A REVIEW OF HEALTH LEADERSHIP AND MANAGEMENT CAPACITY IN TIMOR-LESTE

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ACRONYMS

ADB       Asian Development Bank
AusAID    Australian Agency for International Development
DHMT      district health management team
GDP       gross domestic product
GSB       Ministry of Finance General State Budget
HRH       human resources for health
HR        human resources
ICS       Instituto de Ciencia Saude (Institute of Health Sciences)
IFC       International Finance Corporation
Lao PDR   Lao People's Democratic Republic
MAKER     Managers taking Action based on Knowledge and Effective use of Resources
MDG       Millennium Development Goals
MoH       Ministry of Health
PPP       purchasing power parity
PSM       procurement and supply management
SAMES     Serviço Autonomo de Medicamentos e Equipamentos de Saude (National Drug Procurement Agency)
SPK       Sekolah Perawat Kesehatan (equivalent to Nursing Certificate or high school level)
SISCa     Serviço Integrado de Saúde Comunitária (Integrated Community Health Service)
THExp     total health expenditure
UN        United Nations
UNDP      United Nations Development Programme
UNSW      University of New South Wales
US$       United States dollars
WHO       World Health Organization

A note about the use of acronyms in this publication
Acronyms are used in both the singular and the plural, e.g. MDG (singular) and MDGs (plural). Acronyms are also used throughout the references and citations to shorten some organisations with long names.
This review describes the current situation of health leadership and management capacity in Timor-Leste. Timorese health authorities have identified management and leadership capacity development as an important area needing attention.

The country has made significant progress in re-building its health system since becoming a sovereign nation in 2002. The necessary structures for the Ministry of Health (MoH) have been established and health sector strategic planning strengthened in collaboration with donors.

Despite this progress, Timor-Leste remains one of the poorest countries in the Asia-Pacific region. About half of the country’s 1.1 million population lives below the basic needs poverty line and nearly 40% has no sustainable access to an improved water source.

Access to health services, including maternal and child services, remains limited especially in the rural areas, leading to high maternal and child mortality. Unless progress in service delivery is accelerated, Timor-Leste will miss some key Millennium Development Goal (MDG) targets by 2015. Strong and effective management and leadership capacity and performance are necessary for accelerating service delivery.

There were approximately 50 senior managers and about 130 middle managers in the Timor-Leste health system as of November 2007, and a similar number today. Health service delivery at the district level is managed and led by middle managers usually in teams of six members. The head of the team (the designated manager) is the District Director of Health Services. Each of the 13 districts has a district health management team.

Managerial competence at the district level appears low. None of the district managers at the time of this review had a formal qualification in management or in a management-related discipline; almost all of them have the Timorese nursing school certificate or diploma (SPK¹). Efforts have been made to provide in-service training in Community Health Centre Management and Leadership by the Timorese Institute of Health Services and donor agencies, but the impact of such training on management performance remains largely unknown as no evaluative studies have yet been conducted.

The working environment of district managers in Timor-Leste is challenging. Specific roles and functions of managers and teams are not properly defined and no clear career pathways for district health managers and their deputies exist.

Novice district managers receive little supportive supervision from their more experienced management colleagues at higher levels. Most district health managers perform dual roles as both nurses and managers, conducting a clinical role while also performing management and administrative functions.

Key management support systems, particularly the procurement and supply system, do not function adequately in support of managers. Supply of essential drugs and materials is often erratic, compromising the effectiveness of managers.

The performance of the national drug procurement agency – SAMES² – has been a concern to the MoH, which is making efforts to strengthen supervision and monitoring in order to ensure efficient procurement and supply and to ensure essential pharmaceuticals are available in the districts.

In conclusion, factors affecting the capacity and performance of district health managers in Timor-Leste are both individual and system related. In seeking to strengthen the leadership and management capacity of district managers, Timor-Leste must focus on building the competence of individual managers, while also looking more broadly at the systemic issues that affect their performance and effectiveness.

¹ Sekolah Perawat Kesehatan (equivalent to Nursing Certificate or high school level)
² Servicio Autonomo de Medicamentos e Equipamentos de Saude (National Drug Procurement Agency)
SNAPSHOT: TIMOR-LESTE
BASIC DEMOGRAPHIC AND SOCIO-ECONOMIC DATA

Population in 2007
1.1 million

GDP per capita (PPP US$) in 2007
$717

Life expectancy at birth in 2009
62 years

Under age 5 mortality in 2007
97 per 1,000 live births

Nursing and midwifery density from 2000 to 2007
22 per 10,000 people

Maternal mortality in 2008
370 per 100,000 live births

Doctor density from 2000 to 2007
4 per 10,000 people

Key to acronyms
GDP: gross domestic product
PPP: purchasing power parity
US$: United States dollars

(Adapted from UNDP 2009, UNICEF 2010, WHO 2009b)
INTRODUCTION

Timor-Leste has made considerable progress since becoming an independent nation in 2002. In 2005 it was ranked 150 out of 177 countries on the United Nations Development Programme Human Development Index. In 2010 it improved its ranking to 120 out of 169 countries, reflecting a continuing progress in human development (UNDP 2008; UNDP 2009; UNDP 2010).

The thrust of government policy has been to integrate the health sector with other sectors and targeting groups to achieve the greatest health impacts. There has also been a focus on developing human resources for health policies that are appropriate to the needs of the country; promoting access to basic health care by vulnerable groups; and mainstreaming gender health concerns in all programs (Government of Timor-Leste 2002).

In the past five years, Timor-Leste has developed a basic services package for primary health care and hospital services package for clinical care and is currently in the process of rolling out these packages and consolidating the country’s Health Sector Strategic Plan (Government of Timor-Leste 2007).

Despite these achievements, Timor-Leste remains one of the poorest countries in the Asia-Pacific region. In 2007, half of the country’s 1.1 million population lived below the basic needs poverty line of US$0.88 per person per day and 40% had no sustainable access to an improved water source (Government of Timor-Leste 2009).

Children continue to die from common diseases such as respiratory infections, malaria and diarrhoeal illnesses. The health system faces numerous challenges, including weak capacity to coordinate and monitor donor programs, weak management and leadership capacity at the sub-national level, inadequate funding, unequal delivery of services between urban and rural areas and poor procurement, distribution and management of essential drugs and supplies.

The private sector remains largely underdeveloped, although there are signs of growth, with key providers such as Clinic Cafe Timor expanding services to its members. Human resources for health (HRH) concerns, including undersupply and oversupply in certain types of personnel and inadequate human resource (HR) management and planning capacity within the MoH have been identified (Snell, Martins et al. 2005).

PURPOSE AND APPROACH

The health system faces numerous challenges, including weak capacity to coordinate and monitor donor programs, weak management and leadership capacity.

The purpose of this review is to describe the current situation of health management and leadership capacity and analyse issues that affect the performance of district health managers.

It is intended to inform the development of policy recommendations for improving management and leadership performance in six AusAID priority countries – Cambodia, Fiji, Lao PDR, Papua New Guinea, Solomon Islands and Timor-Leste.

The review was conducted through desk review of published and grey literature and discussions with key individuals. The first six sections provide a brief description of key aspects of the health system of Timor-Leste and the final four attempt to assess management and leadership capacity using a modified version of the WHO MAKER framework.

Key components of the framework used include numbers and distribution of managers, managerial competence, the management working environment, management support systems and the socio-cultural context in which managers operate.

A summary of key points about management and leadership in Timor-Leste is provided at the end of this report. Detailed analysis and discussion of the issues identified will be available in a separate paper that brings together all the issues identified from the six countries. This synthesis will be available in 2011 from www.hrhhub.unsw.edu.au

3 Clinic Cafe Timor is a not-for-profit cooperative organisation that provides health care to its members who are mainly coffee growers.

4 Managers taking Action based on Knowledge and Effective use of Resources.
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With about three-quarters of the population living in rural areas, access to health care constitutes a major challenge to the Timorese population and government. Although considerable improvements have been made since independence, a great number of the rural population have difficulties accessing basic health services. In general, access to health services in Timor-Leste is through a network of primary and secondary health care facilities. However, health facilities are reportedly too far from many communities, with an average walking time of 70 minutes to reach a health centre (Asian Development Bank 2005).

Access to maternal health services appears to be particularly limited. The country's maternal mortality ratio is among the worst in the Asia-Pacific region. In 2005, the maternal mortality rate stood at about 370 per 100,000 live births (UNICEF 2008)5.

Data from the 2010 Demographic and Health Survey of Timor-Leste indicated that while 86% of mothers received antenatal care from a health professional (i.e. a doctor, nurse, midwife or assistant nurse), only 30% of births were attended by a skilled health professional, and just 22% took place in a health facility (Government of Timor-Leste 2010). Nonetheless, this is still an improvement over the figures reported in the 2003 Demographic and Health Survey; in which only 10% of births took place in a health facility and almost 18% of babies were delivered by a skilled health professional (Government of Timor-Leste 2003b).

Education plays a key role, with 88% of births to women with more than secondary education being attended by a health professional compared to only 14% of births to women with no education (Government of Timor-Leste 2010).

Access to secondary health services is also a major challenge. Only 5 of the 13 districts have a referral hospital. Efforts are being made to create better linkages between primary and secondary care, to provide more specialised services, and to establish a referral network encompassing selected Indonesian and Australian hospitals.

An important initiative implemented by the government in a bid to improve access is SISCa6, an integrated community health services program that seeks to take the country’s basic services package to the village (sanco) level. The government is hopeful that the SISCa initiative will further improve access to health services (Government of Timor-Leste 2007).

The cost of providing health care in Timor-Leste is carried by the government, a range of donor agencies and the private sector. In 2009 the government financed about 60% of the health expenditure and donors financed about 40% (Timor-Leste Ministry of Finance 2009).

There is no information about the cost of health care to households and the private sector. As a proportion of gross domestic product (GDP), total health expenditure in Timor-Leste has been steadily rising since it became a sovereign nation. Figure 1 provides the GDP per capita in US dollars (purchasing power parity) and the total health expenditure as a proportion of GDP from 2000 to 2005.

Donor funding supports both capital and recurrent health expenditures, except for salaries. The majority of donors in Timor-Leste channel their funds directly into supporting projects, despite efforts by the World Bank and other major donors, to encourage contribution into a multi-donor trust fund. Projects operating outside the multi-donor trust fund mechanism reduce MoH control over a significant proportion of funds that flow into the health sector. However, most of the donors operating outside the multi-donor trust fund are supporting projects and activities that contribute to achieving the objectives of the Timorese Health Sector Strategic Plan.

Overall, donor funding to the Timor-Leste health sector appears to be on the decline. Based on current donor commitments, the government will finance nearly 92% of health care expenditure by 2012, with donors financing only about 8% (Figure 2).

Timor Leste is depending on significant economic growth in the next few years. However, given its large petroleum and natural gas reserves, there is some optimism that it will be able to wean itself off donor funding once commercial exploitation of these resources takes off.

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5 Past data have suggested a much higher maternal mortality rate – UNICEF estimated around 800 per 100,000 live births in 2003 (UNICEF 2003).

6 Serviço Integrado de Saúde Comunitária (Integrated Community Health Service).
FIGURE 1. GDP PER CAPITA AND TOTAL HEALTH SPENDING AS A PROPORTION OF GDP, 2000 – 2005
(Adapted from International Monetary Fund 2007; World Economic Outlook 2007)

Key to acronyms in Figures 1 and 2
GDP: gross domestic product
GSB: Ministry of Finance General State Budget
PPP: purchasing power parity
THExp: total health expenditure
US$: United States dollars

FIGURE 2. ACTUAL AND PLANNED HEALTH SECTOR EXPENDITURE: 2006/07 – 2012
(Adapted from Dewdney et al. 2009)
**HUMAN RESOURCES FOR HEALTH**

International and local non-government organisations also employ a considerable number of health and support personnel in areas such as nutrition, environmental health, health promotion, training and related health services.

HRH development remains a challenge to the Timor-Leste government. The country's health workforce was decimated by the withdrawal of Indonesian health personnel following the 1999 referendum and subsequent declaration of independence in 2002. However, the arrival of about 230 Cuban doctors from 2004 completely changed the health workforce landscape.

Overall, it is estimated that about 4,000 health workers are working in Timor-Leste, although the fragmented and incomplete health workforce information system does not provide a comprehensive up-to-date picture of the size and structure of the health workforce (Dewdney et al. 2009).

The health workforce includes clinicians, clinical support workers, managerial and technical staff, training personnel and a range of ancillary support workers. Between 3,000 and 3,500 are believed to be civil servants located within MoH institutions and units.

The Cuban Medical Brigade constitutes a major component of the clinical workforce, providing two of every three doctors in Timor-Leste. International and local non-government organisations also employ a considerable number of health and support personnel, the majority of them involved in health system support work in areas such as nutrition, environmental health, health promotion, training and related health services.

The number of health workers employed in the private sector from traditional practitioners to non-profit private organisations like Clinic Cafe Timor, and in the for-profit private sector, remains largely undocumented and analysed.

A significant number of medical students from Timor-Leste are currently in training. About 700 students are studying medicine in Cuba under the Cuban medical cooperation with the Government of Timor-Leste. Additionally, around 180 students are studying medicine locally under a program conducted by the Cuban Medical Brigade in cooperation with the National University of Timor-Leste and Ministry of Health (Dewdney et al. 2009).

One of the main HRH challenges facing Timor-Leste is how to integrate the newly trained doctors into the health system. The sudden increase in the number of doctors and in the equipment and resources they will use will require a significant enhancement of the MoH's recurrent budget. So far, only 18 of the 700 trainees in Cuba have returned home (in 2010), but a large number of students is expected to return within the next three years.

Another HRH challenge confronting Timor-Leste relates to the development of a critical mass of specialist clinicians. Since 2002, apart from seven specialists who undertook training on MoH scholarships or at their own cost, the MoH has not yet invested in training of much-needed specialist clinicians and other professionals. As of 2008, only one qualified pharmacist was working in the public health sector (Government of Timor-Leste 2008a).

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7 Four of the seven specialists studied under full Ministry of Health scholarship and three were partly subsidised for their living allowance by the Ministry.
Health management, including the management of human resources for health, is primarily the responsibility of the MoH, although the Public Service Commission conducts matters of personnel administration. The various non-government employers of health personnel have their own personnel administration arrangements.

The MoH is headed by a public servant, a Director General (see Appendix 1 for organisational structure of the MoH). The government health service operates at three levels – national/central, district and sub-district/community (Government of Timor-Leste 2005).

Currently, the MoH central office designs, directs, manages and coordinates all government sector health care and pharmaceutical policy and supply throughout the country. However, plans to implement a policy of decentralisation will see most of these functions transferred to the municipal and district levels, although central controls will remain. As in many nations, the degree of decentralisation of many functions will take time to finalise; so managers can anticipate some role uncertainties to arise.

Figure 3 provides the organisation and management structure of district health service in Timor-Leste.

HRH management within the MoH is the responsibility of the National Directorate of Human Resource at the MoH. The directorate was established by law and enshrined in Chapter V of Diploma Ministerial No 01/2008 of 27 February 2008, the Organic Law relating to Central Services of the Ministry of Health8.

Key responsibilities of the directorate include:

- drafting the development plan for health human resources and guiding its implementation
- drafting technical rules and coordinating, monitoring and evaluating the training of health human resources
- ensuring the management of staff in central services and coordinating technical support to the various services of the Ministry of Health
- managing the registration of health professionals working in the national health system.

There are plans to implement a policy of decentralisation from 2010 which will see most of these functions transferred to the municipal and district levels.

The National Directorate of Human Resources has three main arms: Department of Human Resource Planning, Department of Personnel Management and Department of Health Professional Registration and Development.

The key responsibilities are as follows (also see Figure 4):

- Department of Human Resource Planning: plans for the health workforce needs of the health ministry, including planning for health personnel training and distribution
- Department of Personnel Management: handles all activities relating to personnel management within the MoH
- Department of Health Professional Registration and Development: is in charge of registration of health professionals and conducts some minor professional development roles.

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8 This legislation is written in Portuguese. The Ministry of Health has an English translation but the precise interpretation of legislation and then the translation of that interpretation into another language may be fraught with difficulties (Government of Timor-Leste, 2008b).
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FIGURE 3. ORGANISATIONAL AND MANAGEMENT STRUCTURE OF THE DISTRICT HEALTH SYSTEM IN TIMOR-LESTE

(Adapted from Government of Timor-Leste 2002)
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The revised National Health Workforce Plan 2007–2015 estimates that as of November 2007, there were approximately 50 senior managers or directors (graded at civil service Level 6 or above) and about 130 middle-management personnel at Level 5 grading (de Araujo et al. 2007).

At the district level, the health system is managed by district health management teams (DHMTs) which are regarded in Timor-Leste as the core unit for ensuring the provision of integrated and effective primary health care to the population (de Araujo et al. 2007). The country’s 2003 Health Organic Law9 envisaged a DHMT of four persons – a manager, a deputy manager and two public health officers. However, the current composition of the DHMT includes six core persons: a manager, a deputy manager and four public health officers in charge of communicable disease control, maternal and child health, health management information systems and planning, and environmental health (Table 1). The six-member management team is supported in each district by a varying number of management and administrative support staff, including an administrative officer, a financial assistant, security personnel and a cleaner.

Proposals to expand the DHMT suggest the inclusion of a medical officer and two public health officers in charge of non-communicable disease control and nutrition respectively. This will fulfil the minimum staffing establishment for the implementation of the country’s new basic services package (de Araujo et al. 2007).

Based on the evidence above, Timor-Leste appears to have an adequate number of health managers and management support workers at the district level. The key task is to increase their managerial competence in a range of areas and to define the managerial roles and responsibilities at each level of a decentralising system.

9 Government Decree Law No. 5/2003 Organic Structure of the Ministry of Health (repealed); Government of Timor-Leste (2003a)
### TABLE 1. DISTRIBUTION OF HEALTH PERSONNEL AND FACILITIES BY DISTRICTS AND COMPOSITION OF DISTRICT HEALTH MANAGEMENT TEAMS IN TIMOR-LESTE, 2007

(Adapted from Government of Timor-Leste 2007; Asante 2009, personal communication)

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>POPULATION</th>
<th>HEALTH FACILITIES*</th>
<th>HEALTH PERSONNEL^</th>
<th>HEALTH WORKER PER POPULATION (RATIO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aileu</td>
<td>43,160</td>
<td>14</td>
<td>47</td>
<td>1:918</td>
</tr>
<tr>
<td>Ainaro</td>
<td>58,620</td>
<td>15</td>
<td>53</td>
<td>1:1,106</td>
</tr>
<tr>
<td>Baucau</td>
<td>110,400</td>
<td>29</td>
<td>111</td>
<td>1:995</td>
</tr>
<tr>
<td>Bobonaro</td>
<td>90,960</td>
<td>26</td>
<td>64</td>
<td>1:1,421</td>
</tr>
<tr>
<td>Covalima</td>
<td>58,900</td>
<td>18</td>
<td>45</td>
<td>1:1,309</td>
</tr>
<tr>
<td>Dili</td>
<td>188,600</td>
<td>14</td>
<td>105</td>
<td>1:1,796</td>
</tr>
<tr>
<td>Ermera</td>
<td>113,870</td>
<td>24</td>
<td>66</td>
<td>1:1,725</td>
</tr>
<tr>
<td>Lautem</td>
<td>62,550</td>
<td>24</td>
<td>72</td>
<td>1:869</td>
</tr>
<tr>
<td>Liquica</td>
<td>62,990</td>
<td>19</td>
<td>53</td>
<td>1:1,188</td>
</tr>
<tr>
<td>Manufahi</td>
<td>50,340</td>
<td>18</td>
<td>62</td>
<td>1:812</td>
</tr>
<tr>
<td>Manatuto</td>
<td>40,160</td>
<td>24</td>
<td>63</td>
<td>1:637</td>
</tr>
<tr>
<td>Oecusse</td>
<td>63,730</td>
<td>12</td>
<td>34</td>
<td>1:1,874</td>
</tr>
<tr>
<td>Viqueque</td>
<td>71,440</td>
<td>22</td>
<td>88</td>
<td>1:812</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,015,190</strong></td>
<td><strong>259</strong></td>
<td><strong>863</strong></td>
<td><strong>1:1,176</strong></td>
</tr>
</tbody>
</table>

### COMPOSITION OF DISTRICT HEALTH MANAGEMENT TEAMS

<table>
<thead>
<tr>
<th>STAFFING ESTABLISHMENT, APRIL 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>District manager Level 6*</td>
</tr>
<tr>
<td>Deputy manager Level 5*</td>
</tr>
<tr>
<td>District Public Health Officer (Communicable Disease Control) Level 4#</td>
</tr>
<tr>
<td>District Public Health Officer (Maternal and Child Health) Level 4#</td>
</tr>
<tr>
<td>District Public Health Officer (Health Management Information Systems/Planning) Level 4#</td>
</tr>
<tr>
<td>District Public Health Officer (Environmental Health) Level 4*</td>
</tr>
</tbody>
</table>

**Key to symbols in Table 1**

* Comprised of only Community Health Centres and Health Post
^ Includes doctors, nurses and midwives
+ Minimum qualification: Health Care Management and Leadership Certificate or Diploma
# Minimum qualification: Diploma III in area of responsibility
COMPETENCE OF LOCAL MANAGERS

Many managers have had limited exposure to in-service management training or continuing education in front-line management protocols and procedures such as financial management and accounting, strategic and operational planning and personnel management and supervision.

Due to the many training needs identified and activities supported by UN agencies and donors, in early 2009 the MoH developed a training coordination guideline which highlights the roles of the MoH Directorate of Human Resources and the ICS in managing and coordinating all health worker training activities. This guideline is being distributed to relevant stakeholders for implementation (Dewdney et al. 2009).

One of the proposals put forward in the revised National Health Workforce Plan 2007–2015 (Government of Timor-Leste, 2007) is that district health managers and their deputies should have both a clinical background and suitable management credentials (de Araujo et al. 2007).

As of the time of this review, almost all DHMTs are headed by middle-level managers and deputy managers graded mostly at Level 5 or below on the civil service scale. Very few are at Level 6. None have formal qualifications in management or in a management-related discipline; almost all have the SPK, the Timorese nursing school certificate or diploma. A great majority were appointed to their present management positions based on their clinical background and experience in nursing (de Araujo et al. 2007).

Some efforts have been made to provide members of DHMTs with basic training in health care management and leadership. A three-month in-service training by the ICS in Timor-Leste includes Community Health Centre Management and Leadership, which all the current district managers have undergone. In addition to the ICS training, WHO and other UN agencies, non-government organisations and bilateral donors provide in-service, short-course training that includes health management and leadership. For example, between 1999 and 2007, around 110 Timorese health personnel participated in management and leadership training facilitated by the WHO Country Office in Timor-Leste (WHO 2009).

Such opportunities are not frequent and, overall, most district health managers have had limited exposure to in-service management training or continuing education in front-line management protocols and procedures, particularly in critical areas such as financial management, strategic and operational planning, and personnel management and supervision (de Araujo et al. 2007).

 Instituto de Ciencia Saude (Institute of Health Sciences).
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As a new health system, the working environment for district managers in Timor-Leste offers many difficult challenges and some opportunities. Firstly, despite the importance attached to DHMTs in the organisation and delivery of health care in Timor-Leste, their specific functions are still not properly defined and there are no clear career pathways for district health managers and their deputies (Government of Timor-Leste 2007).

Secondly, novice district managers receive little supportive supervision from their more experienced management colleagues at higher levels who could act as mentors and advisors. More recently, the MoH has attempted to improve supervision and mentoring by appointing a team of four senior health service administrators as regional operational management advisers; one covering four districts and the rest covering three districts each (Dewdney et al. 2009). However, with no clear job description and statement of roles and responsibilities, these regional advisers have frequently been used for other activities that are not related to advising and supporting district managers in operational matters (Asante 2009, personal communication).

A major challenge to district managers in Timor-Leste is the dual roles that many of them have to perform. As most of the current group of district health managers and their deputies are nurses with years of experience in the health system; and, as a result of the shortage of qualified and experienced management personnel, many combine clinical roles with their management and administrative functions. In the absence of a cadre of health administrators Timor-Leste, like many developing countries, has combined clinical and managerial roles at the district management level.

Most public health officers in the DHMTs face the same struggle, with heavy dual workloads at the local level while also serving the information needs of vertical program coordinators at the central level (Asante 2009, personal communication).

But along with these challenges, district health managers in Timor-Leste have unique opportunities rarely seen in other health systems, so health worker motivation in the country is high. Although salary levels are low, there are few complaints from health workers. An informal consultation with a MoH official revealed that many Timorese see the current stage of their country’s development as a rebuilding stage to which they are contributing, and therefore do not expect much in terms of salaries.

Another motivating reason was that as the country has recently emerged from a period of instability, so many health workers count themselves lucky to have found a stable job which guarantees them a salary, no matter how small (Asante 2009, personal communication).

The Timorese health system is still under development, and several innovative approaches to scaling up services are being tested. The working environment is bound to become more challenging for district managers. In particular, the continuing roll-out of the basic and hospital services packages, the implementation of the SISCa initiative, and the replacement of Cuban health personnel with Timorese personnel trained in Cuba are likely to pose significant operational management challenges at the district level.

11 A doctor in Timor-Leste starts with a basic monthly salary of US$298 (Level C or 5 on civil service grade).
FUNCTIONING OF MANAGEMENT SUPPORT SYSTEMS

The fragile nature of the Timorese health system means that several of the support systems critically important for effective management of the district health services are not functioning optimally. The logistics management system, in particular, has been problematic for district managers and the MoH as a whole. Transport is a key example – the MoH has no effective system of managing its vehicles to ensure they are used optimally.

An informal discussion with a district manager revealed that at one point six of the district’s eight vehicles were not road worthy and three of their six radios have been out of order for months (Asante 2009, personal communication). These failures affect the operations of the DHMT and, in turn, constrain health care delivery in the district.

Procurement and supply presents another challenge to district managers, as persistent problems with the management of pharmaceutical supplies in Timor-Leste (de Araujo et al. 2007) have resulted in frequent complaints by health care staff and community members of the lack of essential drugs (IFC and ADB 2007).

The performance of the country’s national drug procurement agency – SAMES12 has been largely unsatisfactory, contributing to the frequent shortages of drugs in districts. The MoH recognises the problem and is making the effort to strengthen supervision and by monitoring the performance of SAMES to address issues of erratic supply.

The planning and budgeting system of the MoH has improved considerably since independence. The MoH is among the best-performing ministries in terms of financial management (IFC and ADB 2007). However, several bottlenecks remain, especially in the area of capacity constraints and centralisation of several procedures.

A key weakness in the existing planning and budgeting system is the separation of district planning and budgeting processes (districts prepare their action plans but the budget is determined at the central level). The MoH has no effective mechanism to link district health plans with the MoH budget, sometimes leaving several planned district activities with no budget to implement them.

More recently, the MoH has initiated a move away from centrally based budgeting to a decentralised budgeting system where districts (or municipalities) will be provided a resource allocation framework to negotiate needs-based funding (de Araujo et al. 2007).

A key weakness in the existing planning and budgeting system is the separation of district planning and budgeting processes (districts prepare their action plans but the budget is determined at the central level).

Another budgeting issue that affects the operations of the DHMTs is the minimal threshold of the petty cash account kept in the districts. Following the decentralisation of some financial management procedures by the Ministry of Planning and Finance, the MoH now manages procurement for contracts up to $100,000 and keeps petty cash accounts at the district level, which permits district managers to more easily procure essentials like fuel directly from suppliers (IFC and ADB 2007).

While the petty cash system has worked well for district managers, some believe the spending limit of $20,000 per month is too small and should be increased to give these managers enough room to manoeuvre (Asante 2009, personal communication). However, with the current limited financial management capacity of districts, the MoH will need to invest in strengthening financial management at the district level before any decision to raise the petty cash spending threshold is made.

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12 Serviço Autonomo de Medicamentos e Equipamentos de Saúde (national drug procurement agency).
SOCIO-CULTURAL CONTEXT

Timor-Leste is traditionally a patriarchal society with men dominating in almost all fields. In general, tradition and customary laws favour men over women; men own and inherit property and occupy the majority of leadership and decision-making roles (Henfry 2004). The health workforce in Timor-Leste is dominated by men.

In 2007, for example, men outnumbered women by nearly 2 to 1 (1,420 to 753) in the MoH health personnel establishment posts (de Araujo et al. 2007). The great majority of members of the DHMTs are men. This is in line with the dominant ideology and traditional social structure of Timor-Leste, although this can be anticipated to change through the multiple inputs of UN agencies.

Providing health services while being sensitive to tradition and culture poses management challenges, as tradition or recent history are sometimes found to be the constraining factors. The low rate of utilisation of health care by women poses special challenges in Timor-Leste. Compared to men, their use of health care is significantly lower (Zwi et al. 2009).

The higher proportion of male staff would no doubt be a factor in this, but historical factors are also to be overcome. Distrust by Timorese women of modern health care is allegedly due to a history of Timorese women who had sought family planning services being coerced into sterilisation in the pre-independence era. Many women have avoided the state-run health system (Henfry 2004).

For district managers attempting to improve health outcomes, including reducing the country’s high maternal and infant mortality rates, the lower social status of women and their ‘negative’ perceptions of the state-run health system are challenges to addressing high maternal and infant death rates.

Compared to men, the use of health care among women is significantly low. Part of the problem is the distrust by Timorese women of the modern health care system.

13 The heads (or managers) of the DHMTs are all male.
A review of health leadership and management capacity in Timor-Leste
Augustine Asante et al.

Access and utilisation of health care
- Timor-Leste has made significant progress in health sector development since independence in 2002, however, it remains one of the poorest countries in the Asia-Pacific region. Health services are provided through a network of primary and secondary health care facilities, reportedly accessible in an average walking time of 70 minutes. Only 5 of the 13 districts have a referral hospital. In 2010 only 30% of births were attended by a skilled health professional, and just 22% took place in a health facility.

Financing the health system
- As a proportion of gross domestic product, total health expenditure in Timor-Leste has been steadily rising since independence. Overall, donor funding to the Timor-Leste health sector appears to be declining. The MoH has no effective mechanism to link district health plans with the MoH budget, sometimes leaving planned district level activities with no budget to implement them. Plans to decentralise management functions will require an increase in financial management capacity at the district level.

Human resources for health
- It is estimated that about 4,000 health workers are working in Timor-Leste, the majority of whom are male. Between 3,000 and 3,500 are believed to be civil servants located within MoH institutions and units. Health workforce development has been a major priority of the government. The number of health workers employed in the private sector from, traditional practitioners to non-profit private organisations and the private sector remains largely undocumented and analysed.
- The Cuban Medical Brigade constitutes a major component of the clinical workforce, providing two of every three doctors in Timor-Leste. About 700 students from Timor-Leste are studying medicine in Cuba. Managing their return, funding and deployment will present a major management challenge.

Health management structure
- The MoH central office designs, directs, manages and coordinates all government health care and pharmaceutical policy and activities throughout the country. Plans to implement a policy of decentralisation will see some functions transferred to the municipal and district levels, although central controls will remain. As in many nations, the degree of decentralisation of functions will take time to finalise; so managers can anticipate some role uncertainties to arise.

Number and distribution of managers
- Each of the 13 districts in Timor-Leste, at the time of this review, had a district health management team headed by the District Director of Health Services, which is responsible for managing the district health service. There were about 50 senior managers/directors and 130 middle-management personnel reportedly working in the Timor-Leste health care system as at November 2007. Almost all the district-level managers had nursing backgrounds and clinical roles.

Competence of district health managers
- Management and leadership capacity remains low as the majority of district managers have no formal qualification in management or a related discipline. New district health managers receive little supportive supervision from their more experienced colleagues at higher levels. The MoH has made efforts to provide the district health management team with management and leadership training.
- WHO has facilitated management training of health personnel and multiple donors provide short courses in management, although in response to the need for coordination and minimisation of service disruption the MoH has introduced guidelines to coordinate training activities.

Management working environment
- Despite significant challenges, district health managers in Timor-Leste have unique opportunities rarely seen in other health systems, so health worker motivation in the country is high. Recently independent, many Timorese see the current stage of their country's development as a rebuilding stage to which they are contributing.

Functioning of management support systems
- District health managers face numerous challenges in coordinating and monitoring donor programs, weak management and leadership capacity at higher levels, inadequate funding, poor procurement, distribution and management of essential drugs and supplies and transport difficulties.
New district health managers receive little supportive supervision from their more experienced colleagues at higher levels. The MoH has made efforts to provide the district health management team with management and leadership training.

The socio-cultural context

- For district managers attempting to improve health outcomes, including reducing the country’s high maternal and infant mortality rates, the lower social status of women, their under-representation in the health workforce and their negative perceptions of the state-run health system present major challenges to reducing high maternal and infant mortality rates.

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APPENDIX

ORGANISATIONAL STRUCTURE OF THE MINISTRY OF HEALTH
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