minister's instruction indicated MoH domination in decision-making, at the expense of the healthcare professionals. This was reflected by a statement of an NGO worker, who was also a member of the committee: "[It was] a top down approach, a technical committee was used more as the process of validation than technical debate. Limited knowledge, skills and expertise of committee members might have created this scenario" (quoted in Martins et al. 2013: p.5-6). This evidence suggests that, although the MoH could exercise more control in development practice, health professionals continuously had little ownership of the health priorities for the country.

D. The USAID Health Programme (2005-the present day)

The previous case study demonstrated a productive collaboration between donors and the MoH which meant that leadership in the Ministry were more able to claim ownership in development of the process. The next case study examines the dynamics of the 'ownership' struggle with respect to the family planning programme which was funded and organized by the United States Agency for International Development (USAID) in Timor-Leste.

Since the FRETILIN government era, family planning has been a very sensitive topic and has involved certain influential groups within the country. As a result, although MoH-donor collaboration was successful, the MoH had to deal with many interests – most significantly those of the Church – and could not really exercise independent decision-making, which affected their development ownership. This also meant that donors' family planning programmes have not been successfully implemented and only partially reached their targets.

The USAID has become an important donor in providing family planning assistance in Timor-Leste since 2005. This intervention was undertaken as a response to the MoH research evaluation which found that Timor-Leste had an overall fertility rate of 7.8 births per woman (the highest in the world at that time), that almost all the women never used contraception and did not know how to do so, and that 2.8 percent of girls were married between 15 and 19 years old (MoH Timor-Leste et al. 2004). Under the family planning project, USAID sought to promote the use of modern contraception which would enable Timorese women and adolescents to control the timing and number of pregnancies throughout their lives (John Snow Inc. 2015). As a way to fulfil this target, USAID contracted international NGOs to assist the MoH in improving the quality of family planning and the contraception service delivery. During the period 2005-2010, Health Alliance International, a United States-based organisation, became the main recipient of USAID grants (Mize 2008). After this, from 2011 up to the present, John Snow Inc., a non-profit organization from the United States, continuously received a five-year cooperative agreement with USAID to continue work on maternal, neonatal and child health interventions, including family planning (USAID 2017a; 2017b). After the implementation of the family planning programme in three districts, there were some noticeable results, including a rise in family planning counselling sessions from about 17,000 in 2012 to more than 22,000 in 2015 (John Snow Inc. 2015).

The USAID agenda regarding family planning faced constraints particularly due to the position of the Catholic Church, which believed preventing unwanted and unplanned pregnancies should be conducted through a natural process rather than an artificial one. This idea has been endorsed by the government since the FRETILIN leadership era (Rosser and Bremner 2015b). The Church's successful claim to represent national identity in post-conflict Timor and its role in undermining the FRETILIN government through the demonstrations against the secular curriculum in 2005 (as discussed in Chapter 5), had proved the Church's power as an influential actor in shaping development policy, particularly on issues of religious significance, which included family planning. A Timorese priest explained the reason for this: "Artificial methods of family planning are not good because they are against human nature. The Church is against artificial methods" (quoted in Esther 2009: p.227). Meanwhile, another local priest argued that promoting the family

planning programme constitutes a serious issue for the population and may encourage people to have sex outside marriage:

> The problem is that lots of money comes into the country from the UN and other sources to focus on artificial methods. Like the emphasis in HIV/AIDS on condom use…This will lead to encouraging the society to engage in free sex (quoted in Esther 2009: p.227-228).

Consequently, the Church's doctrine on the subject affected the MoH's approach to the family planning agenda. However, in the early years after independence and with assistance from various international agencies (including USAID), the MoH articulated a vision of reproductive health in the National Family Planning Policy 2004 which supported modern methods of contraception. This illustrates the effects of donors' visible power in intervening in decision-making of family planning programme:

> The Government undertakes [the family planning programme] to provide the public health system with technical and financial assistance from the international community if necessary, a secure supply and effective distribution of the widest possible range of contraceptives in order to ensure that the choices and needs of couples and individuals in Timor-Leste are met (MoH Timor-Leste 2004: p.11).

After the Church emphasised its opposition, the MoH shifted its health agendas by looking carefully the Church's aspirations, which became problematic for USAID's implementation of the family planning programme. A foreign worker at an international NGO that received grants from USAID explained how this affected a programme aimed at adolescents:

> In the previous project we were supposed to focus quite a bit on adolescent reproductive health [an issue that is a very sensitive topic here]. Once we realized that there was no where we could have result on that. We kind of negotiated with USAID and saying that the programme is part of the work plan but we won't be able to implement because the MoH is not ready. If there is nobody to drive any programme from the MoH what

> is the point to pushing the programme. It has happened before with an adolescent programme which made us have to go step by step. I tried to work with them to implement intervention until they felt the programme spiritually acceptable (Respondent 30).

Moreover, the MoH became more careful when launching family planning documents, making sure the ideas followed the Church's values – to avoid alienating its political support. As a result, even though family planning guidelines had already been promulgated, the MoH asked donors to revise the content. This is apparent in the formulation of the National Reproductive Health Strategy (NRHS). During an interview, a foreign worker at an international NGO pointed out that:

> I don't think they always realize the importance of their present in that workshop. Because once the strategic plan approved, it is too late. One example is NRHS 2004-2015. [Furthermore] for making the strategic document, there were many consultations meetings. Everyone had come into the forum and commented on it. And after being approved it was disseminated. Now we have been asked to return it to the MoH because there are some technical problems in it. And it is related probably to adolescent preventive health. But why does it happen only now? They were in workshop? I think we should change the mentality like when they sent somebody coming for planning workshops they need to be 100 percent focusing on it (Respondent 30).

The informant explained that the actions of the MoH leadership in repeatedly asking donors to revise NRHS guidance content after it had been formulated was very off-putting to donors to the point where they questioned the ministry's political commitment (Respondent 30). Meanwhile, for the MoH, revising NRHS document was important because it was concerned to maintain good relations with the Church, a powerful actor who had political ideas and promoted its development ownership through imposing the natural birth control as the only family planning method.

In 2017, the MoH formulated a new draft of NFPP document which accommodated the Church aspirations. This document stated that family

planning could only be accessed by married couples and that health workers will only promote the Billings method, which relies on counting the days in the monthly cycle to naturally control pregnancy. However, this met with resistance from the Timorese feminist group. In a petition to the Prime Minister, the Timorese group pointed out their reasons, including that:

> Everyone has the right to access family planning, regardless of their age of civil status; everyone has the right to freely choose any method of family planning; everyone has the right to freely decide whether or not to have children, the timing and spacing of having children, and how many children to have (Timorese Feminist Group 2017).

The group also strongly recommended that the Prime Minister give more thought to the policy:

> We request that the process of approving this draft Family Planning Policy cannot be rushed. Rather, we ask that the MoH conducts further and broader consultations on this matter, to include the perspectives of all stakeholders, including civil society organisations working in this area (Timorese Feminist Group 2017).

It is important to note that United Nations Population Fund (UNFPA) also experienced difficulties in implementing the family planning programme as evidenced by the following response by a foreign worker:

> I would say family planning is not a priority of the MoH. The policy is there. But in term of implementation of the programme and services it doesn't have the same support as some other health issues. There is a multiple health issues that are existed but the Minister and the Vice Minister are not passion about family planning. The previous Minister was a bit anti to family planning. It was not his priority and after a year the programme got rejection. The programme will either move forward or not move forward depend on emphasis from leadership and the absence of emphasis nothing much happen. When I first arrived in December 2012, they were already talking about the billboard, first family being spokesperson for the

> family planning programme. It says it is good for you, it is good for the mother, it is good for the family, it is good for the baby, it is good for the nation. It is very nice quotation. I thought that was being finalized. [But] when I arrived in 2012[54] it has printed but has not even installed. It was not until within the last 2 months [when finally it was installed]. [It means] we are talking about it took them 3 years to finalize and get the billboard put on. Is this the priority when I took you 3 years to process the message? To me that is sort of indicative but it's a policy so we don't talk about it very much (Respondent 21).

While the Church's influence significantly limited the MoH's ability to introduce the family planning programme, it also meant that healthcare professionals had very little say in the decision-making, particularly regarding service delivery. A Timorese midwife, who supported providing access to all modes of contraceptives (regardless of married status), explained this:

> We [the midwives] want to be flexible and allow them to use contraceptives so they can continue their study, but our religion does not allow this. In the past 10 years, the MoH has given out boxes of condoms, but to this day we have not used the boxes because this is against our religion... Young unmarried people never come to us to ask for contraceptives... we in the clinic do not make it public that anyone can come to access condoms (quoted in Cummins 2017: p.19).

NFPP policy document has not been able to be finalized.

E. Conclusion

The findings from the analysis of the four health programmes show how the political struggle between the various different groups to influence and win ownership over development policy affected the course of development policies and this raises questions as to how national ownership should be conceptualised. Furthermore, it demonstrates through its political economy approach that national ownership is a problematic concept that fails to take into

[54]He means 2015.

account the deep differences among political groups and the implications of the lack of institutions and processes for managing this in the early stages of the formation of democracy in a country, such as Timor-Leste; all of which constitute challenges that make 'national ownership' impossible to reach agreement.

This research also demonstrates that there are a variety of perspectives on national ownership in Timor-Leste. On one hand, the Cuban programme shows how socialist ideology of Timorese elites was implemented through welcoming Cuban aid, based on populist politics rather than a liberal-technocrat approach and with an implementation process that was imposed on the MoH leadership. The policy created divisions among healthcare professionals that further complicate the issue of country ownership. The story of the Cuban health programme in Timor-Leste also shows that Cuban aid is provided with conditions. While ostensibly it was a matter of socialist solidarity, in reality, it constitutes development ownership by the elites rather than an entirely nationally-owned. The context of aid relationships between Cuba and Timor-Leste government also further strengthens the argument made in in Chapter 2 that, rather than being mutual relationships, relations between countries identified as the Global South are highly influenced by power and interests. Oil money was a factor in empowering the MoH but it was not the whole story. Some senior civil servants at the MoH consistently pointed out that although the Ministry has received oil money from Central Government, the amount has not been enough to make it able to function independently of external donors, especially as it has to finance free healthcare treatment which consumes the MoH budget rather than generating income from the health sector. This makes the MoH still answerable to donors and greatly appreciative of their inputs.

However, the case of the World Bank health programme shows the lack of trust between the Bank and the MoH, and also some local leaders who became critical of the Bank, to the extent that key individuals working with the Bank were not able to manage the tensions. Meanwhile, on the Bank side, there was distrust regarding corruption and leadership changes, which eventually resulted in its decision to stop funding the SISCa programme. These political 'dynamics', also, resulted in the MoH decision to stop collaboration with the Bank. This decision-making was partially empowered by the presence of oil money to support the health programme, combined with the support of some donors who

were agreeable to implementing health programmes aligned to local priorities and to listening to the MoH leadership 'expectations'. But, this does not mean that the MoH had full ownership of development because within the ministry, itself, there was a contest of ownership among the different Ministers of Health.

Meanwhile, the constructive collaborations between donors and MoH through the WHO health programme demonstrates an approach whereby the leadership in the MoH had more control in decision-making and donors were responsive to their needs, including in providing funding allocations to support the MoH health programme – and, recently, more donors have used this approach. This increased the MoH trust in donors' money and also awarded them greater development ownership. The context of the World Bank and the WHO health programmes illustrates how national ownership can become an issue of who controls the money rather a question of particular priorities.

On the other hand, the case study of the USAID funded family planning programme shows how the Catholic Church, which has gained significant political influence post-independence and which has strong views on contraception, affects policy in the health sector. Since the Church has such widespread popular support – a legacy of the independence struggle – it has an effective veto over health policy that no politician wants to challenge, including external donors. Although the Church argues that their decisions on health policy reflect ownership by the Timorese people – which some say is true – others argue that decision of the Church to stop family planning programme was based on its own political view rather than to reflect the aspirations of the whole community. This also makes the Church's claim to represent the Timorese people unreliable because in reality it represents a non-elite group which is powerful and has interests and control over development agendas. As a result, there is no national agreement on family planning policies and this has delayed the programme. The lack of agreement also means that there is no basis for 'ownership', and while the MoH is disempowered by these divisions, the healthcare professionals have no say in policies about which they are best qualified to contribute informed decisions.

Therefore, data collected from the fieldwork and desk research suggests that ownership largely concentrates among certain powerful groups of actors (donors, political leaders, the MoH and the Church) and thus development policy continues to reflect ownership of these small groups of people rather than

the whole population. So, to the extent that we can talk about national ownership we are actually referring to outcomes of political contestation among and/or between various developments actors involving donors, elites, and non-elite groups. This implies that the Paris Declaration greatly oversimplifies what is involved in increasing national ownership to address local problems through donor support. In the case studies above, even foreign agencies had to build coalitions with particular groups of actors to reach their 'reform' targets; otherwise they could only partially achieve their intended outcomes.

The examination of the four health programmes in Timor, discussed above, demonstrates the issues highlighted in the conclusion of Chapter 5 whereby health professionals who became key to providing effective service delivery had limited contribution in decision-making and continuously experienced little ownership in healthcare delivery policy, and the general public even less so.

Thus, the nature of ownership itself has many layers and development policy requires more than simply achieving an idealised notion of national ownership; rather, it is about the politics of who owns what and how to mobilise resources to reach political goals. Even for donors, as the case studies have shown, the key to success of promoting neoliberal agendas depends on their ability to understand local ownership; otherwise they find it even more difficult to achieve their expected outcomes. Based on these overall findings, the next chapter presents the overall general conclusions from this research project.

Chapter 7: Conclusion

This thesis examined the main research question: What is the political economy of healthcare delivery in Timor-Leste post-independence? It explored how the politisation of healthcare in Timor-Leste has meant that public policies reflect the ownership of particular groups of key actors (donors, elites, MoH and the Church) at the expense of healthcare professionals and healthcare-users in the broader population, who lack the political resources to allow them influence in decision-making. The analysis shows how contestation of ownership in policy-making and the power struggle among different groups with different interests means that quality healthcare is accessible to a small group rather than the majority of the populace because it has been used as a political strategy for maintaining power. Moreover, because policy-making is often conducted with limited technocratic approach, it reduces the effectiveness and efficiency of implementation while benefiting dominant groups with interests in healthcare delivery. Consequently, national ownership, supposedly a mainstay of democracy and development, has proved impossible to achieve, without significant reappraisal of the concept and its implications.

This chapter firstly presents the main conclusions of the research in Section A. The second section then considers some implications of the findings, both for Timor-Leste and also more generically for our understanding of the issues involved in the concepts of ownership and aid effectiveness in relation to healthcare and similar development sector areas in fragile developing contexts. This section also indicates how international donors might contribute to more effective achievement in the field of healthcare by using political economy analyses and also focusing on cooperation with local healthcare professionals. Following this, Section C provides some suggestions for future research.

A. Main Findings

This section presents the main findings of the analysis that sought to explain the politics of healthcare ownership in policy-making and how it has affected donor programmes in Timor-Leste since 2002. This will be discussed by answering the primary and secondary research questions as presented in Chapter 1.

1. The Politics of Elites in Healthcare Policy-Making

The detailed examination and analysis presented in this thesis found that, between 2002 and 2017, Timorese elites (in both FRETILIN and CNRT) consistently combined patronage and populist models of policy-making as a political machine for maintaining power and interests. Neopatrimonialism, which had become the major political practice among political leaders, was evident in the allocation of government positions, infrastructure contracts and pension policies oriented toward certain constituencies from where, in return, elites received political support. At the same time, elites introduced populist policies (such as national consultation, pension and infrastructure development) – which has been used as their vehicles as charismatic leaders (or 'the masses of the people') in seeking to make the nation great and promoting policies much driven by popular sentiment (visible and unsophisticated) – and used these as tools to convince the Timorese people that good work was being 'done' the country and so engender support for programmes and their implementation. However, both patronage and populist policy choices are different from a liberal-rationalist-technocratic approach which focuses more on problem solving – that is, not just determined by what is popular but what is going to work. The investigation of the context of Timorese politics since the crisis (2006 till present) showed that, to maintain populist and patronage practices in government, political elites could use state resources to keep buying powerful actors and groups into political settlements and pacts.

Analysis of the research findings shows that, in the context of healthcare delivery sector, both FRETILIN and CNRT leaders had a similar vision for creating a 'better' healthcare system to enable an improved future for Timorese people. This meant that the politisation of healthcare was conducted through populist rather than patronage-based politics. This can be seen from the Cuban capacity programme and infrastructure projects intended to 'improve' healthcare facilities and services in Timor-Leste. However, the operationalisation of the policies which were dominated by the populist motives rather than public-oriented purposes, has made healthcare services remain poor for the Timorese people who largely live in the remote mountainous villages scattered across the country. For instance, analysis of Chapter 5 shows how decision to implement Health in the Family Programme was subject to populist appeal on the side of FRETILIN elites which conducted with limited consultation with Timorese

healthcare professionals. In fact, Timorese patients desperately need more access to emergency services. Similarly, based on an argument from senior official in MoH (see Sub-Section C, Chapter 5), the idea of developing infrastructure projects as a way of providing better healthcare delivery did not really enable MoH to reach their health targets because it was implemented without consideration on how to best approach healthcare system for the benefit of Timorese population. In the meantime, these political practices have successfully benefited FRETILIN and CNRT elites as a way of appealing to the population for purposes of mobilising support.

Interestingly, however, the implementation of populist policies in healthcare delivery utilised a mixture of formal and informal political practices. Formally, it functioned as a tool of political appeal which aimed to build legitimacy and confidence in the government's intention to approach development in direction that answered to a wide constituency. Informally, these policies served patronage-based relationships between particular groups of people and the elites. This is evident, for example, in infrastructure contracts and pension policies that largely benefited veterans and their families, which also shows that patronage politics remained a key driving force to gain support in the Timor-Leste health sector.

Thus, the analysis demonstrates that the practice of patronage and populist politics among Timorese elites has had a detrimental impact on the liberal-technocratic policies developed within the MoH. This is largely because institutions are controlled by elites and their decision-making and, consequently, the MoH has had to contend with structural constraints compelling it to validate rather than act against elites' populist programmes. Accordingly, they could only accept and implement health programmes that suit elite political agendas, even when this did not reflect MoH priorities. The decision to cooperate with the Cuban government and to have a free healthcare system reflected this since its design and implementation was imposed on the MoH. In fact, this cooperation was settled with limited consultation with the Ministry and healthcare professionals who had technical capacity in healthcare delivery. Indeed, although the elites had legitimate reasons for their policy decisions, in fact, these were largely made through political considerations rather than concern for the welfare of the nation.

2. Actors, Interests and their Relationships

The analysis presented in Chapter 5 and 6 found that the politics of health in Timor-Leste has been divided into two levels: one of electoral politics and the other of bureaucratic politics within the MoH. As explained above, at the electoral level, elites consistently use patronage and populist political strategies to maintain power and influence. These elites are divided according to their political constituencies: FRETILIN elites continue to largely rely on support from eastern voters while CNRT elites retain political support from the veterans and the Church. As consequence, the direction of health development has been a contest of political influence between those political elites who are inspired by socialist ideology and those who support Catholicism. Meanwhile, at the bureaucratic level, the dynamics of the political relationships between MoH and healthcare professionals are prevalent – in some cases, these actors have managed to cooperate, while in different contexts both have contested some healthcare policies and their implementations.

The analysis also indicated that only some healthcare programmes figure on the political agenda. These are those that can be politicised by the elites because they relate to broader political struggles between elites, reflecting concerns about national identity and the contending views concerning this. For instance, under the FRETILIN government, socialist ideology remained a central idea to develop healthcare and it has been implemented through the establishment of two policies. Firstly, FRETILIN leaders decided to welcome the Cuban health programme (instead of cooperating with Western donors) which was motivated by the desire to obtain quick and cheap assistance and also a bid to popularise FRETILIN post-independence which conducted through implementing socialist healthcare system as a way to improve health situation in the country.

This was an idea which became central to FRETILIN's campaign since the 1970s, and was supported by the Cuban socialist government rather than Timorese health professionals, as discussed in Chapter 6. Secondly, the political elites also introduced a national policy of a free healthcare system as a way to improve the health status of the population, again based on the Cuban model. Some of the interviewees argued these policies have increased the number of health professionals which, in turn, has led to an increase in access to healthcare in rural areas; thus, citizens in poorer areas are now able to

access healthcare services that were previously too distant or too expensive. However, another group of respondents argued that the Cuban approach is not suitable for Timor-Leste due to differences in health issues and treatment procedures between the two countries. Some respondents were even questioning the capacity of Cuban-trained health workers because the curriculum in their training course was based on Cuban health education rather than Timor-Leste. Many doctors were dissatisfied with the free healthcare policies arguing that it was not suitable for the context of Timorese society.

In other programmes, non-medical actors became involved and influenced decisions in healthcare priorities. This was evident during the CNRT leadership when the Church further politised the USAID funded health programme by influencing family planning policies so that they aligned with Catholic beliefs. No actor dared to challenge the Church's decision due its powerful influence throughout Timor.

The findings of this study suggest that the World Bank and WHO health programmes became subject to bureaucratic politics among ministry officials. During both collaborations, the MoH requested donors to put the Ministry in control of budget allocation to enable it to implement policies according to the National Plan. The significant difference between the outcomes of this for each programme was that the MoH had to stop collaboration with the Bank in 2015 because the Bank did not respect MoH aspirations on budget control.

Meanwhile the MoH and WHO cooperation continues into the present day because donors were responsive to MoH needs, particularly regarding funding allocation and priorities. However, interviews with some healthcare professionals show that the actual implementation of the four programmes (as examined in Chapter 6) was conducted with very little input from them or from healthcare users. Thus, this raises a question about the effectiveness of the implementation of some healthcare programmes because it was decided mainly through political and bureaucratic control rather than either the professional control of the medical-profession or a more democratic community-based control by users. The striking absence of the voice of healthcare providers and healthcare users in decision-making is liable to affect the ability of the health system to improve the health status in Timor-Leste.

Overall, based on the above findings, it can be concluded that the use of structuralist political economy in this thesis has allowed different perspectives on understanding healthcare policy-making in Timor-Leste. Firstly, as analysis of Chapter 4, 5 and 6 shows how institutions become important vehicle for Timorese elites to implement their political strategies. This is to ensure the allocation of state resources benefits their political coalitions and power bases which then sustain inequality among Timorese society. Secondly, as this research indicates, structuralist political economy remains strong in understanding that elite political practices do not only motivate by material interests, but also political ideology and ideas. Thirdly, as evidence in the case of USAID family planning programme, healthcare policy-making becomes subject of contestation not only among elites and non-elites groups, but it involves the power of the Church which represents a non-medical actor but has interests in health directions. Thus, this supports structuralist political economy arguments which states that development-policy will involve struggle between different groups (whether it is medical or non-medical) and their political agendas.

3. The Impact of Local Politics on Donor Interventions

The analysis of the four healthcare programmes discussed in Chapter 6 examined how power and interests on the ground determine the success of donor neoliberal reforms in healthcare delivery. In the case of the Cuban health programme, for instance, although Western donors continuously provided development assistance for developing the health sector since 1999, Timorese elites preferred to adopt the Cuban socialist approach to healthcare because it linked to their ideology of populist modernization – and consequently Cuban capacity-building aid continues to date.

In implementation, Timorese political leaders were also satisfied with their decision because Cuban aid had a different approach to the West's, as exemplified in the cases of the World Bank and the USAID programmes. Firstly, Cuban aid works under directions of the local authority, while Western donors came with their own aid system which often subordinates the recipient government. Secondly, during the political crisis of 2006, Cuban doctors continued to stay and work in rural areas providing medical care, while American doctors left the country although there was no threat to their safety.

Thus, elites' socialist-inspired idea on healthcare delivery reduces the ability of donors to implement a neoliberal marketization agenda in Timor-Leste.

The case of USAID family planning program explains how the donor was too confident in its agenda and lacked understanding that the actors to whom they transferred resources are politically situated and engaged with other group interests. Therefore, even though since 2004/2005 donors had taken lead and spent resources for the family planning programme, their agenda has not really been successfully implemented because it has been faced with the ideology of Catholicism promoted by the Church – an influential political actor with a dominant role in policy-making compared to electorate and bureaucratic elites. Although leaderships at the MoH originally supported the donor-funded family planning programme and had been involved in various activities to prepare the policy documents, the MoH changed their approach in response to the opposition of the Church (which favours traditional birth control rather than modern methods), and is now careful to consider the opinion of the Church before making decisions. Thus, the politisation of family planning by the Catholic Church has made it difficult for the donor program to penetrate Timorese society. Thus, the external donors, USAID and UNFPA, could not really achieve their reform targets and, even in recent times, the family planning policy document continues to be revised to fit the Church's political ideas – as consequence, the programme has not really been able to be implemented effectively.

The examples of the World Bank and WHO health programmes showed that, although donors are resourceful, their ability to work within the existing social order can also affect the success of their programme implementation. In the case of the World Bank programme, the donor was not responsive to the MoH aspirations to control money allocation. Although both parties engaged in negotiations, this issue became deadlocked, resulting in this health cooperation ending in 2015. The WHO and MoH cooperation, by contrast, achieved an effective collaboration between donor and national health authority because the donor was more attentive to MoH aspirations and responsive to their needs, particularly regarding support such as funding and technical advice. As a result, WHO became an important aid partner of the MoH and remains able to implement its health agendas in Timor.

4. National Ownership in Healthcare Policy-Making

The results of this study indicate that local political processes make development continuously benefit small groups of people who have power and resources. As Chapter 5 and Chapter 6 show, powerful elites were not overly concerned with healthcare; rather it has become a subject of their ideological power struggle in the guise of creating a 'modern' healthcare system. However, both main parties differed slightly in that FRETILIN elites favoured a socialist approach, while CNRT leaders preferred to use developmentalist ideas. Although Timor-Leste has received huge amounts of oil money since 2006, the allocation of resources was controlled by elites with their own points of view about development priorities, and healthcare was not high on the list. Therefore, the MoH continuously received a limited budget.

In Chapter 5 documented the ways in which political elites focused on infrastructures rather than healthcare because they are simpler to develop – you draw up a contract, sign it and then implement it. Meanwhile, the health sector is more complex because it involves a broad spectrum of interests and needs, which the elites have to satisfy through their policies.

This research also found that, during the aid-dependence and oil-dependence eras, donors continually used their various dimensions of power as means to maintain their effort to set and dominate agendas. This can be seen, for example, when the Bank asked the MoH to introduce an operation procedure before programme implementations (governmentality). Moreover, some donors were also actively assisting the MoH in preparing some health policy documents (hidden power), while other donors tried to influence decision-making of the MoH by convincing the Ministry that their project initiative was suitable for the country (invisible power). Meanwhile, some other groups of foreign agencies were also given the power, formally or informally, to directly intervene in development policies (visible power). Thus, as a result of the various power plays, donors maintained some ownership of development compared to local authorities.

At the same time, actors like the MoH and the Church have also played dominant roles over the direction of health development by implementing programmes based on their ideology and political ideas. These domination practices have meant that Timorese healthcare professionals (and also healthcare users) have had poor ownership of development. Consequently,

ownership is only enjoyed by small groups of people rather than being achieved at a national level.

Also, as consequence of elites' limited attention to the health sector, Timorese people, who largely live in rural areas, have had to struggle to get access to quality healthcare. As the discussion in Chapter 4 shows, although some efforts had been made by the Government to increase access and quality of healthcare throughout districts and subdistricts, healthcare services were still inadequate for rural villagers and this means that the only solution for them is to rely on traditional care practices.

Interestingly, elites have not been personally affected by the poor quality of healthcare services in the country since they are able to access decent healthcare services through the overseas referral system, while the majority of citizens cannot access this service. It is important to note that, although healthcare quality was still poor in the country, people have not conducted massive protests about this to the government. This is very different compared to during the Indonesian period when Timorese people were very active in protesting some Indonesian policies (including those relating to healthcare).

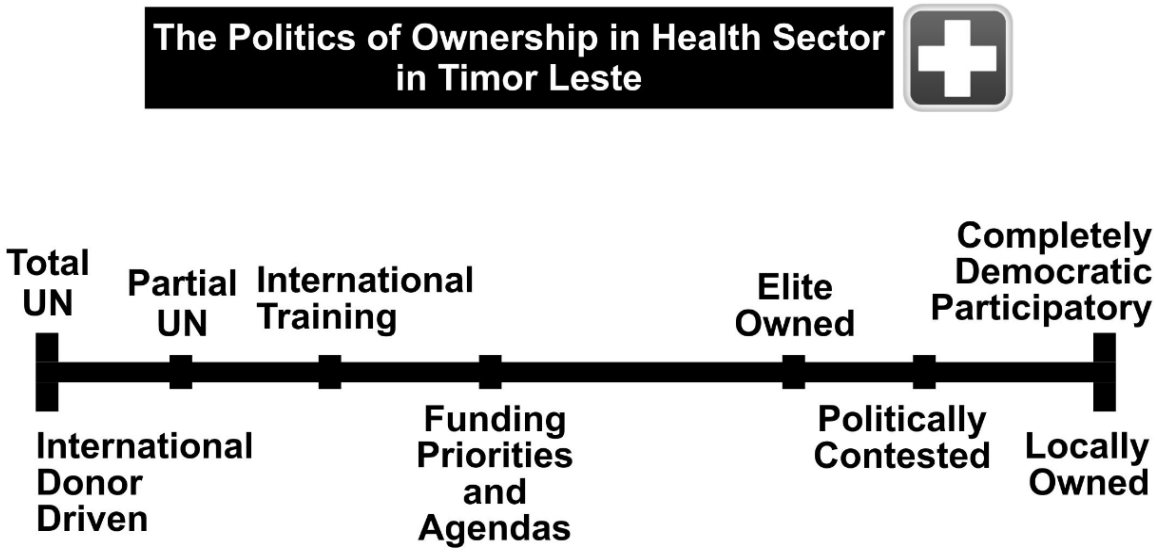
The findings of this thesis demonstrate that, although Timor-Leste currently plays an active role in the G7+ forum, ownership within the country itself has not been established through democratic processes or coherent government positions. Development plans and programmes have been largely decided and implemented by powerful actors with little ownership on the side of healthcare professionals. This means that efforts to develop the healthcare system are often ineffective because they are not suited to the local context. But it is never going to be disinterested or based upon a national consensus.

A further significant point that this research highlights is how healthcare development reflects the political transitions that Timor-Leste has been experiencing in almost two decades. This is from being international donor-driven to a more national government led democratising country, where some national actors are able to contest development ownership. This contestation mainly occurred among elites (electoral level) and between ministry officials bureaucratic. Thus, power is not evenly distributed; rather, some constituencies are more powerful than others.

However, as represented in Figure 7.1 below, several phases of transition make up a trajectory that may eventually result in a real process of good

democratic governance that is responsive to the needs of the people, as articulated largely by the healthcare professionals. Meanwhile, this research found that the latter have very little political influence and opportunity because they are still organizing themselves post-independence. Thus, this next stage, whereby they become politically influential may involve contestation among health associations that has not previously been experienced.

Figure 7.1: Timeline showing the Range of Possible Forms of Policy Ownership in Timor-Leste since Independence



A significant question arose from this analysis of the context of politics and healthcare delivery decision-making in Timor-Leste: What does this mean for the concept of ownership? Many documents, like the Paris Declaration, argue that emphasising the principle of ownership would encourage decision-making based on expertise suitable for local needs. But, as the evidence regarding the implementation of the four health programmes discussed in Chapter 6 shows, ownership is contested among development actors and the power differentials among them mean that health policies benefit only certain groups. Thus, when we discuss country ownership, it is important to have an understanding of the power dynamics involved within policy-making and implementation – and what strategies will benefit the populace rather than a privileged few.

B. Implications for Development Practices

Based on the analysis presented above, this section discusses the implications of these issues and suggests some recommendations for promoting further effective development programmes in Timor-Leste that, by extension, may contribute to our understanding of this in developing countries in comparable circumstances.

1. Problematize Notions of 'National Ownership'

This thesis has provided evidence that is specific to the context of the fragile and weak state of Timor-Leste regarding the challenges facing those in the development aid community who place country ownership of policies and programmes at the centre of the international aid reform agenda. This evidence demonstrated that the idea of country ownership, as embodied in the Paris Declaration on Aid Effectiveness in 2005, may good in idea that national development can be reached through democratic means under the leadership of local authorities. However, in reality, it oversimplifies relationships among actors in the local context. The weakness in this is that it assumes recipient countries are already led by representatives who have a commitment to a shared national vision, as well as strong leadership supported and controlled by democratic mechanisms, combined with decentralisation and de-concentration of power and resources to local citizens, through which donors can support the implementations.

On the contrary, as the case of healthcare delivery in Timor-Leste shows, ownership is a problematic term and has various understandings and viewpoints across development actors which have different structural opportunity and power, three of which are especially influential. Firstly, for the national elites, national ownership means implementing Cuban socialist solidarity and infrastructure projects, which links to their historical political campaign, as an agenda focussed on 'improving' healthcare quality and service delivery in the country. Meanwhile, for the MoH, national ownership is largely about financial control rather than policy control, in response to past experiences of cooperating with donors who did not fulfil their commitments when plans had previously been agreed. According to this understanding, when donors provide financial support, the MoH would be able to implement programmes in line with its own targets and priorities. The third influential idea

of ownership is that of the Catholic Church, which reflects its particular view on contraception that, in turn, affects decision-making throughout healthcare delivery. As a result, there has been no national agreement on policies and the family planning programme was delayed. Moreover, there is no basis for 'ownership' of health delivery policy because no one wants ownership due to the opposition of the Church, a powerful development player which could challenge the domination of the elites.

In the context of healthcare delivery in Timor-Leste, the domination of particular actors means that ownership in decision-making is in the combined (but disparate) hands of the elites, the MoH, the Church; meanwhile, Timorese healthcare professionals, who lack structural opportunity and power, have been excluded from the development process. Moreover, donors themselves are political actors involved in the struggle to achieve development reforms, and their efforts must contend with various populist policies promoted by the local actors in their desire to ensure their ownership of development. Thus, these different viewpoints and positions of 'country-owned' among elite and non-elite groups has made it impossible for an ownership consensus to be reached nationally; rather, the reality reflects the influence and domination of powerful political actors who have interests in policy-making.

Based on the conclusions above, this thesis suggests that future donor agendas should stop using the 'country ownership' principle, because in practice the term has been co-opted by certain groups of actors in various ways to serve their interests under the mantel of achieving development agenda. This is in line with Buiter's argument that, despite the term having been useful in some contexts, it has often simply created "a pleasant buzz to distract the uninformed and unwary" (Buiter 2010: p.223). Meanwhile, in development practice, the term has proved unhelpful, even misleading in that it obscures the actual dynamics involved, therefore, making it difficult for aid efforts to achieve their targets. This is especially true in the case of fragile states like Timor-Leste, which have weak institutions and powerful social forces, due to power relations among actors affecting development policies and implementation. Therefore, this research argues that the term country ownership should be deleted from the aid intervention dictionary to avoid further problematic use.

2. How can Donors contribute to better Healthcare Delivery?

This research has examined four donor healthcare programmes with various results that were strongly influenced by political processes in the country. The WHO health programmes continue to the present day as a result of the effective collaboration between donor and MoH. Meanwhile, due to local political dynamics, the other three programmes were not so successful in terms of meeting donor expectations. The Cuban socialist health programmes serves the ideology of the elites in that it frustrates the implementation of the donor neoliberal agenda, while the World Bank programme had to close down and the USAID programme was postponed, both due to the influence and domination of local actors.

These case studies suggest that donors need to have more knowledge about local politics in their aid practices, rather than thinking of development simply as delivering public goods in which particular actors will be in position to promote a particular solution. Otherwise they will continue to risk failing to produce sustainable gains.

Therefore, this research argues that if donor agencies are serious about the need for governance reform and willing to engage seriously with pro-poor health policies, they need to base their strategies on approaches such as structuralist political economy that will enable them to map the local constellation of forces. Through this, they can decide which specific reforms are most appropriate, and make provision for solutions that can be practically implemented in aid recipient countries; thus they could obtain tangible improvements for poor and marginalised groups, as also argued by Hutchison et al. (2014) and Hout (2015). Otherwise, as in the case of the family planning programme, various donors will continue to provide finances even though their reform programme may problematic to implement effectively due to opposition from self-interested parties, which eventually makes aid become less effective and does not directly benefit the poor.

A further strategy that this analysis supports as a means to improving access and quality of healthcare delivery focusses on increasing and strengthening the role of healthcare professionals in decision-making. This thesis' findings indicate that both international and local development actors need to evaluate the model of healthcare intervention they promote with awareness of whose voice is heard in policy-making. The case in Chapter 6

shows that many Cuban health workers did not speak the local language which served to exclude Timorese health workers and so affected local ownership. Meanwhile, in the family planning programme, the Church had a dominant voice compared to that of health practitioners despite the latter's first-hand understanding of the issues involved. Therefore, this thesis recommends that future development programmes need to be focussed to enable health professionals to have a significant voice in developing a better healthcare system. To do so, the process should be discussed with healthcare workers before implementation – this can be done by involving healthcare associations in planning and implementation of healthcare projects and/or consulting through the healthcare professional assembly. By applying this approach, healthcare delivery would be designed and implemented in ways that are more suitable to those responsible for their delivery and so more effective for the local country.

Thus, as pointed out in Chapter 3, healthcare professionals need to have a more influential role in health policy since, because they have regular contact with patients, they understand the social, medical and cultural context of the people. Consequently, they are in a positon to know what health policy would be suitable to fulfil the needs of patients to ensure their sustainable health. Moreover, if healthcare professionals are allowed a greater role in decision-making this would complement a liberal-technocrat approach to medical interventions in which decisions are made by qualified people with medical expertise. However, many medical workers have not been empowered by the system to have any significant say in decision-making. Under the Cuban, the World Bank, WHO and USAID health programmes, for instance, Timorese healthcare professionals were even excluded from planning to implementation. Although Cuban program involved the capacity of Timorese doctors, it further divided local healthcare professionals between those who were familiar with and sympathetic to the Cuban health approach (generally younger doctors) and those who had been trained according to the Indonesian neoliberal ideology regarding healthcare delivery.

C. Suggestions for Further Research

In this section, some suggestions for future research are provided, aiming to benefit and enrich further studies on the politics of healthcare policy ownership.

It also seeks to give insight into how donors can effectively deliver aid more effectively in fragile and weak states.

1. Within Timor-Leste

The Politics of Healthcare Delivery

Beyond the scope of this study, further research is needed that involves wider health worker participation to provide information and understanding from more perspectives regarding the healthcare situation in Timor-Leste and to compare their various experiences working in different health facilities throughout Timor-Leste. In particular, insights from healthcare professionals in the districts and subdistricts could provide data that would be useful for comparisons regarding healthcare policy-making and implementation – both between the views of those who work in urban and rural areas and between those of westerners and easterners.

Similarly, interviews with healthcare users living in and outside Dili, particularly in rural areas, would also be necessary in future studies in order to consider more widely how service delivery functions in terms of the evolving state-society relationship. As democracy is still developing in Timor-Leste, this could provide useful insight into its progress, as well as reflections on the drivers and challenges to nascent democracies in developing countries. The broader perspective would help to evaluate the implementation of specific healthcare programmes at all levels of healthcare facilities in the country. For instance, it would be useful to answer such questions as: What was the real contribution of the Saude na Familia programme towards improving healthcare access and quality for villagers? How did the context and views of Timorese affect the programme? It would also have been useful to know a spectrum of Timorese opinions regarding specific infrastructure projects, such as the one in Oecusse, which promise better healthcare treatment facility for the Timorese people. Discussing these topics would provide richer data on the different perspectives among healthcare users on healthcare delivery policy and implementation. This will also further reveal the political dynamics involved in the relationship between state and people, and the further challenges to improving healthcare services.

In future investigations, it would also be useful to look at how better service delivery may improve the legitimacy of the state. Since this is an area of policy that affects the populace directly, improved healthcare is very likely to increase the standing of the government – but this requires verification. Furthermore, in the context of Timor-Leste, elites have neglected service delivery in favour of big infrastructure programmes which arguably have not addressed the fragility of the post-independence regime. Although some health users still believe that infrastructures are important for improving healthcare services, in reality, most Timorese still suffer from treatable ill health and, in emergency, still lack access to the necessary treatment facilities.

The Politics of Development in Other Areas of Public Services

The analysis of this research has highlighted the need for future studies of the politics of policy ownership between and among elites and non-elites in different sectors – like education, which was also on the main agenda of FRETILIN's socialist reforms since the struggle for independence – and of how this affects development directions in the local context. This would provide more evidence of the areas and sectors that have become the subject of elites' patronage politics or where populist rather than patronage politics are used in the allocation of resources.

It would also be useful to introduce key studies on particular sectors to illuminate political relationships among development actors (both local and international) who have different power sources and interests. This will enable identification of powerful actors in such sectors, what kind of programme is especially subject to their politisation, how this affects donor political agendas in development, and what strategies donors use to deal with local domination practices.

In particular, further research analysing the politics of the Church as a powerful non-elite group actor and identifying which sectors are subject to their politisation could be helpful in revealing practices of the Church that dominate the direction of development policies and which actor(s) are capable of challenging it. The result of such future studies would enrich discussion about the dynamics of development in Timor-Leste from different perspectives, especially post-2017, and possibly provide insight into the situation in other developing countries.

2. Politics of Public Services Elsewhere

Similar studies of the politics of policy ownership in public service delivery in other countries in Southeast Asia would provide a more comprehensive understanding of the characteristics of elites and their domination practices in the region. For instance, this research has discussed how, under Suharto's authoritarian government, patronage and populist strategies became the main political machine of the elites enabling the building of coalitions and gaining support from the population while allocating state resources for the benefit particular groups in Timor-Leste rather than the whole populace. Thus, further research could extend this study by looking at the politics of public services in Indonesia following the reformation in 1998 which toppled Suharto. Moreover, the questions generated by this research could prove useful to addressing the dynamics of elites and non-elites relationships in development ownership in the post-Suharto era, such as: Who are the dominant actors of development in Indonesia post-1999? What are their interests? What kind of political strategies have been used by the elites to maintain their power? How does the relationship among actors affect development direction in the country? What is the impact of local political process on donor intervention? Do poor people have the means to challenge elite domination? The answers to these questions would be helpful to reveal the ongoing political dynamics in Indonesia, particularly in the field of public service delivery.

Overall, this study demonstrates that, in Timor-Leste, 'country ownership' is a hollow concept disguising political contestation over state-building and development programming. Consequently, similar research analysing the politics of ownership in Southeast Asian countries would enable better conceptualisation of the idea of country-owned. In particular, a fundamental re-conceptualisation of ownership as a dynamic process involving diverse groups would reflect the complexities and implications for fragile states more accurately than interpreting the concept as a national consensus, since the latter inevitably serves to fulfil the interests of those with most political capital rather than the needs of the populace.

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Appendix

List of Interviewees

Respondent 1: Former senior official and adviser at MoH (M)
Respondent 2: Health programme manager at international NGO (F)
Respondent 3: Health programme leader at international development agency (F)
Respondent 4: Senior official at MoH (M)
Respondent 5: Senior operations officer for health at international financial institution (F)
Respondent 6: Senior medical officer at multilateral health organisation (M)
Respondent 7: Senior official at MoH (M)
Respondent 8: Foreign technical adviser to MoH working from an international agency (M)
Respondent 9: International financial adviser for MoH funded by a foreign government (M)
Respondent 10: Junior healthcare professional working at HNGV (F)
Respondent 11: Foreign health manager working at an international NGO (F)
Respondent 12: Foreign staff working as communication specialist at an international NGO (F)
Respondent 13: Senior staff at local NGO (M)
Respondent 14: Foreign officer at international humanitarian and development organisation (F)
Respondent 15: Programme officer at local NGO (F)
Respondent 16: Senior lecturer at Faculty of Health Science, University National of Timor-Leste (M)
Respondent 17: Junior healthcare professional working at HNGV (M)
Respondent 18: Former senior official at MoH, working at international health organisation at the time of the interview (M)
Respondent 19: Senior Timorese health adviser for Minister of Health (M)
Respondent 20: Senior international staff at international health organisation (M)
Respondent 21: Senior Timorese staff at international health organisation (F)
Respondent 22: Former senior official at MoH (F)

Respondent 23: Junior healthcare professional working at HNGV (F)

Respondent 24: Junior healthcare professional working at HNGV (F)

Respondent 25: Senior healthcare professional working at HNGV (M)

Respondent 26: Senior healthcare professional working at HNGV (M)

Respondent 27: Senior healthcare professional working at HNGV (M)

Respondent 28: Senior official at MoH (M)

Respondent 29: Senior official at MoH (M)

Respondent 30: Foreign worker at international NGO (M)

Respondent 31: Senior healthcare professional working at HNGV (M)

Respondent 32: Senior healthcare professional working at HNGV (F)

Respondent 33: Junior healthcare professional working at HNGV (F)

Respondent 34: Junior healthcare professional working at HNGV (F)

Respondent 35: Junior healthcare professional working at HNGV (F)

Respondent 36: Junior healthcare professional working at HNGV (F)

Respondent 37: Former Indonesian senior health official (M)

Respondent 38: Former Indonesian senior health official (F)

Respondent 39: Former Indonesian senior health official (M)

Respondent 40: Former Indonesian senior health official (M)

Respondent 41: Senior member of healthcare professional association (M)

Respondent 42: Senior member at Commission Anti-Corruption (M)

Respondent 43: Member of the National Parliament (M)

Respondent 44: Senior international doctor working since 1998 (M)

Respondent 45: Senior healthcare professional working at HNGV (M)