A case study on health in all policies in a post conflict environment

Introduction

At the time of writing (April, 2013), Timor Leste did not have a specific Health in All Policies (HiAP) approach to public policy. However, commitment to inter-sectoral actions to improve health have been expressed through a number of government policies and strategies. There are also examples of formal and informal coordination between the health sector and ministries, such as education, agriculture, transportation, to tackle issues which have a health impact.

However, implementation of mandated policies or programs has been mixed. In this, Timor Leste presents a paradox. Any important legislation or project has to be approved by the Presidency of Council of Ministers that consists of the Prime Minister, the Vice Prime Minister and the Ministers. However, the cross-disciplinary nature of this exercise is not always reflected in the implementation.

The WHO HiAP

An approach to public policy across sectors which encourages taking into account the health implications of decisions and working collaboratively to improve the population health and health equity outcomes.

The 6 components for HiAP in action are:

1. Establish the need and priorities for HiAP
2. Frame planned action
3. Identify supportive structures and processes
4. Facilitate assessment and engagement
5. Ensure monitoring, evaluation, and reporting
6. Build capacity. [1]

Figure 1

Through a HiAP lens, this paper identifies factors at the national and local level which create an enabling environment for an inter-sectoral response to health. Using specific examples of inter-sectoral programs and actions, the paper also outlines drivers, facilitators and barriers to the implementation of these programs. Finally,
The case study offers recommendations which could strengthen inter-sectoral coordination and the implementation of inter-sectoral programs and policies in the future.

### Box 1
**Understanding East Timor’s country context**
Timor-Leste was declared a sovereign nation in 2002 after decades of civil conflict and 24 years of occupation by Indonesia. At the time of independence, most of the country’s infrastructure including health was destroyed. In 2006 the country suffered a major setback due to violence triggered by an internal conflict which resulted in the displacement of 150,000 people (approximately 15% of the population), destruction of property and disruption to all development plans and activities.[2,3] Though classified as a fragile state, the country has now established successful systems of national governance as seen through the presidential and parliamentary elections in 2007 and 2012.

### Factors creating an enabling environment for inter-sectoral action at a national level

#### Political commitment
Since being declared a sovereign nation in 2002, the Government of Timor Leste has made a political commitment to universal health care (enshrined in the Constitution) and, through various national policy documents including the National Development Plan and the Strategic Development Plan 2011-2030 (SDP), to use an inter-sectoral approach to public policy.

The country’s Strategic Development Plan 2011-2030 (SDP) specifically identified the role of other sectors to improve health. Examples include [4]:

1. Agricultural initiatives such as food self-sufficiency, increased livestock production and fisheries, will enable more diversified and nutritionally-balanced diets.

2. Infrastructure initiatives such as the provision of electrical systems powered either by renewable energies or from distribution lines direct to houses will reduce lung and chest diseases by reducing pollutants from traditional indoor cooking.

3. Proper sanitation will reduce the spread of communicable diseases transferred in waste and improved water supplies will reduce the amount of stomach-borne illnesses and infections.

4. Better housing facilities, lower fertility rates, increased knowledge of family planning, and a decrease in overcrowding in households will reduce transferable and airborne diseases.

5. National integration of roads, telecommunications and access to the internet will provide connectivity to enable more immediate responses to the management of urgent and critical health care issues.

Just like HiAP, the SDP clearly recognized the need for all sectors to address the social determinants of health, such as public transportation, access to healthy food and proper sanitation. Similarly, the first Health Policy Framework (2002), the Inter-sectoral Action Framework (2005) and the subsequent proposed Sector Investment Program (2006), also recognized the need for all sectors to address the social determinants of health through inter-sectoral action.

The general unrest in 2006 (see Box 1) caused major interruption in Government plans and shifted focus towards restoring peace and stability. Nevertheless, in its most recent National Health Strategic Plan (2011-2030), the Government has shown its continued commitment to tackling the social determinants of health and driving inter-sectoral action. Promoting inter-
sector collaboration, for example, is one of the guiding principles and strategies under the sector wide approach to health service delivery [5].

**Structures promoting inter-sectoral dialogue**

Just as HiAP recommends mechanisms for the of health implications of policy to be assessed within government (component 4), there are various mechanisms at the national level which provide opportunities for scrutiny of the legislative process and promotion of support for inter-sectoral action. The figure below lists the key structures:

The Presidency of the Council of Ministers, for example, has responsibility for approving any important legislation or project. Members include: the Prime Minister, the Vice Prime Minister and the 15 Ministers. The body meets every fortnight and a range of health and health related matters have been discussed and legislations approved. Examples include approval of National Policy for Inclusion and Promotion of the Rights of Persons and Disabilities, the Basic Law on the Environment, National Sanitation Policy and the implementation of International Health Regulations.

While each of the mechanisms highlight various tools for enabling and strengthening inter-sectoral dialogue, they also show that there is minimal engagement with civil society at the local level. This top down approach might partially explain why, despite the best of intentions, there tends to be failure in the implementation phase which is described in greater detail in the following section.

**Enabling factors at a local level - the role of community leaders**

While various enabling factors, such as engagement mechanisms are present at the national level, the extent of coordination varies at the district and community level. During interviews with district authorities, for example, it emerged that meetings are considered an important tool for coordination (i.e. enabling inter-sectoral dialogue). However, unlike at the national level which has committed to a whole-government approach to public policy (such

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*Figure 2: Structures promoting inter-sectoral dialogue and policy development*
as the role of Presidency of the Council of Ministers), coordination at district and sub-district levels is based on individual initiative and dependent on the program needs.

**An analysis of the implementation of inter-sectoral actions**

There are a number of examples of formal and informal collaboration between health and other sectors in various policy areas including school health, nutrition and food safety, water and sanitation, disaster risk management and emergency preparedness, and road safety.

There are a wide range of examples of inter-sectoral coordination with health, including joint policy formulation, a common monitoring framework, a jointly signed strategy, need based informal arrangements and formal arrangements. The following table identifies the drivers, facilitators and barriers to the implementation of 4 areas of formal collaboration which impact health - Nutrition, National Disaster Risk Management and Emergency Preparedness, Food Safety and Water and Sanitation.

Although not formally recognized, components of the HiAP approach (see figure 1) are evident in facilitating these collaborative efforts. However, some of these components, such as the delineation of roles and responsibilities, an activity for ‘framed plan of action’, are also identified in certain examples as not being present and thus create a barrier to the effective implementation of collaborative efforts.

**Recommendations to strengthen the implementation of inter-sectoral actions**

Given the barriers identified in the implementation of formal collaboration efforts between health and other sectors (see table 2), a number of recommendations are made to strengthen inter-sectoral actions. They include:

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Partner Ministries</th>
<th>Drivers</th>
<th>Facilitators</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>Seven ministries</td>
<td>Political will</td>
<td>• Inter-ministerial task force which meets quarterly established</td>
<td>• Inter-sectoral coordination remained weak</td>
</tr>
<tr>
<td></td>
<td>including: Education; Agriculture and Fisheries; Finance; Health; Commerce, Industry and Environment; Economic Development; and Social Solidarity</td>
<td>- Comodor Declaration(2010) Evidence: • more than half of all children are stunted • Of all children between 6-59 months, more than one third are anaemic.</td>
<td>• Nutrition working group composed of different ministries, NGOs and donor agencies. Holds two monthly meetings. • Civil society involved • Ministry level data collected • District level initiatives are present</td>
<td>• Financial constraints • Human resource constraint • No analysis of data</td>
</tr>
</tbody>
</table>

1 All information in the table was taken from (Timore Leste 2013)
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| National Disaster Risk Management and Emergency Preparedness | Ministry of Social Solidarity                                                       | • Clear roles and responsibilities for ministries/departments/agencies.  
• Some coordination mechanisms exist:  
- Inter-Ministerial Commission for Disaster Management (CIGD) which included MoH. (GoTL 2008).  
- Emergency Coordination Meetings;  
  each ministry has a designated focal point;  
- SoPs to notify in case of emergency exist. |                                                                                                                                                                                                          | • Lack of inter-sectoral coordination.  
• Proposed action plan and sub-sector plans never materialized.  
• Absence of appropriate legislation (i.e. no legislation for health emergency)  
• Lack of decision making power. Most technical focal points that attend meetings have limited decision making power  
• Lack of advocacy for further engagement of other sectors due to human resource and financial constraints.                                                                                     |
• Technical focal points of ministries involved in developing guidelines have no decision making powers  
• Limited human resources  
• Minimal financial resources |
| Water and Sanitation                             | Ministry of Infrastructure/Ministry of public works.                                 | 2010 Timor-Leste Population and Housing Census which found:  
• 29% used improved latrine facilities.  
• 57% access in rural areas and 91% in urban areas to drinking water.  
• Handwashing with soap practiced in less than 25% of households. | • An intensive consultative process spanning 3 years  
• Policy clearly assigns roles and responsibilities  
• A central level Sanitation Working Group formed to strengthen relationship between the two ministries.  
• A WASH forum also meets every three months.  
• MOH has developed national standards for drinking water, monitoring guidelines and is taking initiatives in strengthening health laboratory on water quality testing. | Coordination and collaboration between the two ministries has been a challenge but is improving  
• Weak coordination at district level because policy not yet disseminated at district and sub district level  
• Roles not clearly understood at a community level  
• Resource intensive (2137300 USD split across several donors)  
• Time intensive reducing replicability |
1. **Fostering inter-departmental coordination between sectors**

Meetings of unit heads of different departments, for example, could serve as a mechanism for improving inter-departmental coordination.

2. **Enhance understanding of linkages**

Orientating health sector on the role of other sectors in determining health outcomes and inter-linkages of interventions within the health sector.

3. **Identify and strengthen budget processes**

It is important to align health policy/strategy/plan formulation, operation and budgeting processes to ensure budget allocation reflects program priorities.

4. **Engagement with community leaders**

Further engagement with community leaders, Suco (village) Aldeia (hamlet) Chiefs in health related issues can be considered. This is particularly important in context of identifying local priorities and implementation of community development plans. This will assist in leveraging resources for health. For example, under the National Program for Development of Sucos (Villages) financial and technical support will be provided for implementation of national priorities at Suco level for a period of eight years (2013-2020) [6]. Sucos need to plan for six sectors which include health.

5. **Strengthen human resources**

Strengthening human resources for health includes allocation of more staff, strengthening technical and managerial skills of health and allied health staff. For instance, inter-sectoral action by health staff at field level various levels like district, sub-district and field level by provision of on-going job training that enhances their understanding of the role of health and social determinants of health.

6. **Strengthen collaboration with other sectors**

Linkages with other sectors can be strengthened by identifying strategic entry points. For example, uniformed services personnel, such as the military and police, are vulnerable to HIV, Tuberculosis, Malaria and Dengue due in part to their age and environment. They are also a significant blood donor group. Ministry of Health can plan interventions in these areas. Initiatives can be promoted in areas of common interest like alcohol breath analysis in the area of road safety.

7. **Define clear roles and responsibilities**

Clear definition of the roles and responsibilities of partner sectors is integral for effective and sustainable inter-sectoral action.

Some of these recommendations are similar to the activities suggested in the framework for applying HiAP. For example, just as HiAP identifies the importance of building capacity, recommendation 5 highlights a need to strengthen human resources, such as increasing the allocation of staff as well as technical and managerial skills for health and allied health staff.

Notwithstanding this, the advantage of the above recommendations for improving the implementation of inter-sectoral actions is that they are specific to Timor Leste. In fact, the HiAP framework for action (figure 1) advises individual countries to adopt and adjust the components to their specific governance, social and economic contexts.
Conclusion

With a commitment to universal health care, Timor Leste is rebuilding much of its health system starting with a strategic plan framework that, although not formally recognized, embodies a HiAP approach to tackle the social determinants of health. At the national government level and through key examples of formal collaboration, political commitment, tools for inter-sectoral dialogue, technical and financial resources, particularly where donor support is present, have emerged as drivers and facilitators of inter-sectoral coordination in Timor Leste. There is, however, a disconnect between the national health policy/strategy/plan formulation, operation and budgeting processes. As a consequence the budget allocation does not reflect program priorities and is inadequate. There is also a lack of understanding of inter-linkages between policy interventions within health sector and other sectors. Timor Leste shows that jointly signed strategy documents are not an assurance of inter-sectoral coordination as sectors may still work in isolation. Nevertheless, similar to the HiAP framework, a number of recommendations specific to Timor Leste have been made to strengthen inter-sectoral coordination and the implementation of inter-sectoral programs and policies in the future.

References


Note: The information for this article is based on the case study commissioned by WHO-SEARO, which was written by Dr Shilpa Modi Pandav, Dilli, Timor Leste, April, 2013. The case study included information from a literature review and interviews with key informants from various ministries and civil society members in Timor Leste. The case study (hereafter Timor Leste 2013) was presented at a WHO meeting in Helsinki in June 2013. This is simply a summation of the case study and uses much of the original content.

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