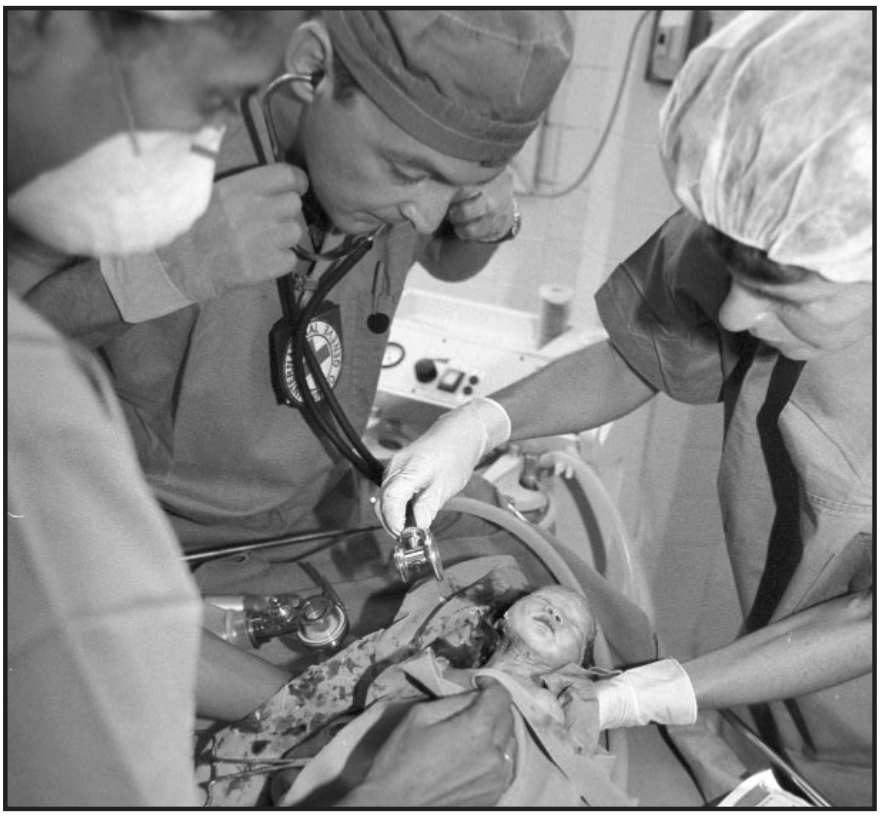
External
Resources

Special Report

Goodbye and thank you …



The ICRC experience in Dili General Hospital 1999-2001

"Goodbye and thank you …" **is, in short, the way the East Timorese reacted to the end of the ICRC's involvement in the Dili hospital following the vote for independence in the summer of 1999 and the handover, 22 months later, of the hospital in June 2001. It exemplifies their resolve to handle matters on their own from then on and recognizes the welcome help received to make this possible in a relatively short time.**

This Special Report looks back on the ICRC's operation and activities in East Timor during this period and seeks to clarify some of the issues that needed to be addressed.

ICRC

EXECUTIVE SUMMARY

How was it in fact possible that, in less than a year, the Dili General Hospital has become the primary medical centre of East Timor providing specialized surgical, obstetric, paediatric and medical care for approximately 200 outpatients per week with 226 in-patient beds? In all, from September 1999 to June 2001, the hospital cared for:

- 144,630 patients, of which
- 133,339 outpatients, while another
- 11,291 patients were admitted and treated in the hospital, where
- 3,882 surgical operations were performed.

This Special Report looks back on the ICRC's operation and activities in East Timor during this period. Beyond a description as to what was done regarding the hospital and the care it dispensed to the East Timorese, this experience provides a case study of the relation and complementarity between protection and assistance activities of the ICRC. To do so, the ICRC's Dili hospital experience is placed against the background of a theoretical protection model developed over recent years in the framework of several interagency workshops organized by the ICRC. This model seeks to clarify the links between different levels of intervention, be they the immediate response to save lives in the midst of crisis, the efforts needed to rehabilitate after the first emergency has subsided, or the framework needed to sustain efforts deployed over the long-term. The model also presents a useful tool to clarify the essential coordination and cooperation -- and indeed complementarity -- between different humanitarian organizations involved.

For the ICRC, the experience in Dili General Hospital, East Timor began in September 1999 with the setting up of emergency hospital referral services for the population of East Timor following the violent events during the summer of 1999. It was the first time the ICRC had been involved in running a general hospital with paediatric, obstetric and medical wards and that did not focus only on surgical and war-wounded activities (as, for example, hospital assistance programmes in Afghanistan and Somalia). In the absence of any national or local authorities, the hospital was fully managed by the ICRC until it was handed over to the newly established East Timorese Department of Health Services some 22 months later on 30 June 2001. It remains the main general referral hospital for the population of East Timor, now an independent country since 20 May 2002.

As the ICRC had been present in the country since 1975, a relationship had already developed with both the population and authorities well before the crisis. The contacts it had developed were essential in obtaining the necessary protection and security guarantees needed to actual operate the hospital and solve any number of issues. Open dialogue helped gain the confidence of the local population. Cooperation with the United Nations agencies, WHO and NGOs were equally essential in maintaining synergy while tackling different, acute needs. The ICRC rapidly brought in its own logistics -- planes, ships and trucks -- thus solving a transportation problem which gave it the necessary operational flexibility particularly during the early phases of the crisis, but also for the needed rehabilitation of the hospital. Similarly, the ICRC's human resource management in sending in experienced expatriates with a good mix of skills was similarly extremely valuable.

Long-term planning -- environment building -- was an important factor in the strategy of assisting Dili in that from the start the intention was to hand over to a local counterpart, rather than close the hospital. Thus, the emphasis was on training, maintenance, capacity building, and sustainability. Initially operating in a 'vacuum' of authority meant that many procedures had to be set up from scratch, but also meant that the level of sustainable standards had to be carefully assessed. The impact of the ICRC's presence and work in Dili General Hospital was significant. Many of the ICRC's patient and hospital management tools, such as nursing guidelines, hospital forms, personnel administration methods and human resource management policies were adopted by the Department of Health Services as standard practice in East Timor and are still being used today.

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ACRONYMS

CORDAID	Catholic Organization for Relief and Development (a Dutch NGO)
CNRT	National Council of Timorese Resistance
DHS	East Timorese Department of Health Services
INTERFET	International Force East Timor
TNI	Indonesian Armed Forces
UNTAET	United Nations Transitional Administration in East Timor
WHO	World Health Organisation

Maps in this document are illustrative and are not intended to have any political significance

I History and Context

In the 18th century, the island of Timor was divided between the Netherlands and Portugal. The Netherlands took the western half, which became part of the Dutch East Indies and, after the Second World War, part of Indonesia. The eastern half became a Portuguese colony. East Timor remained under Portuguese rule until the mid-1970s when the Portuguese colonial empire disintegrated.

Few places have suffered as dramatic a recent history as East Timor. The disorderly withdrawal of the colonial power followed by a military campaign, subsequent annexation by Indonesia (a move never recognized by the United Nations) and continued opposition to Indonesian rule caused tremendous suffering for the people of East Timor.

In January 1999, the Indonesian president raised the possibility of independence for East Timor and on 5 May of the same year an agreement between Indonesia and Portugal was signed, providing for the UN to conduct a ballot (popular consultation) that would determine East Timor's future.

In the wake of the 30 August 1999 popular consultation when nearly the entire population eligible to vote in East Timor turned up at the UN administered poll, backing the independence option, violence of unprecedented intensity broke out leading to deaths, disappearances, massive displacement of the population and wide-scale destruction of property. Every town and village was affected and virtually no family was spared suffering of some sort. Even the Church and the ICRC, which to that date had been protected from the worse excesses of violence in the territory in the last two decades, became targets.

"The ICRC was the voice of the voiceless"

The ICRC started operating in East Timor as early as 1975. In the mid-1980s, it established a permanent presence of under five expatriates as a sub-delegation of the ICRC's Indonesia delegation based in Jakarta.

As the only international humanitarian agency in the territory until 1998, the ICRC focused primarily on protection-related activities. These included visits to East Timorese detained within and outside East Timor and undertaking steps on behalf of the local population to improve their living conditions and protect their basic rights. In the words of a prominent East Timorese cleric, *"the ICRC was the voice of the voiceless"*.

By January 2000, the ICRC had opened a full delegation with 53 expatriates and 284 locally hired staff. Today, in 2002 the ICRC maintains a much reduced presence in East Timor with three expatriates and 20 locally hired staff.[1]

Security, weapons and the "magic badge"

Assessments as early as March 1999 predicted extreme violence around the forthcoming referendum on 30 August. Events in early September confirmed this and forced evacuation of all ICRC personnel from East Timor on 6 September. Following a week of intensive negotiations with the Indonesian authorities in Jakarta, the ICRC obtained permission to return to the ravaged territory and commence assessing the humanitarian needs. ICRC delegates returned to East Timor on 14 September to begin assessing the emergency situation. United Nations international peacekeeping troops, INTERFET ensured relatively secure working conditions throughout the country following their arrival on 20 September.

"We went up into the mountains and they come only with their magic badge and their commitment". This was peoples' perception of the ICRC as they returned while the situation was still unclear and insecure, as voiced by Dr Rui Paulo de Jesus, then Deputy Head of the Department of Health Services. Until the Indonesian forces left the country, the East Timorese people were still very afraid, the situation was tense and the atmosphere insecure. In their minds, the war was clearly not over.

1 Excerpt from: East Timorese Artifacts, Symeon Antoulas & Philippe Mathez, International Red Cross and Red Crescent Museum, Geneva, December 2001

In Dili, during the weeks following the ICRC's return, there was occasional violence surrounding the identification and arrest of the pro-Indonesian militia[1]. Later, as the general situation stabilized and reconstruction of the country began, these incidents decreased significantly and consequently, the focus of the hospital was on normal activities rather than surgery for the war-wounded.

Returnees in the Dili Municipal Stadium

Setting up the hospital

Setting up a hospital in an emergency in an area of armed conflict is not a new experience for the ICRC. Previous experiences include, for example, the setting up of field hospitals in Afghanistan and Sudan, and the running of a *de facto* hospital service at its compound during the Rwandan genocide. However, there were a number of distinguishing features in the Dili operation.

In the country:

- The primary objective was to preserve a sustainable system for the future.
- The initial phase of the operation was unusual in that there was no existing competent authority.
- The relatively rapid setting up of secure conditions by INTERFET enabled the population to return and humanitarian work to proceed.
- The UN was accepted and established as the interim authority in the country, with its equivalent, World Health Organisation representatives, in the Health Sector.
- There were no anti-personnel- or landmines in East Timor. This had a significant effect on the activities both of the delegation and the hospital. For the delegation, it meant that field activities could start as soon as general security conditions were adequate.

In the hospital:

- The speed at which the hospital was set up allowed the medical teams to begin their work rapidly during the emergency phase.
- Usually, ICRC hospital actions focus on the treatment of war-wounded and emergency surgery. This was the first time the ICRC had decided to provide all essential hospital services from the outset, including paediatrics, obstetrics and internal medicine.

2 ICRC Annual Report 1999, pp. 195-200

- Indonesian staff had held the key positions in the health sector, but Indonesian nationals left the country when violence broke out in the wake of the referendum. All senior and middle management (down to ward management level in the hospital) had fled, leaving a population inadequately prepared to run the hospital.
- This was one of the rare occasions that a hospital had been set up by the ICRC in a conflict area where the results of anti-personnel- or landmines did not contribute significantly to the workload. There was thus a reduction in the overall need for surgical and nursing time, blood transfusion services and limited need for a prosthetic service

A framework of protection

The ICRC's activities in East Timor after September 1999 fit into a protection framework where protection can be defined as:

"an activity that creates an environment conducive to respect for human beings, that prevents and/or alleviates the immediate effects of a specific pattern of abuse and restores dignified conditions of life through reparation, restitution and rehabilitation".

The protection framework comprises three sets of linked activities undertaken by a humanitarian (and human rights) agency or agencies, which work in one or more of these that are complementary to others:

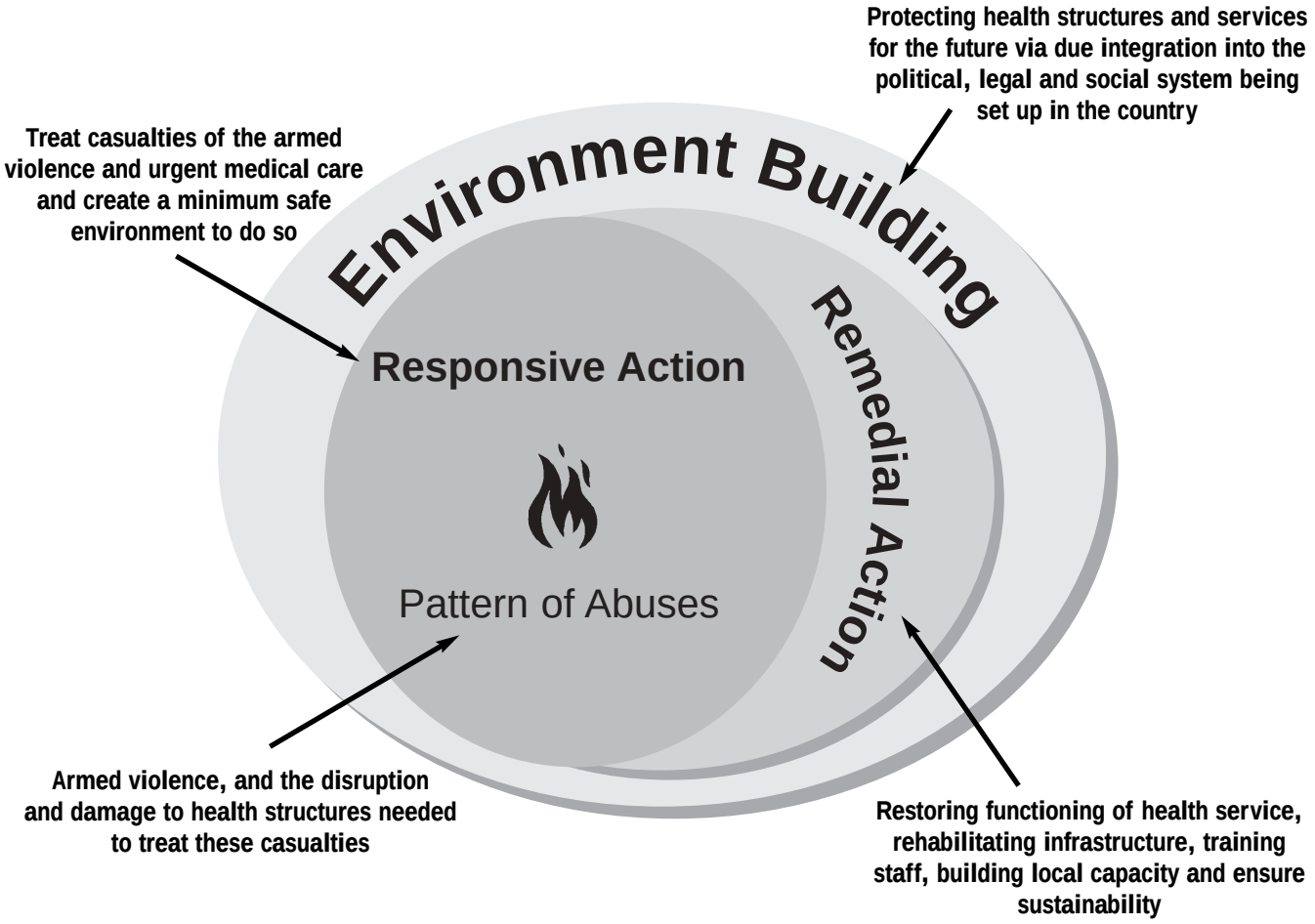
- **Responsive action**: any activity undertaken in connection with an emerging pattern of violence and aimed at alleviating its immediate effects. This included the provision of direct services to the beneficiary population.
- **Remedial action**: any activity aimed at ensuring adequate living conditions, including engaging the outgoing and incoming (military) authorities in a constructive dialogue, with a view to obtaining the necessary security guarantees, conducive to creating a space for humanitarian activities.
- **Environment building action**: any activity aimed at creating (and consolidating) an environment conducive to full respect for the rights of the individual, including (through provision of training) helping to create sustainable structures and institutions

The protection framework and definition are those developed during the interagency workshops held by the ICRC over the past few years, the reports[3] of which were published by the ICRC. One of the advantages of the model is that it illustrates that all aspects of action are interdependent and need to be considered — and indeed tackled — at the same time and cannot be dissociated. For example, treating casualties (responsive action) requires a minimum of security and normative environment that allows this to take place (environment building action). Similarly, rehabilitation of hospital structure and functioning (remedial action) needs to be considered already when responding in the emergency phase and requires the legal, administrative and political structures (environment building action) that can accommodate the system being rehabilitated to allow it to be sustainable. Not all of these actions are the focus or responsibility of the ICRC alone; indeed other organisations and instances are needed, but the ICRCRC's humanitarian activities cannot work in isolation but should be complementary to that of others and vice versa. The ICRC's operation in Dili is a good example of how this protection framework may be applied practically.

The protection framework and the Dili hospital

In the wake of the 30 August 1999 referendum, widespread violence and lawlessness generated a situation in which the authorities were unable to provide even the most basic services to the community. The ICRC's involvement therefore covered all three sets of activities.

1 For example: Workshop on protection for Human Rights & Humanitarian Organizations, Doing something about it and doing it well, Report of the workshop held at the International Committee of the Red Cross, Geneva, 18-20 January 1999, ICRC, Geneva, January 2000.



In line with the above framework, in practical terms the ICRC's key objectives in Dili General hospital were to:

- create a space for humanitarian activities
- offer protection and treatment
- ensure stabilization and sustainability
- train local staff and build capacity
- prepare handover

Although the ICRC had been active in the region for many years, previous attempts to place an ICRC surgical team in Dili General Hospital, in spite of formal agreement with the relevant authorities at the highest level in Jakarta, had failed. Thus, while there had been no direct ICRC involvement in the hospital before 1999, the ICRC was not entirely new to the context and was familiar with the hospital and its activities prior to the recent events.

Information which was available indicated that the hospital had a poor reputation among the population. People had been harassed, human rights had not been respected, arrests had been made in the emergency room. The care and treatment were perceived as poor. The majority of doctors (including all surgeons), most senior nurses and middle management were Indonesian.

During 1999, it became clear that if violence broke out, there would be a vacuum in terms of medical human resources. The ICRC would have to intervene and total substitution of all medical services and hospital management would be the only option in a situation where the health system would completely fail.

Initial assessment after the return of ICRC delegates to Dili on 14 September revealed that, despite the

general destruction in Dili, including the ICRC delegation, the hospital was one of the rare buildings that had suffered only from vandalism and looting of equipment and supplies. A few East Timorese nursing staff and patients remained, and the hospital compound was sheltering up to 500 civilians who had sought safety there.

Creating a space for humanitarian activities

As a first step, the ICRC managed to secure protection by the Indonesian military authorities (Indonesian Armed Forces (TNI) of the hospital site, patients and staff. This was possible as a result of its longstanding presence in Indonesia and the relations – including at the highest levels in Jakarta — it had developed over the years.

The ICRC then sought and obtained approval from the Indonesian military authorities to use the hospital as a base for all ICRC activities and as accommodation for the expatriate team. This arrangement gave the ICRC a viable base to start with in the midst of what was other wise a still highly volatile situation in a destroyed town, at a time when the future evolution of events was all but certain.

"We are present, we are working, we need logistics"

The ICRC's choosing the hospital as a base for its activities was a crucial step in creating a space for humanitarian activities. Using the hospital for a humanitarian task clearly sent the message "we are present, we are working, we need logistics", principally to the other actors in the field, initially the TNI and INTERFET.

INTERFET Patrol

For the population, it was important to have a visible presence and clear focus for the whole range of ICRC activities. Practical considerations in finding an operational base in Dili where much of the infrastructure had been destroyed posed many problems for the numerous NGOs, which arrived later. Having an established base at the hospital gave the ICRC a head start. Previous contacts with the Indonesian authorities made negotiation and decision-making much easier in these early phases.

The ICRC focused on protection of patients and staff and the population already sheltering in the hospital by providing emergency hospital services for the population and by preserving hospital buildings and facilities for the future. The strategy to achieve these protective measures was to create a space for humanitarian activities. Firstly, the ICRC maintained its dialogue with the Indonesian commander to ensure understanding and approval of its work in the hospital and in the country. Secondly, the ICRC placed expatriates in the hospital. Thirdly, information was given to the population during field trips that the hospital was functional and that it was safe to seek treatment there. All of these contributed to restoring the population's confidence in the hospital.

The internal hospital strategy applied was to:

- set up essential services (medical and non-medical) to assure emergency hospital care;
- assess all departments and services;
- set up a system of hospital and patient management;
- assess the needs of the population for hospital care and
- build capacity.

Streamlining

Once the needs of the population had been defined, the capacity of the hospital adjusted accordingly and the political situation stabilized as the United Nations Transitional Administration in East Timor (UNTAET) took on its responsibilities, management of the hospital entered a new phase.

The streamlining of hospital management and clinical care is part of a normal process which takes place in all ICRC hospital actions after the initial assessment and emergency intervention. It typically involves clarification of staff terms and conditions of employment, the development of standard working practices, teaching programmes based on appropriate clinical guidelines and a reduction in the size of the expatriate team as local staff take on more responsibility. In this respect, the streamlining process in Dili was similar to other hospital actions.

East Timorese gather at the delegation's tracing office in the hospital

II Launching the Hospital

Coordination and communication

The importance of good communication and effective coordination has been stressed many times. An emergency operation cannot be managed without fast and reliable communication between ICRC units, both in Geneva and the field, between the ICRC and the population that it assists and between all the actors in the field.

Coordinating health activities

From the outset, meetings between humanitarian organizations and local partners were held in the central hospital of Dili to coordinate the response to the crisis and work towards sustainable solutions in all aspects of humanitarian assistance. These meetings were chaired by representatives from the various international agencies, in cooperation with their counterparts from the National Council of Timorese Resistance (CNRT), the umbrella organization of East Timorese political parties.

The health sector had its own specific coordination meetings. This was especially important from the perspective of Dili General Hospital, to ensure that all NGOs, who were referring patients to the hospital from the peripheral health structures they were supporting, were aware of what treatment was available in the hospital.

Translators

Throughout the ICRC's time in the hospital, there were many sensitive, difficult and occasionally confidential issues to discuss with East Timorese patients and staff. The lack of good translators caused misunderstandings on both sides. Numerous translators had to work in all hospital departments and for the key ICRC staff as well as in the delegation. Translators were scarce as the ICRC had to compete with all other agencies for their services. As well as proficiency in English, it became apparent that the translators had to be trusted by the East Timorese staff and this often depended on their political affiliation.

Nobody was really able to check the quality of translation, both spoken and written, nor were the translators provided with any form of training. This is an issue that the ICRC did not address adequately. Language training should be provided as considerable difficulties arise due to lack of good communication. However, finding the right human resources with knowledge of the local language and English in an emergency situation will prove problematic.

Logistics

The ICRC's Logistics Division had been restructured and in 1999 was still untested by such an operation of this size and complexity. During the months prior to the September 1999 crisis, as the situation in East Timor became increasingly unstable, the Division in Geneva prepared kits of medical supplies, administrative and technological support for transport. However, once the scale of the violence became apparent, it was difficult to find air companies prepared to fly in.

For a general description of situation, we refer to the *ICRC Quarterly Donor Reports*[1] relative to the period. Suffice it here to draw attention to a number of essential points.

The key factors to re-establishing the supply chain were:

- deciding to send in a Norwegian Red Cross field hospital, which involved rapidly transporting a large volume of equipment at huge cost. This was entirely taken on by the Norwegian Red Cross;
- finding a solution to the lack of local transport by using trucks to avoid a bottleneck at the forward logistics base;
- defining the ICRC's operational strategy. Decisions were made as to which programmes were to have priority. Medical, water, shelter and food have different logistical requirements.

The ICRC flew in a large plane to set up a Norwegian Red Cross field hospital. Having planes and ships to re-establish the supply chain from the outside, and trucks as means of transport within East Timor gave the ICRC a huge advantage over other agencies in terms of mobility initially. In fact, the ICRC was operational by air and sea before the multinational force,

1 ICRC Quarterly Donor Report Asia and the Pacific — July-September 1999, pp. 47-53; and ICRC Quarterly Donor Report Asia and the Pacific — October-December 1999, pp.48-55

INTERFET. The careful mix of human resources and supplies was fundamental to setting up a delegation promptly. Housing had to be found rapidly for the expatriate staff and this problem was solved by temporarily using a hospital ward and part of the outpatient department as accommodation. The fast response resulted in good press which generated broad public interest.

Surabaya (Indonesia) was initially identified as a logistics and purchasing base – allowing further supplies to be sent by sea or air as appropriate. Cooperation with the Australian Red Cross through their Northern Territories branch made Darwin another obvious choice for a logistics base.

ICRC trucks arriving at Dili port

Medical Logistics

This was also early days for the ICRC medical logistics. It was a huge challenge to set up and supply a general hospital in an emergency situation, where communication is difficult and sources of supply are unclear. The standard list of drugs and equipment, which usually focused on surgical activities, had to be extended to cover the needs of paediatric, obstetric and internal medicine.

All donations of equipment and medical supplies were assessed on an individual basis to ensure that they were appropriate for the situation and medical practice, and with the future in mind in terms of long-term sustainability.

Infrastructure, construction, rehabilitation and maintenance

As there was no detailed prior information about the extent of the damage caused by the violence – at the hospital or town — the ICRC mobilized several water and habitat engineers. An emergency needs assessment for the population was carried out and the provision of adequate water, food and shelter was addressed. A detailed account of the rehabilitation of the water system[1], food distributions, the provision of material assistance for building shelters can be found in *ICRC Quarterly Donor Reports*. Other humanitarian agencies and NGOs participated in these programmes. The hospital was, however, considered a top priority.

[1] See Annexe II

Unpacking the Norwegian field hospital

Once on the spot, initial assessment showed that although the hospital had not been destroyed, its infrastructure had been neglected for many years and was in need of repair and maintenance. The hospital functioned, but there were endless problems with sewage disposal, rubbish collection and disposal, vector control and power supply. Some beds were unusable as there was no running water, and toilets in the wards were blocked. Rehabilitation of the hospital's infrastructure became the main priority to provide a safe and healthy environment for the patients.

This hospital rehabilitation involved:

- setting priorities with the hospital management team to provide all essential services;
- establishing the standard of work. This was based on safety as a minimum – but aimed to restore it to the level it was before;
- setting minimum technical standards for every ward and department;
- upgrading installations – the water supply, the electrical board, rewiring, installing laundry and kitchen equipment – based on management requests and priorities;
- establishing a hospital repair and maintenance team (local technicians with initial expatriate management) and a system for requesting such repairs and maintenance.

As the delegation was using part of the hospital for office space and accommodation, rehabilitation of the amenities served a dual purpose.

Managing the hospital

Clinical management in a general hospital

The general principles of hospital management remain the same, whether the hospital admits only people wounded in an acute conflict or provides a general referral and emergency service in a longer-term chronic conflict. The main differences between the two are less of a focus on surgery and increased attention to the management of more diverse clinical services.

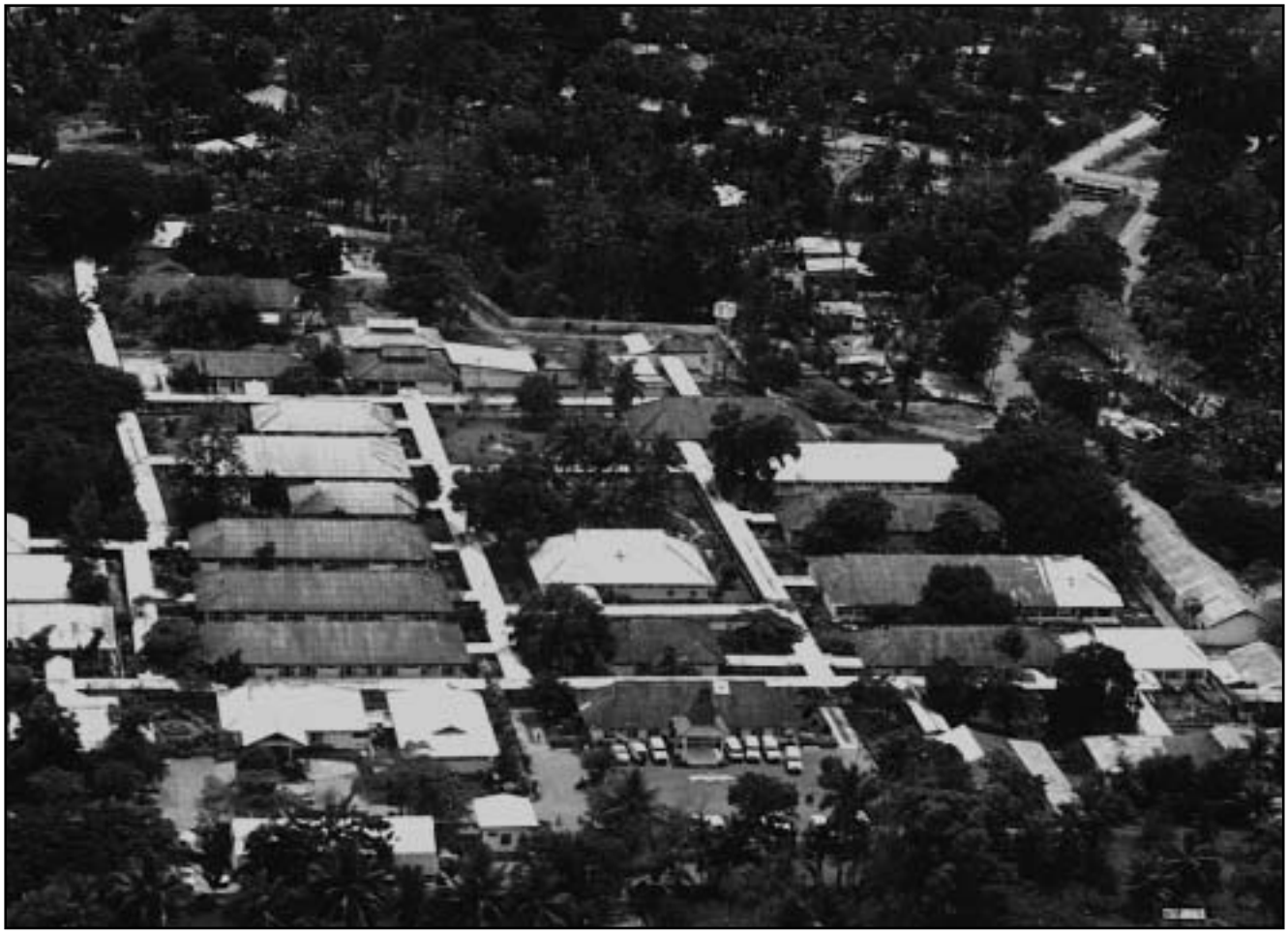
For the ICRC, the experience in managing Dili General Hospital showed that with good hospital management, based on a tried and tested system, it was possible to take over the clinical management of all essential hospital services. The key elements of this showed to be that:

- overall political analysis of the situation is important. A long term, chronic conflict requires a more developmental approach to project and hospital management;
- the outcome of a hospital project set up in this kind of situation is likely to result in a handover to a competent authority rather than closure. The reason for this is that the purpose of such a hospital is not purely to treat war-wounded, but to provide a general referral hospital service to the population;
- the professional profiles of the expatriate and local medical, nursing and technical staff will be more diverse, as will the range of supplies and equipment required. This inevitably means a bigger team and more complex management.

Hospital assessment

A detailed assessment using the ICRC hospital assessment tool was made in December 1999. The results of this were used to establish priorities and set specific short-term objectives for the team. It also provided a baseline of information against which future hospital performance could be measured.

The assessment was repeated in April 2001 and showed that a target of improving hospital performance by 20% had been met. Standards of care were being maintained while more responsibility was given to the local staff.[1]



Aerial View of Dili Hospital Compound

1 The internal ICRC assessments by Jennifer Hayward are available upon request.

III Inputs & Outputs

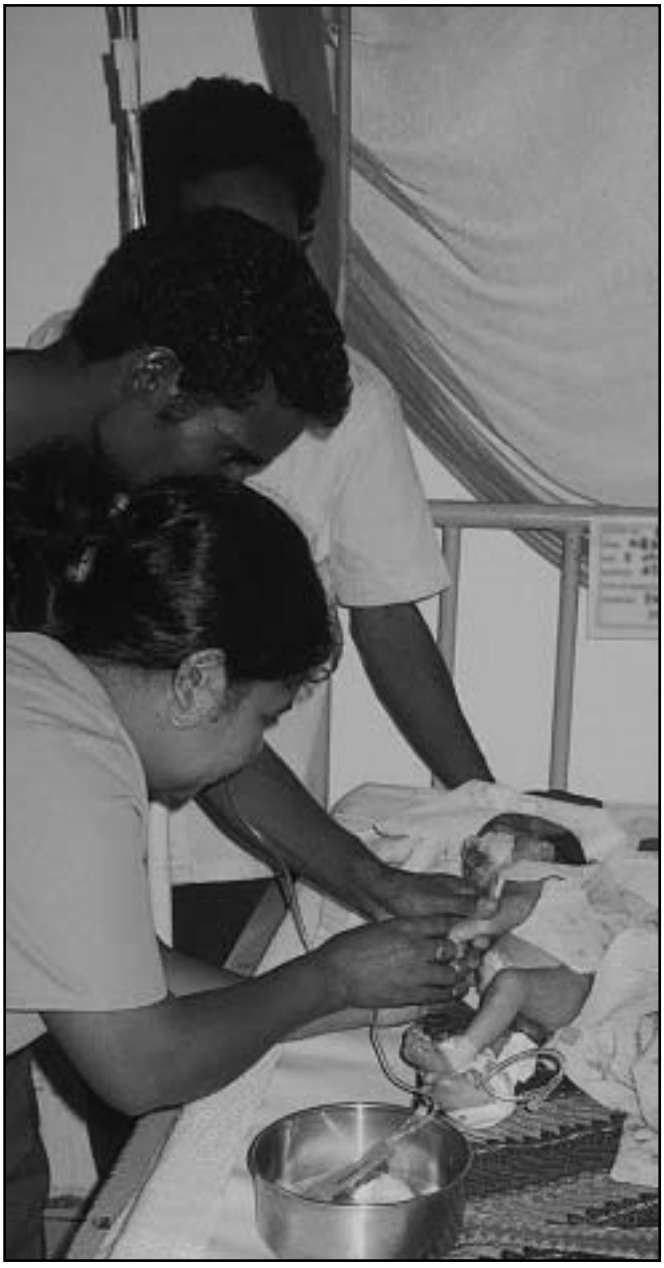
Hospital activities

When the ICRC medical team first arrived in the hospital, they found 42 patients being cared for by a handful of East Timorese nursing staff. As the population returned to Dili and the staff returned to work, hospital activities increased dramatically. The ICRC increased the bed capacity of the hospital to accommodate the rising numbers of patients admitted for treatment.

The hospital now has medical, surgical, paediatric and obstetrical facilities with total bed capacity of 226.

- Surgical: 54 beds (26 male and 28 female)
- Medical: 46 beds (27 male and 19 female)
- Paediatric: 28 beds
- Maternity: 24 beds
- Maternity observation: 6 beds
- Observation room: 8 beds
- Intensive Care Unit: 6 beds
- Low dependency ward: 26 beds (incl. 9 paediatric beds)
- Isolation ward: 28 beds

The ICRC provided the necessary to establish fully functioning medical departments. This included an operating theatre with two tables, a post anaesthetic room and a central sterilizing unit, a physiotherapy department, an emergency room, a laboratory and X-ray department. There is also an outpatient clinic with facilities for various consultation services.
Similarly, the ICRC provided the essentials for the non-medical departments, a pharmacy, kitchen, laundry, cleaning service and maintenance team. This included a 250 kW generator, a mortuary, two boreholes for the hospital water supply, and an incinerator, as well as staff quarters and workshops.



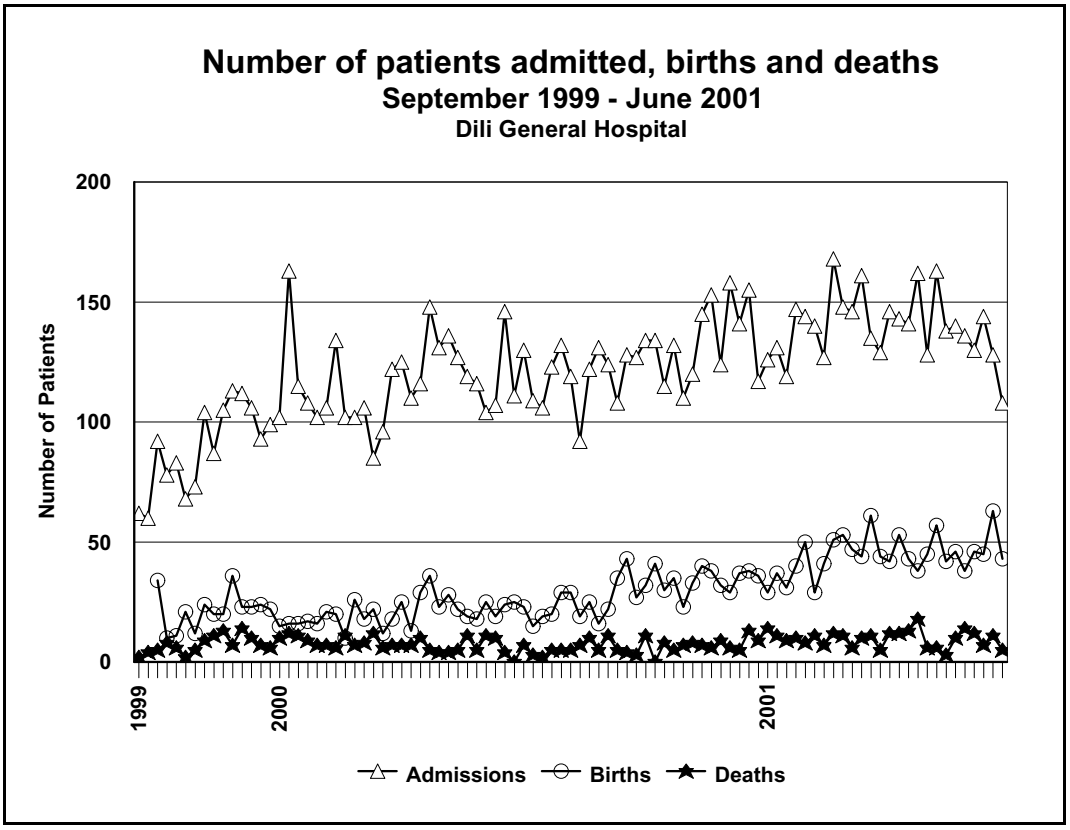
Timorese nurses with sick newborn baby

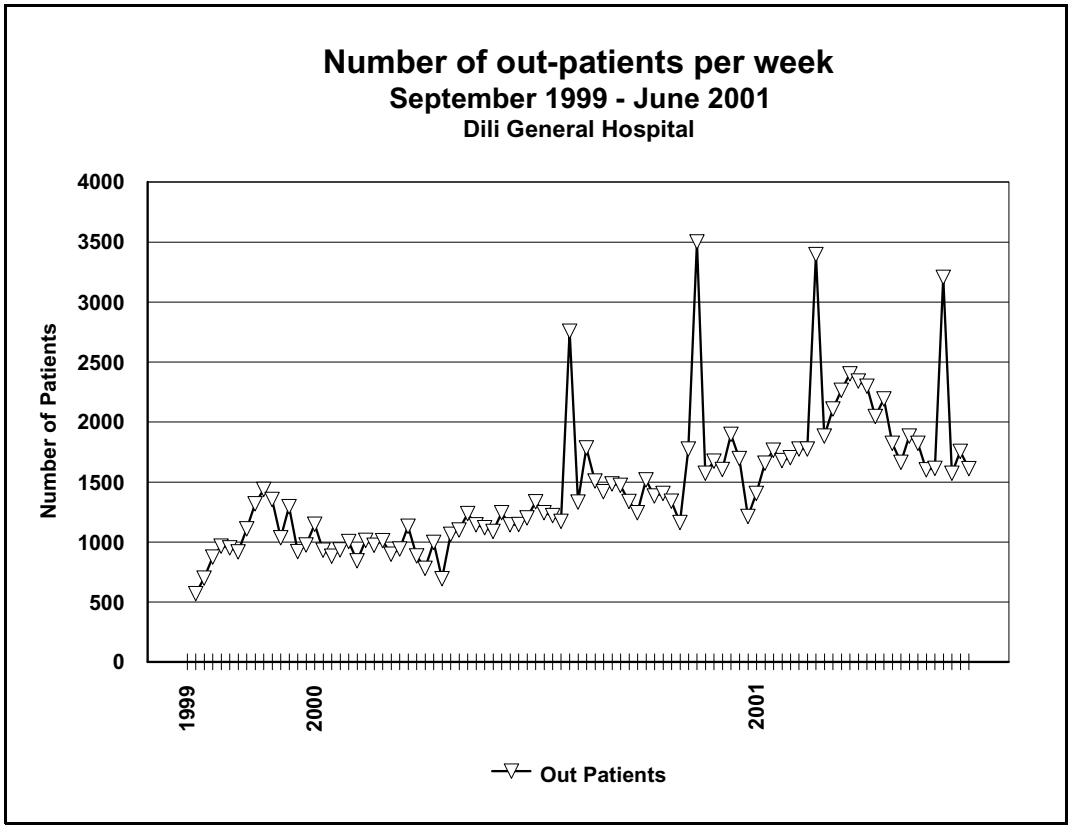
Medical care

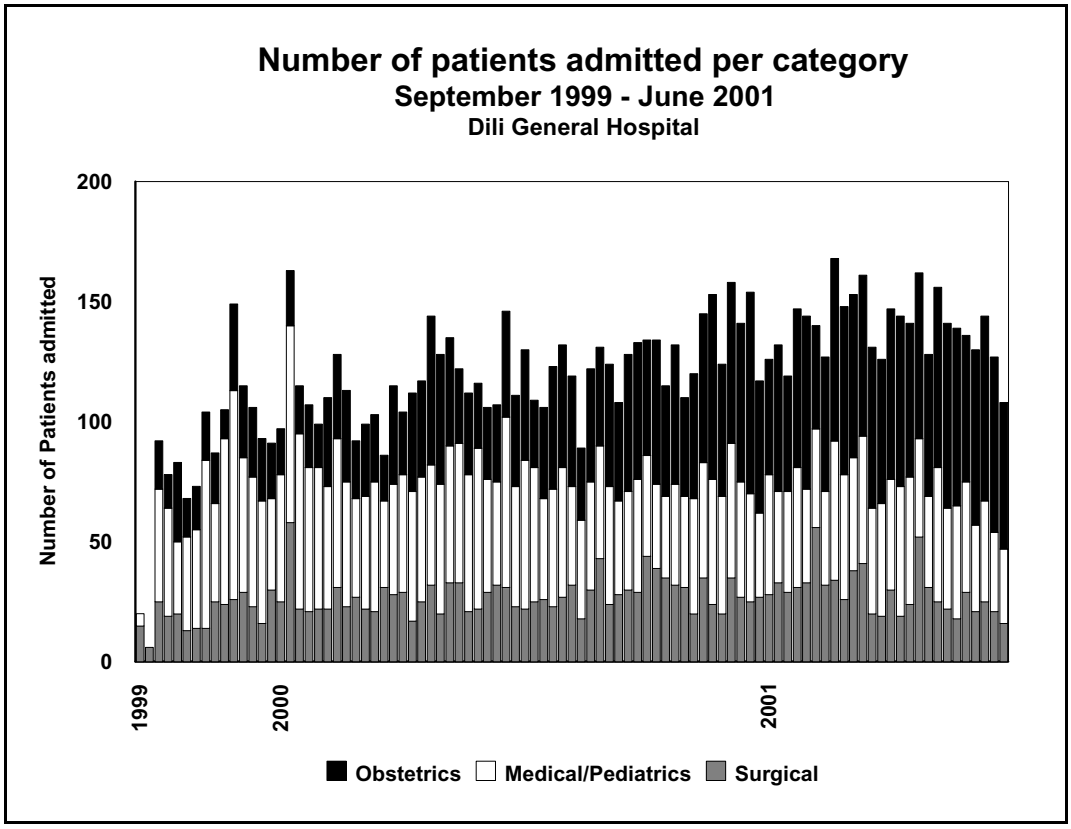
The treatment provided in the hospital combines WHO standard treatment protocols and medicines with international standards and ICRC practices.
The most common diseases are malaria, lower respiratory tract infections, asthma, tuberculosis, gastroenteritis, and other medical problems.

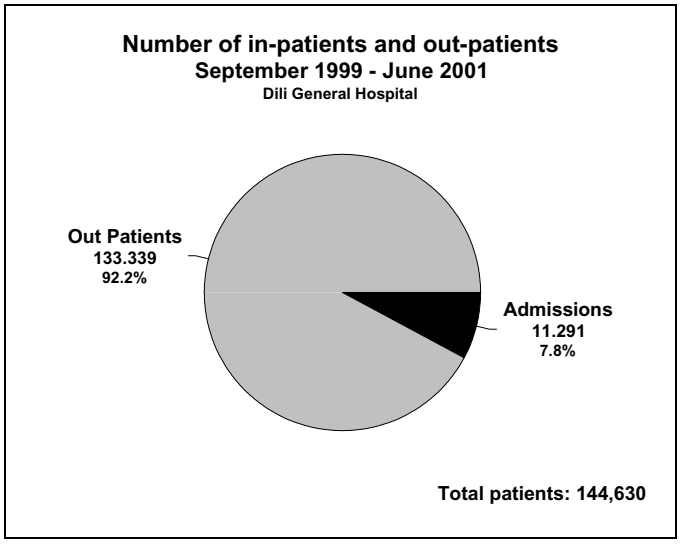
The surgical cases are related to trauma, orthopaedic or obstetrical problems, acute abdominal pain, and to chronic conditions such as hernias, kidney stones, goitre, and tumours.

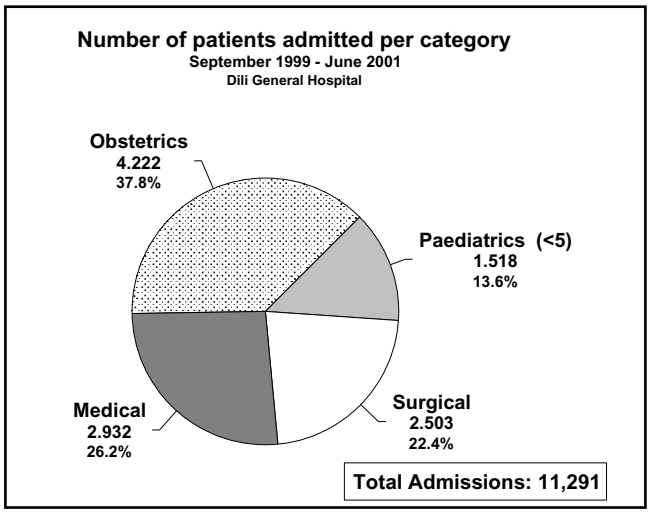
Statistics


Number of patients admitted, births and deaths
September 1999 - June 2001
Dili General Hospital
Number of Patients
200
150
100
50
0
1999
2000
2001
Admissions
Births
Deaths


Number of out-patients per week
September 1999 - June 2001
Dili General Hospital
Number of Patients
4000
3500
3000
2500
2000
1500
1000
500
0
1999
2000
2001
Out Patients


Number of patients admitted per category
September 1999 - June 2001
Dili General Hospital
Number of Patients admitted
200
150
100
50
0
1999
2000
2001
Obstetrics
Medical/Pediatrics
Surgical


Number of in-patients and out-patients
September 1999 - June 2001
Dili General Hospital
Out Patients
133.339
92.2%
Admissions
11.291
7.8%
Total patients: 144,630


Number of patients admitted per category
September 1999 - June 2001
Dili General Hospital
Obstetrics
4.222
37.8%
Paediatrics (<5)
1.518
13.6%
Surgical
2.503
22.4%
Medical
2.932
26.2%
Total Admissions: 11,291

Human resource management

The expatriate medical team

In the absence of East Timorese management, medical and nursing staff, a team needed to be selected and sent in to meet the immediate treatment needs of patients, train the local staff and set up the system of patient and hospital management.

As in all of the ICRC's large hospital experiences, National Societies provided the majority of the expatriates forming the hospital team. Key hospital management staff had experience from other ICRC actions which was essential for both the initial and handover stages. An important element of this experience was the ability to respond quickly to recruitment needs and to manage diverse professional profiles.

The ICRC hospital management team was pivotal to the smooth running of the hospital, maintaining clinical standards and coordination with other ICRC services, other humanitarian agencies and the INTERFET medical services. The key positions were those of the hospital administrator to manage all non-medical departments, the medical coordinator for clinical supervision, and the hospital project manager for nursing supervision, human resource management and overall project management. Two surgical teams, a paediatrician, a medical doctor, a midwife, ten ward nurses, a laboratory technician and an X-ray technician completed the team.

The streamlining phase followed a pattern typical to other ICRC hospital experiences, with the emphasis on teaching and training to ensure a safe standard of care and prepare the local medical and nursing staff to take on more responsibility.

Several important points were noted which are common to large hospital actions of this kind.

- A good mix of skills, experience, personalities and nationalities works well.
- Timing the introduction of first mission team members needs careful planning.
- The deliberate choice of experienced people on short missions for the first phase is a lesson learned from previous actions. These people are able to "hit the ground running", become effective in a very short time and are flexible about their roles during the emergency phase.
- This large team of expatriates is likely to be needed for at least six months in a situation of total substitution, as was the case in Dili.

The following National Societies provided staff for the hospital:
Australia, Austria, Canada, Denmark, Finland, Germany, Ireland, Iceland, Italy, Japan, New Zealand, Norway, Sweden, United Kingdom, and the United States of America.

Japanese Red Cross ward nurse

Timorese hospital staff

Staff management is one of the most complex and time-consuming hospital management activities and requires careful, sensitive handling. In the absence of national or local authorities or any employment laws, a clear and consistent management line has to be adopted and adhered to. This is never an easy task and East Timor was no exception.

Once adequate security was established, the East Timorese hospital staff returned to work rapidly, soon totalling around 300. The main management problem was to control this return, ensure that properly qualified people were in appropriate positions, and keep track of who was working where.

Within two months, all staff had been interviewed, nursing qualifications checked, identity cards issued, salary scales and grades established, and personnel files set up. A new ward nursing structure had been developed to accommodate the changing situation and clarify vacant positions. This helped to monitor the flow of former hospital employees as they returned to work.

Teaching and training

Teaching and training was a priority to maintain and improve the standard of care in the hospital. It was a key part of the strategy for handover in order to increase the competence of the East Timorese medical, nursing and technical staff and devolve responsibility to them.

The expatriate medical team understood that teaching forms an integral part of their task in any hospital. This is even more important when working in an existing hospital which will eventually be handed over to the national authorities.

An important factor was the timing of teaching programmes. The hospital staff had also suffered from the trauma of the recent events, faced an uncertain future, and consequently needed time to develop a relationship of trust and confidence with ICRC staff before training could begin.

The major obstacle common to all the teaching programmes was communication. Finding an adequate translator proved very difficult, as was identifying a suitable counterpart from the existing nursing school. An additional complication was the lack of professional accountability. A “blaming culture” exists in East Timor and there was a general fear of reprisals from relatives on medical or nursing staff if treatment of the patient was unsuccessful.

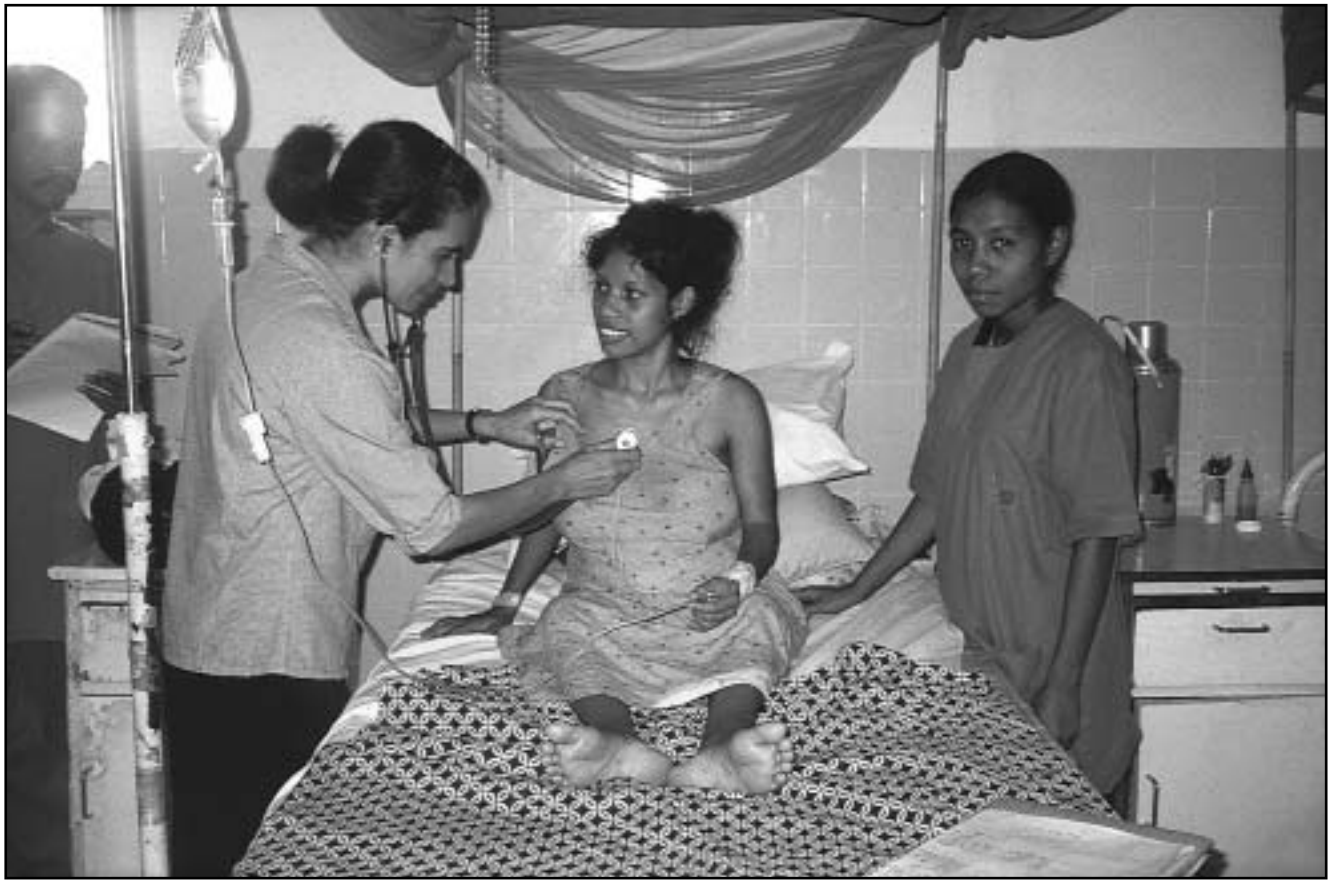
Timorese nurses in outpatient department

Nurses

An expatriate teaching nurse arrived in April 2000 to coordinate training, workshops and develop nursing guidelines and protocols.

A short course in ward management proved successful, as did the introduction and training of Nurse Supervisors, who required intensive clinical training and guidance for three months, but eventually proved to be crucial in the success of the handover process.

With the re-opening of the nursing school in Dili, nursing students were introduced on the wards for practical training.



Timorese doctor visiting a patient

Doctors

A teaching programme for the East Timorese doctors commenced in November 2000 to improve basic clinical skills and provide a sound basis for more formal specialist training at a later stage.

Eventually, the East Timorese doctors were able to work independently in the outpatient department, emergency room, paediatric and internal medicine wards and to take the on-call duties during the night. However, the ICRC medical coordinator was still responsible for clinical supervision.

Laboratory and X-ray technicians

Additional training was provided for laboratory and X-ray technicians. While they were already very competent in some areas, quality control procedures were put into place as well and some additional training in the management of blood for transfusion was given.

Physiotherapists

The ICRC re-established the physiotherapy department in the hospital, which is the only such service in East Timor and completed a six-month training programme for six nurses in basic physiotherapy in December 2000.

IV Handover

UNTAET was recognized as the national authority and employment laws and conditions began to be set out. Certain elements were retained from the former Indonesian labour laws. The prospect of the hospital being handed over to the DHS created a feeling of insecurity among the Timorese staff. Many changes were in the process of being implemented nationally by the interim authority; UNTAET and permanent recruiting for all health sector positions began.

The ICRC developed strong links with the DHS and this excellent relationship was helpful in overcoming many problems. All staff signed a contract of employment prior to handover, but this was not a permanent contract and job security remained a major issue.

Eventually, the interim Health Authority developed the Public Service Commission Terms of Employment, which set out terms and conditions of employment and benefits for health workers; these were implemented in September 2000.

On 13 March 2000, it was decided that the hospital should be handed over to a competent authority by 30 June 2001.

The timing was right

The newly established East Timorese Department of Health Services (DHS) were officially responsible for the hospital; a health budget and strategy for the whole country was being developed. Nevertheless, it was evident that the East Timorese would not be in a position to provide all the appropriately trained and experienced staff needed to manage the hospital or to fill key clinical positions. A partner clearly had to be found to help them through the next phase. The Catholic Organisation for Relief and Development (CORDAID), a Dutch NGO was subsequently announced as the agency to take over this responsibility from the ICRC.

In January 2001 it became evident that the timing was right and the East Timorese became "reluctantly eager" to step forward and take over. This reflected a general change of mood throughout the country. A Memorandum of Understanding was drawn up between the ICRC and UNTAET on behalf of the DHS. This clarified the responsibilities of both parties in handing over the hospital, especially on sensitive issues regarding patient and staff files.

The practical aspects of the handover had been very well prepared in the hospital. During the last month, the medical team let the East Timorese manage the hospital and patients, providing support from a distance. The ICRC's smooth, timely handover of the hospital increased its credibility with the East Timorese authorities, the UN and NGOs.

Sustainability

Perceptions have changed. Vocabulary such as "counterparts", "training", "capacity-building" are terms now used routinely and no longer cause raised eyebrows and protestations that the ICRC is not a development agency. Other agencies and authorities also expect the programmes started by the ICRC to be sustainable.

Sustainability is as much about motivation, management and health being firmly on the political agenda as it is about budget. In Dili, the ICRC was fortunate to be able to hand the hospital over to a competent authority. The East Timorese Department of Health Services was clearly ready to assume it responsibilities, supported by UNTAET and an adequate budget.

Furthermore, the fact that the East Timorese staff were ready to assume responsibility for the management and clinical care within Dili General Hospital, with the support of CORDAID is largely because the ICRC hospital team had worked effectively towards this goal from the beginning of the action.

Key factors in striving towards sustainability

Previous ICRC experiences in Kandahar and Karte Seh (Afghanistan), Keysaney and Berbera (Somalia), show that the systems of hospital and patient management initiated by the ICRC continue to function, in some cases for many years after handover. They illustrate that the ICRC can build local capacity and contribute to sustainability.

The main factor to consider during the handover phase is sustainability of the technical requirements of the hospital. A trained maintenance team that can function independently is thus essential. The priority was there-

fore, training and capacity building of a hospital maintenance team:

- Local staff was involved in decision-making from the start.
- The ICRC's intention, from the beginning, was to identify and work with local counterparts at every level.
- Training programmes were designed with independence and accountability in mind.
- The ICRC considered a good employer-employee relationship important.
- The ICRC's professional, systematic, concrete, appropriate, practical approach to hospital and patient management gained the respect of hospital staff and enhanced its credibility with its professional counterparts in the DHS and WHO.
- Good hospital management is key to ensuring proper medical care.
- The ICRC's practical approach made it very easy for other agencies to adopt or adapt the ICRC's system and procedures.
- Local hospital staff developed a sense of pride in their hospital. It is evident that Dili General Hospital performed better than other hospitals in East Timor. This contributed to the motivation of the local staff.

Experience during the handover phase showed that the local hospital staff was able to run the hospital and manage the patients effectively on a daily basis, indicating that the system put in place by ICRC is and will continue to be sustainable.

It became clear that the training of hospital staff had to be carried out at the same pace as political change was occurring within the country as a whole. The challenge was to balance this with the needs of the patients, maintaining clinical standards while gradually handing over responsibility.

The ICRC's hospital and patient management tools were handed over to the DHS for review and possible adoption by hospitals throughout East Timor. If this goes ahead, it will contribute to the sustainability of the system in Dili General Hospital as its staff is already accustomed to using these tools.

Among the expatriate medical team, those who had a direct local counterpart tended to find their mission much more satisfying that those whom did not.

Impact

The importance of maintaining a hospital referral service for the population of East Timor during a time of conflict and great political change cannot be underestimated. Apart from providing treatment for thousands of patients, the hospital also provided a stable point of reference in an unstable environment; people came to work, had salaries and structure in their lives in very uncertain and insecure times. This has given strength to the people who were part of this process of change.

For a time, during the emergency phase, the ICRC was the biggest single employer in East Timor, and remained so in the health sector until health staff was contracted to the DHS. All hospital managers were acutely aware that, in a new country, with new systems of administration being set up, the decisions made and management style adopted by ICRC would have an impact on the future development of the hospital and staff.

The ICRC salary system for hospital staff was adopted in the emergency phase by all health sectors NGOs. This set the salary scales for health staff in the whole country and proved to be realistic and sustainable, eventually becoming incorporated into the DHS system.

Once the emergency phase was over, the fact that the ICRC was managing the hospital took pressure off the DHS in the early stages of its development. The DHS could concentrate on policy and developing a health system for East Timor without worrying about the practical aspects of their largest referral hospital. On a technical level, the impact of the ICRC's presence and work in Dili General Hospital was significant as many of the ICRC's patient and hospital management tools were adopted by the DHS as standard practice in East Timor and are still being used.

These included:

- **Nursing guidelines** – which will form the basis of national nursing guidelines.
- **Hospital forms** – those used in Dili General Hospital were given to the Health Policy and Planning unit in the DHS as examples for a standard documentation system for all hospitals in East Timor.
- **Administration** – the ICRC's method of leave control, filing system, human resource management and appraisal policies were adopted.

All of the above contributed to the ICRC's credibility in the health sector. The UN counterpart of the DHS in East Timor is the World Health Organisation (WHO) and their validation of the ICRC's hospital management tools and clinical guidelines is recognition of the ICRC's professional approach.

The ICRC went into Dili hospital during an emergency situation. Areas of expertise unfamiliar to the ICRC were developed. Yet, the set objectives were met, and the ICRC's professional approach much appreciated.

Xanana Gusmao, elected president on 14 April 2002 being shown around the hospital in 2001 by Jenny Hayward-Karlsson, the hospital manager.

V Conclusion

A milestone in humanitarian affairs

The ICRC had been active in East Timor for nearly 25 years prior to September 1999, establishing contacts with the local and national authorities and accumulating knowledge of the actual and potential needs of the population.

Thus, the ICRC's ability to respond efficiently to the emergency, when it came in September 1999 represented a synergy of the various aspects of the ICRC's previous work, in East Timor and in Indonesia, at ICRC headquarters in Geneva and throughout the Red Cross and Red Crescent Movement in order to rapidly mobilize the appropriate resources to address the needs of the East Timorese people.

This synergy, which allowed the ICRC to create a space for humanitarian activities and be operational before many other agencies in East Timor, represents a milestone in humanitarian affairs, as expressed by Mr. Sergio Vieira de Mello, the UN Transitional Administrator at the handover ceremony of 29 June 2001:

"Dear Colleagues,

How was this possible? was the first thought that crossed my mind when I reflected on today's ceremony.

How was it in fact possible that, in less than a year, the Dili General Hospital has become the primary medical centre of East Timor providing specialized surgical, obstetric, paediatric and medical care for approximately 200 outpatients per week with 226 in-patient beds.

How was this possible? Well it was possible as we all know thanks to the commitment and the partnership of a very few, very brave ICRC staff and a very few, very brave East Timorese staff of this hospital.

In late September 1999, only days after the rampage had abated, 7 ICRC delegates began working in Dili General Hospital, looking after 35 patients that they found there with the assistance of 9 East Timorese staff.

Although the buildings were largely intact, most of the equipment and furnishings had been looted or badly damaged.

21 months later one can see the truly remarkable progress made since these humble beginnings. The East Timorese now have a hospital that they can be proud of.

This achievement is due to the extraordinarily dedicated work of the ICRC, with extraordinarily dedicated East Timorese staff. Over the last 21 months, the ICRC has entirely, totally supported this hospital at an approximate cost of US$ 4 million - a huge saving for the consolidated budget of East Timor, and, up until today it has covered all the expenses associated with the equipping, staffing and running of the hospital.

And I would like to express my deepest gratitude to that organization for the outstanding job they have performed here.

As Lise[1] and some of you here are aware, I have had the privilege of working with the ICRC throughout my career and have developed, from the very early stages an admiration for that institution and their staff, their integrity and their courage, all qualities that they have displayed in East Timor.

Our gratitude to you Lise, your colleagues and your predecessors, not only for the job that you have performed here since September 1999, but for the admirable work that ICRC has performed in and for East Timor and the East Timorese people since 1975. Some of it is known, but some of it, perhaps the most important work that ICRC has done for the East Timorese is less known. That is the way that ICRC operates, and in fact that confidentiality has enabled it do much more than other organizations, including the United Nations Organization was able to do, and this, the East Timorese are aware of and hugely grateful for."

[1] Ms Lise Boudreault, the ICRC Head of Delegation in East Timor at the time.

Annexes

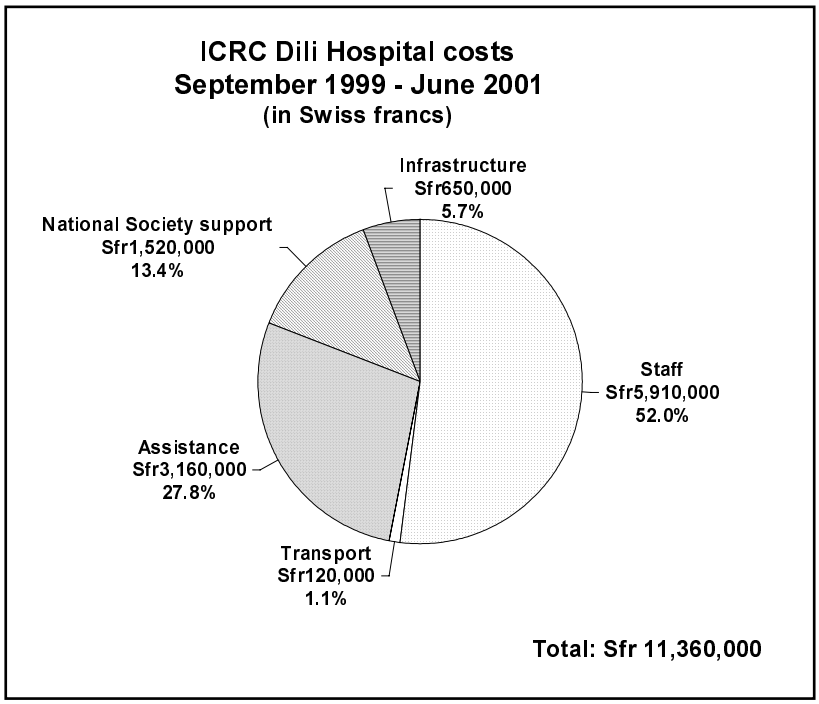
Annexe I - Finance, Expenditure, Contributions

Annexe II - Dili Water Supply System

Annexe I

Finance
The Dili hospital was part of and included in the overall ICRC operations carried out in East Timor. The overall ICRC operation has been reported on in the ICRC 's standard reporting documents such as the institution's Quarterly Donor Report and Annual Reports for 1999 under the Jakarta regional delegation, and for 2000 and 2001 under the East Timor delegation.

Expenditure
The chart below details the overall expenditure by the ICRC for the Dili hospital over the period September 1999 to June 2001 by type of expenditure.



Contributions
The ICRC wishes to thank the following donors who specifically contributed to its East Timor operation over the period considered by this special report either with cash and/or with in-kind contributions:

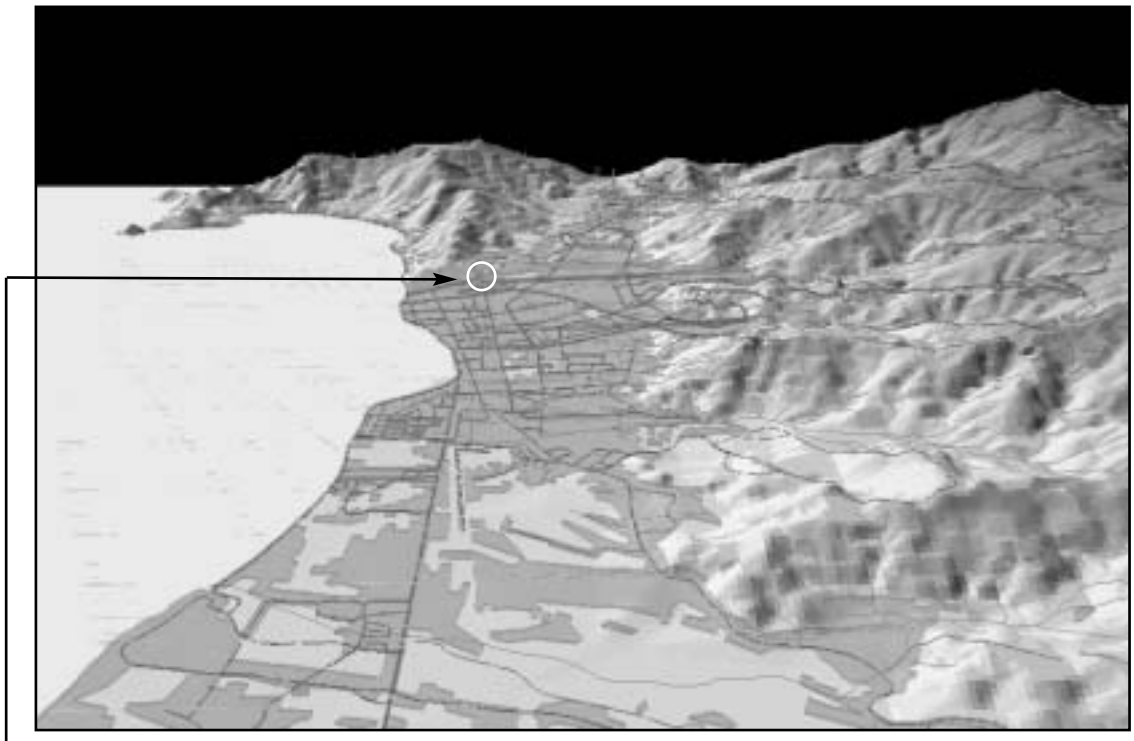
Government donors
- Australia
- Canada
- Denmark
- Finland
- Germany
- Italy
- Japan
- The Netherlands
- Norway
- Sweden
- Switzerland
- United States

National Red Cross Society donors
- Australia
- Austria
- Denmark
- Ireland
- Japan
- New Zealand
- Norway
- Sweden

The following National Red Cross Societies seconded staff to the hospital
- Australia
- Austria
- Canada
- Denmark
- Finland
- Germany
- Ireland
- Iceland
- Italy
- Japan
- New Zealand
- Norway
- Sweden
- United Kingdom
- United States

Annexe II

Dili Water Supply System



Dr. P.G. Nembrini, Geneva Foundation

Dili Hospital and ICRC Delegation

ICRC

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