CHALLENGES IN MOBILISING, RETAINING AND SUPPORTING HEALTH WORKERS DURING A PERIOD OF POLITICAL UPHEAVAL

A case study from Timor-Leste’s experience in 2006

João Soares Martins, Anthony B Zwi & Lisa M Thompson
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Anthony B Zwi.
School of Social Sciences, Faculty of Arts and Social Sciences, The University of New South Wales, Sydney, Australia.
Lisa M Thompson.
Human Resource for Health Knowledge Hub, School of Public Health and Community Medicine, The University of New South Wales, Sydney, Australia.

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Level 2, Samuels Building,
School of Public Health and Community Medicine,
Faculty of Medicine, The University of New South Wales,
Sydney, NSW, 2052,
Australia
Telephone: +61 2 9385 8464
Facsimile: +61 2 9385 1104
Web: www.hrhhub.unsw.edu.au
Email: hrhhub@unsw.edu.au
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ACRONYMS

BPC  Bairo Pite Clinic
CHC  Community Health Centres
CMB  Cuban Medical Brigade
DFID  Department for International Development
DHS  District Health Services
HBP  Health as a Bridge for Peace
HDI  Human Development Index
HRH  Human resources for health
HWG  Health Working Group
ICRC  International Committee of Red Cross
IDP  Internally displaced person
INTERFET  International Force for East Timor
IOM  International Organization for Migration
IPPNW  International Physician for the Prevention of Nuclear War Prevention
IRC  International Rescue Committee
MDG  Millennium Development Goal
MoH  Ministry of Health
MSF  Medicine Sans Frontières
MTRC  Ministry of Labour and Solidarity (nb. acronym relates to Portuguese equivalent)
NGO  Non-government organisation
PAHO  Pan American Health Organization
SAMES  Autonomous Medical Store (Serviço Autónomo de Medicamento e Equipamentos da Saúde)
SLS  Site Liaison Support
UN  United Nations
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
UNMIT  United Nations Integrated Mission in East Timor
UNTAET  United Nations Transitional Administration for East Timor
US  United States
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. NGO (singular) and NGOs (plural). Acronyms are also used throughout the references and citations to shorten some organisations with long names.
EXECUTIVE SUMMARY

Timor-Leste was marred by political instability in 2006 caused by internal political differences and instigated within the country’s military institution. The crisis caused displacement of approximately 15% of the country’s population. Approximately 5,590 homes were destroyed and up to 150 people were killed.

The main objectives of responding to a humanitarian crisis are to save lives and livelihoods, and to support those affected. An effective response during a crisis requires adequate human, financial and logistic resources. This case study focused on documenting and analysing factors that are relevant to mobilising and retaining health workers to deliver health services during a period of instability.

The case study was documented through real-time qualitative methods by interviewing key informants and reviewing documents which discussed the human resource issues during the time of instability. Key informants were purposively selected.

This case study documents several factors that helped health workers to continue working under difficult circumstances and which supported the Ministry of Health (MoH) in particular, and the health sector in general, to function during the period of instability. These factors were: leadership, coordination, timely availability of expatriate health workers in large numbers, innovation in utilising human resources and values that boost staff morale to work in difficult environments.

An effective intervention requires strong leadership and good coordination. Leadership is required to make timely decisions and to lead the emergency response.

Coordination is required to make sure that stakeholders involved in a crisis response act in an organised manner to avoid duplication of effort. During the conflict in Timor-Leste, the Ministry of Health and its development partners – United Nations (UN) agencies, non-government organisations (NGOs) and other stakeholders – established a health coordination structure to direct health interventions, which proved to be one of the factors that contributed to the success of the emergency response.

The availability of an external workforce can be extremely helpful particularly in ethnic conflict as they can be mobilised and act quickly at a time when local health workers are unable to perform their duties. During the conflict in Timor-Leste the presence of the Cuban Medical Brigade on the ground was timely, as they were quickly mobilised to provide medical assistance and for other health needs of the affected population.

The conflict in Timor-Leste also highlighted important values that boost the morale of health workers and enabled them to perform their duties despite risk to their personal safety. These values were professionalism, neutrality, impartiality and upholding professional oaths as health workers, to serve others who are in need of health care. Apart from providing health services and supporting the functioning of the health system during conflicts, health workers also played roles in preventing open conflict between the uniformed services (Army and Police).

The inhibiting factors that can prevent health workers from performing their duties during conflicts were: insecurity, fear, ethnic identity, ineffective leadership and coordination, and lacking a sense of professionalism.

Four recommendations emerge from this case study:

1. The MoH should formally include the teaching of ethics and professional values in pre-service training and conduct training and refresher training to enhance ethics and professional values among all health workers already in the system.

2. The MoH should formally establish a unit dedicated to responding to conflicts and disasters.
with the objective of facilitating rapid response; this unit should develop plans and strategies for dealing with prevention, preparedness, mitigation, response and recovery.

3. Health has been one important element for conflict prevention and peace-building which has been recognised such as the World Health Organization’s (WHO) initiative on “Health as a Bridge for Peace”. However, in Timor-Leste, health workers role in peace-building has not been widely recognised although, during the crisis health workers clearly demonstrated this role.

4. Government should provide a reward to honour outstanding health workers who have demonstrated leadership, dedication, and self-sacrifice to care for others in unthinkable dangerous settings. Rewarding these health workers would set an example for future health workers to follow.
INTRODUCTION

Timor-Leste was hit by political instability in 2006 just four years after Independence. Before describing this, we present some brief commentary on the broader context within which this struggle took place.

Timor-Leste occupies half of the Timor Island and is located in the eastern-most part of the Indonesian archipelago and northwest of Darwin, Australia. It was a former colony of Portugal, from the 16th century until 1975. The Carnation Revolution on 25 April 1974 overthrew the dictatorial government and forced the Portuguese government to decolonise its colonies in Africa and Timor-Leste.

As a realisation of the decolonisation policy in Timor-Leste, five political parties were formed; namely, União Democrática Timorense (UDT), Associação Social Democrata Timorense (ASDT) later on changed to Frente Revolucionária Timor Leste Independente (Fretelin), Associação Popular Democrática de Timor (APODETI), Klibur Oan Timor Assuwain (KOTA) and Trabalhista. Civil war between UDT and Fretelin broke out from August to September 1975 and left Fretelin in control of the territory. Fretelin leadership unilaterally declared Independence of the Democratic Republic of Timor-Leste on 28 November 1975.

Fearing the left-wing Fretelin party introducing communism in the territory, and with the support of the United States (US) and other western governments, Indonesia invaded East Timor on 7 December 1975 and subsequently occupied it until 1999. The fighting against Indonesia continued throughout the occupation period.

Under the auspices of the United Nations (UN), a referendum was held in August 1999 in Timor-Leste and resulted in an overwhelming outcome in favour of Independence. After the outcome of the referendum was announced, the pro-Indonesia militia backed by Indonesian military systematically unleashed violence, destruction of infrastructure and forced displacement of population to West Timor (Indonesia).

As a result, the United Nations authorised an Australian-led International Force for East Timor to restore the law and order. The referendum result gave a way for the UN to administer and manage the transition process in the territory toward independence, which was achieved on 20 May 2002.

Two transitional governments were formed by the UN and an election for the Constituent Assembly was held in 2001 in which the Fretelin party won 57% of votes. On 20 May 2002, Independence was officially declared and the Fretelin party formed the first Constitutional Government of Timor-Leste.

In 2006 political instability rocked the country and caused population displacement, violence and destruction. In 2007, in the second general election, Fretelin won the election but fell far short of being able to form government on its own. A coalition of four parties led by the former President formed government in 2007 and remained in government.

It was estimated that the population in 2007 was about 1.1 million, about one-fifth of whom resided in the capital Dili. The majority of the population profess Catholic faith and there are also Christian Protestants, Moslems, Buddhists, Hindus and Animists in smaller numbers.

The country is blessed with natural resources such as oil and gas, gold, nickel, aluminium and granite, but most of these natural resources have not been fully explored to date. Among non-oil exports, coffee is the major commodity exported along with copra and macadamia nuts.
BACKGROUND AND CONTEXT

Progress and challenges faced by Timor-Leste

The newly formed Fretilin-led government of Timor-Leste faced a daunting task of rebuilding the country after the unimaginable massive destruction inflicted on the country during the post-referendum violence in 1999. The country embarked on a development-oriented trajectory from transition administration under the United Nations to the present date. Slow but steady progress has been made as reflected in some of the development indicators (Table 1 below).

TABLE 1: KEY SOCIAL, ECONOMIC AND HEALTH INDICATORS BY 2004 (figures for 2004 unless otherwise stated)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Current state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>924, 624 (2004 Census)</td>
</tr>
<tr>
<td>Annual growth rate</td>
<td>3.2</td>
</tr>
<tr>
<td>Median Age (in years)</td>
<td>15.4</td>
</tr>
<tr>
<td>Poverty level (USD 0.55/day)</td>
<td>40% (2001)</td>
</tr>
<tr>
<td>HDI</td>
<td></td>
</tr>
<tr>
<td>Human Development Index</td>
<td>0.426</td>
</tr>
<tr>
<td>Human Development Index Rank</td>
<td>142</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Adult literacy rate</td>
<td>50.1 %</td>
</tr>
<tr>
<td>Health</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>55.5</td>
</tr>
<tr>
<td>Infant mortality rate per 1000 live births</td>
<td>83</td>
</tr>
<tr>
<td>Under five mortality rate per 1000 live births</td>
<td>105</td>
</tr>
<tr>
<td>Maternal Mortality rate per 100,000 live births</td>
<td>660</td>
</tr>
<tr>
<td>Total Fertility rate</td>
<td>7.0</td>
</tr>
<tr>
<td>Prevalence of underweight</td>
<td>45 % (2002)</td>
</tr>
<tr>
<td>Economy</td>
<td></td>
</tr>
<tr>
<td>Non-oil GDP total (million USD)</td>
<td>USD 366 (2006) estimated</td>
</tr>
<tr>
<td>GDP per capita</td>
<td>USD 732</td>
</tr>
<tr>
<td>Labour force participation rate</td>
<td>60%</td>
</tr>
<tr>
<td>Unemployment rate children</td>
<td>8.9%</td>
</tr>
<tr>
<td>Youth unemployment</td>
<td>23.1%</td>
</tr>
<tr>
<td>Main industries</td>
<td>Coffee, oil and natural gas</td>
</tr>
<tr>
<td>Export</td>
<td>Coffee, oil and natural gas</td>
</tr>
<tr>
<td>Major trading partners</td>
<td>Australia, Indonesia, Europe, Japan, United States</td>
</tr>
</tbody>
</table>

Post-independence political instability occurred in 2006 with ongoing intermittent violence up to 2008 posing a significant constraint to the overall development process. The underlying causes of the political crisis were believed to have been multiple and complex socio-political factors that had not been adequately addressed during the early years of Independence [Brady et al. 2006; International Crisis Group 2006; Zwi, AB et al. 2007].

The political instability was triggered by a dismissal of nearly 40% of the army’s soldiers, preceded by poor handling of dissatisfaction in rank promotions within military ranks. The instability spread quickly into the police force and caused an increase in violence and destruction which evolved into an uncontrollable security situation. International forces were brought in to stop the violence and to maintain law and order [International Crisis Group 2006; Zwi, AB et al. 2007].

**TABLE 2. KEY DATES FOR TIMOR-LESTE AND TIMELINES FOR THE POST-INDEPENDENCE VIOLENCE**

<table>
<thead>
<tr>
<th>Events</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timor a Portuguese colony for 460 years</td>
<td>1515-1975</td>
</tr>
<tr>
<td>Brief civil war</td>
<td>August-September 1975</td>
</tr>
<tr>
<td>Unilateral declaration of Independence by Fretelin Party</td>
<td>28 November 1975</td>
</tr>
<tr>
<td>Singing an integration petition by four political parties namely UDT, APODETI, KOTA and TRABALHISTA</td>
<td>30 November 1975</td>
</tr>
<tr>
<td>Invasion by Indonesia</td>
<td>7 December 1975</td>
</tr>
<tr>
<td>East Timor was officially annexed and became Indonesia’s 27th province</td>
<td>17 July 1976</td>
</tr>
<tr>
<td>UN-organised Referendum resulted in 78.5% voters in favour of Independence. Post referendum violence</td>
<td>30 August 1999</td>
</tr>
<tr>
<td>The landing of INTERFET in East Timor</td>
<td>20 September 1999</td>
</tr>
<tr>
<td>Establishment of United Nations Transitional Administration for East Timor (UNTAET)</td>
<td>25 October 1999</td>
</tr>
<tr>
<td>Xanana Gusmao, charismatic resistance leader, elected as the 1st President of the country</td>
<td>14 April 2002</td>
</tr>
<tr>
<td>Declaration of the internationally recognised Independence of Democratic Republic of Timor-Leste</td>
<td>20 May 2002</td>
</tr>
<tr>
<td><strong>Post-Independence</strong></td>
<td></td>
</tr>
<tr>
<td>Signing of petitions by 156 soldiers protesting maltreatment and mismanagement</td>
<td>16 January 2006</td>
</tr>
<tr>
<td>591 soldiers leave barracks in protest of discrimination</td>
<td>8 February 2006</td>
</tr>
<tr>
<td>Sacking of 591 soldier by F-FDTL Commander</td>
<td>25 March 2006</td>
</tr>
<tr>
<td>Peaceful demonstration turned violent</td>
<td>26-28 April 2006</td>
</tr>
<tr>
<td>First violence broke out</td>
<td>28 April 2006</td>
</tr>
<tr>
<td>Fretelin Party Congress and re-election of PM Mari Alkatiri as Party’s Secretary General</td>
<td>18-22 May 2006</td>
</tr>
<tr>
<td>Second violence broke out and led to heavy fighting between government and rebel soldier led by Major Alfredo Alves Reinado</td>
<td>23 May 2006</td>
</tr>
<tr>
<td>Arrival of Australian led-International Force</td>
<td>25 May 2006</td>
</tr>
<tr>
<td>Resignation of Prime Minister Mari Alkatiri</td>
<td>26 June 2006</td>
</tr>
<tr>
<td>Jose Ramos Horta sworn in as the 2nd President of the country</td>
<td>20 May 2007</td>
</tr>
<tr>
<td>General election and Fretelin won the election but failed to form government</td>
<td>30 June 2007</td>
</tr>
<tr>
<td>Formation of AMP government and former President Xanana Gusmao became Prime Minister</td>
<td>12 September 2007</td>
</tr>
<tr>
<td>Assassination attempt on President and PM. President was shot and severely wounded, PM escaped from attack, rebel leader Alfredo Reinado killed in the attack</td>
<td>11 February 2008</td>
</tr>
<tr>
<td>10 Years of independence</td>
<td>20 May 2012</td>
</tr>
</tbody>
</table>
Health system and health workforce at the time of the crisis

Since Independence in 2002, the government of Timor-Leste has endeavoured to develop and rebuild Timor-Leste in all sectors, as the country was severely destroyed following the vote for Independence in 1999.

The health sector was one of the government’s key development priorities. The MoH, which was established in 2001, led health sector development, with support from development partners, to restore health services, reconstruct and develop health infrastructure, build hospitals and the referral system, and develop and strengthen the health system and its policies and strategies.

The health system in Timor-Leste is divided into three layers - national, district and sub-district levels. The MoH has three main components: central services, district health services and specialised services. The central services and the specialised services operate at the national level. The central services consists of a Directorate General and the National Directorates in which, in previous government, there were three national directorates (National Directorates for Service Delivery, Policy and Planning, and Administration and Logistics).

The District Health Services (DHS) comprise 13 District Health Offices based at district level. The DHS is responsible for planning and implementing health services in a district. The DHS is headed by a director assisted by a deputy and several program officers and administrative staff. The DHS oversees the Community Health Centres (CHCs) which are located in sub-districts. Under the CHCs, Health Posts are located at village level, although not all villages possess a Health Post.

The specialised services comprise five institutions, namely the National Hospital, the Referral Hospitals, the Institute of Health Science (formerly National Center for Health Education and Training), the National Laboratory and the Autonomous Medical Store (SAMES) (Figure 1, page 9).

The current government has slightly modified the MoH structure increasing the number of national directorates from three to five (National Directorates for Community Health Services, Hospital Services, Finance and Planning, Human Resource, and Administration and Logistics), but has more or less maintained the structures for District Health Services and Specialised Services.

In 2005, the MoH employed nearly 2000 health staff [Ministry of Health 2005]. By 2007, the MoH staff grew to nearly 2400 [Ministry of Health 2007]. The human resource profile in the MoH in 2005 and 2007 can be seen in Tables 6 and 7 in the Appendices 1 and 2. Data on health workers employed by NGOs and private charities are not known.

The Cuban Medical Brigade (CMB) began arriving in Timor-Leste and providing support to the Timorese health system from 2004. This resulted from a meeting between Cuban President Fidel Castro and Timor-Leste’s President Xanana Gusmão in Kuala Lumpur in February 2003 [Anderson 2008]. By 2006, the CMB had 210 doctors, 22 nurses, and 35 health technicians (radiologists, laboratory workers, electro medical workers, anaesthetists and pharmacists) working in hospitals, districts and sub-districts of Timor-Leste.

Problems and difficulties

At the time of the crisis Timor-Leste faced a number of challenges, including fragile state institutions, lack of financial resources and lack of human resources. All government institutions were in the early stages of development including the MoH. Although the MoH already had considerable structures in place, they were very fragile due to inadequate skills and low bureaucratic competence, with the available human resources thinly spread across multiple portfolios and tasks.
A National Disaster Plan was in place and under the direction of the Ministry of Interior, but at the time of crisis this Plan was not followed through [Zwi, AB et al. 2007]. The MoH nominated a low ranking officer to manage the National Disaster Plan. This contributed to the ineffectiveness of disaster response, as low ranking staff were reluctant to make crucial decisions when needed.

Institutions that took part in this Plan were also inactive. The Ministry of Interior, chiefly responsible for the Police portfolio and also coordinating activities of the National Disaster Plan, was dysfunctional, and the conflict between Army and Police further aggravated the situation. Moreover, the Plan itself dealt more with preparedness for responding to natural disasters rather than civil conflicts.

**FIGURE 1. THE ORGANISATIONAL STRUCTURE OF THE MINISTRY OF HEALTH 2001-2007**
CASE STUDY

Rationale for the case study

The crisis had displaced around 15% of the country’s population, the majority from the capital Dili. Around 60 internally displaced person (IDP) camps were established; those who were displaced in the districts were mostly accommodated by family members. The instability also affected the development progress of the country. The International Organization for Migration (IOM) revealed that approximately 5,590 homes were destroyed [International Organization for Migration 2009b]. From April – May 2006 violence led to the deaths of 37 people, but the intermittent violence that followed led to up to 150 deaths from June 2006 until the end of 2007 [Muggah 2010].

The government appointed the Ministry of Labour and Solidarity (MTRC, its acronym in Portuguese) to coordinate the overall humanitarian response. The main responsibility of the MTRC was to make sure that the basic needs of IDPs – in terms of shelter, food, water and sanitation – were met. The MoH was responsible for all health interventions during the period of instability. The MoH and its development partners (UN agencies, NGOs, donors and other stakeholders) quickly established a coordination structure which was headed by the MoH with the objective of organising and coordinating the health response [Zwi, AB et al. 2007]. The estimated total number of IDPs in June, September and December 2006 were 147,112, 170,573 and 151,327 respectively. The distribution of IDPs by district is presented in Table 3 below.

The instability continued for approximately two years but finally ended towards the end of 2008. Almost all IDPs were able to go back to their homes and start to rebuild their lives, but an estimated 15,000 IDPs were still waiting for re-settlement at the end of 2009 [International Organization for Migration 2009a].

The international community’s response to populations trapped in and/or affected by conflicts first and foremost is to save lives and prevent unnecessary morbidity and mortality. The impacts of conflict and complex emergencies on populations, governance structures, health and livelihood have been well documented [Leatherman & Thomas

<table>
<thead>
<tr>
<th>District</th>
<th>June 2006</th>
<th>September 2006</th>
<th>December 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aileu</td>
<td>5814</td>
<td>3405</td>
<td>6798</td>
</tr>
<tr>
<td>Ainaro</td>
<td>3752</td>
<td>3571</td>
<td>8275</td>
</tr>
<tr>
<td>Baucau</td>
<td>25776</td>
<td>31507</td>
<td>38608</td>
</tr>
<tr>
<td>Bobonaro</td>
<td>3340</td>
<td>11779</td>
<td>3670</td>
</tr>
<tr>
<td>Covalima</td>
<td>2602</td>
<td>5246</td>
<td>6448</td>
</tr>
<tr>
<td>Dili</td>
<td>72872</td>
<td>69600</td>
<td>30000</td>
</tr>
<tr>
<td>Ermera</td>
<td>4380</td>
<td>7836</td>
<td>8935</td>
</tr>
<tr>
<td>Lautem</td>
<td>5841</td>
<td>9332</td>
<td>11478</td>
</tr>
<tr>
<td>Liquica</td>
<td>7942</td>
<td>6507</td>
<td>4457</td>
</tr>
<tr>
<td>Manatuto</td>
<td>2647</td>
<td>5017</td>
<td>5886</td>
</tr>
<tr>
<td>Manufahi</td>
<td>1795</td>
<td>2839</td>
<td>5886</td>
</tr>
<tr>
<td>Oecussi</td>
<td>2326</td>
<td>2447</td>
<td>2200</td>
</tr>
<tr>
<td>Viqueque</td>
<td>8205</td>
<td>11487</td>
<td>18686</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>147112</strong></td>
<td><strong>170573</strong></td>
<td><strong>151327</strong></td>
</tr>
</tbody>
</table>

2009; Levy & Sidel 1999; Pavignani & Colombo 2001; Toole & Waldman 1997]. Conflicts and complex emergencies cause a breakdown of governance and institutions, increase population displacement and have direct and indirect consequences on a population’s health and health system [Zwi & Ugalde 1989; Zwi, AB et al. 2002].

Conflicts often draw international response to provide humanitarian assistance, so that the basic needs of the affected population, including health, can be met. An early and adequate health intervention is necessary to fulfill the humanitarian charter by providing the minimum standard of health care to the people affected by the conflict, thereby reducing morbidity and mortality [McConnan 2000].

Responses to conflicts and complex emergencies are not limited to the provision of humanitarian relief efforts. Broader responses include social and economic development issues, and global political and security issues, plus the links between humanitarian relief and longer term development.

The latter requires the long-term engagement of the international community to reduce the impact of the conflict on populations and contain the spread of instability regionally and globally. There has been increasing concern that the disengagement of the international community in conflict-affected countries would allow adverse conditions to flourish [DFID 2005].

To enable effective service provision in conflict settings requires adequate human resources; just as the effective delivery of health services requires an adequate health workforce. In conflict settings, health workers themselves are often affected directly: they either flee or are displaced to safer areas, or risk being kidnapped or killed during the conflict [Pavignani & Colombo 2001; Zwi & Bunde-Birouste 2005]. During the armed conflict in the Côte d’Ivoire, three-quarters of health professionals abandoned their posts either being killed, displaced or migrated to a more secure area [Betsi et al. 2006].

Providing more attention to human resources for health (HRH) in fragile states not only assists in the provision of health care to affected populations, but will also help these countries achieve their Millennium Development Goals.

Providing more attention to human resources for health in fragile states not only assists in the provision of health care to affected populations, but will also help these countries achieve their Millennium Development Goals.

made disasters have a right to life: to dignity, to protection and security, and to receive humanitarian assistance [The Sphere Project 2004].

The objectives of this case study

Much has been written about the deployment and engagement of the international emergency relief organisations such as the International Committee of Red Cross (ICRC), Medicine Sans Frontieres (MSF), the International Rescue Committee (IRC) and others. They provide emergency health services in conflict-affected countries and during disasters, but little is known about what sustains local health systems and their health workers to continue working in conflict-affected settings.

This case study assesses the enabling factors and challenges for health workers documented from Timor-Leste’s crisis in 2006 and the response to health needs of the population.

Case study methods

The study drew on document reviews and in-depth interviews. The questions guiding the in-depth interviews are listed in Appendix 3.

Documents, published and unpublished, that covered the health sector response during the 2006 political instability and touched on the issue of human resources were reviewed. Unpublished documents included minutes of the health coordination meetings, and policies and/or circulars that discussed or mentioned issues related to the mobilisation and deployment of health and aid workers during the crisis of 2006.

Two approaches framed the key informant interviews. First, a review of previous interviews that had been
undertaken during the data collection for the Health Resilience Study [Zwi et al. 2007] was undertaken. Secondly, additional interviews with key informants were conducted.

The in-depth interviews selected for the review were those that mentioned or highlighted human resource issues in relation to the period of instability. Therefore, interviews were reviewed from key MoH decision-makers at the time of the crisis, those from key agencies involved in the crisis response, those in charge of and/or taking part in the Health Working Group (HWG), and those health workers involved directly in delivering health services.

In total, 29 in-depth interviews were reviewed (Table 4 below). Major HRH themes from these interviews were identified. In addition, interviews with key decisions-makers at the MoH, and personnel associated with UN agencies, NGOs and key officials in the HWG were reviewed.

Some information gaps related to HRH management and challenges during the crisis were identified. This included documenting the personal experience of some health workers. Seven individuals (three health managers, two health workers and two ambulance drivers) were purposively selected. They were interviewed and reflected on their personal experience in organising and delivering health services to populations including IDPs, the challenges they faced as well as the factors that motivated them to continue to perform their duties in a challenging and difficult environment when their own safety was also at risk.

Most of the data collected for this case study was undertaken at the time of crisis when the emergency response was being provided; it represents, therefore, a real-time assessment. Ethics approval was obtained from The University of New South Wales and the Ministry of Health, Timor-Leste.

Data analysis
Thematic analysis was employed to analyse the factors which facilitated health worker mobilisation and deployment during the crisis in 2006 and the challenges and constraints faced. The data analysis was complemented with narrative analysis reflecting stories of health workers’ experience, demonstrating individual resilience and strength that helped support the health sector response and the health system generally during the crisis.

Health sector response to the crises
The political instability in 2006 created an unexpected degree of violence, destruction, and population displacement. The MoH responded quickly to events and rapidly coordinated with its partners to meet the immediate needs of the population affected by the violence. At the same time, the MoH sought to continue functioning and execute its responsibilities for providing health care to the community [Zwi et al. 2007].

<table>
<thead>
<tr>
<th>Organisational affiliation</th>
<th>Position within organisation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>Senior officials</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Mid-level managers</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Health workers</td>
<td>7</td>
</tr>
<tr>
<td>UN Agencies</td>
<td>Management</td>
<td>3</td>
</tr>
<tr>
<td>NGOs</td>
<td>Management and implementation</td>
<td>4</td>
</tr>
<tr>
<td>Private Clinics</td>
<td>Implementation</td>
<td>1</td>
</tr>
<tr>
<td>Professional Association</td>
<td>Management</td>
<td>1</td>
</tr>
<tr>
<td>Cuban Medical Brigade</td>
<td>Management and clinical</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>
Several factors assisted the MoH to undertake its duties. These have been grouped as follows:

1. Health system support strategies:
   - early decision to secure vital health facilities (such as the National Hospital) and support systems (e.g. the agency responsible for procuring and distributing drugs);
   - establishment of the Health Working Group.

2. HRH strategies by the Ministry of Health:
   - delegation to mid-level managers of decision making on technical issues and for keeping higher level decision-makers informed;
   - mobilising and retaining health workers during the crisis;
   - flexible policy on displaced health workers;
   - temporary arrangements in health facilities;
   - sustained leadership from the MoH;
   - making cash available;
   - continually reminding health workers of their professional ethics and obligations.

3. External HRH support:
   - continued support from development partners;
   - the availability of foreign health workers - the Cuban Medical Brigade.

These are discussed, in turn, below.

1. Health system support strategies

   Early decision on securing three important sites

During the chaotic situation of the first violent clash on 28 April 2006, the Minister for Health, Dr Rui Maria de Araujo, had just arrived back from an overseas trip. He was greeted by the MoH protocol staff, among them Ms Ana Isabel, Director of Health Service Delivery, MoH.

Amidst this high security tension, the Minister and his senior officials made a decision to hold an emergency meeting at the MoH office on that day. As the security situation deteriorated, the MoH officials were unable to get to their office and had to use the National Ambulance Office, which was located about 300-400 metres from the MoH office.

An important decision was made at this critical meeting in which officials decided to secure three important sites and services: the ambulance service, the National Hospital and the Autonomous Medical Store known as SAMES (Serviço Autônomo de Medicamento e Equipamentos da Saúde), and to ensure that they remained functional. The quote below shows the tense nature of the situation at that time:

“When we arrived [at the] office we couldn’t pass, the Minister’s car was there and at that time our friends [MoH staff] didn’t go to office, even we wanted to go back but we were not able because the situation was so bad, so I decided to park this car at the National Ambulance and the Minister came to find us ... He said that we needed to secure the ambulance [service], [National] Hospital and SAMES, these three things should continue to function...”

– MoH’s coordinator for the emergence response.

The decision to secure these three sites was based on their vital function of saving lives. It was predicted that whatever the magnitude of the violence, it would result in casualties.

During a crisis situation, when the government is unable to provide life-saving services, the international emergency relief organisations such as the International Committee for the Red Cross or Médecins Sans Frontières (MSF) would normally step in and take over these services. If this were to
This crisis not only displaced ordinary people but also government employees, including health managers and health workers, and the MoH building was also located in a danger zone, opposite the headquarters of the Dili District Police, which was in conflict with the Army.

happen, it would send a signal that the government was not in charge and was incapable of providing basic health care for its people.

“I think this is a very clear orientation [instruction], an orientation which is clear with the thinking that ambulance is a car that can bring or transport people from the location of incidents to hospital. Because of this we need to guarantee that it must function, the national hospital is a place for people to have treatment which is of high level for accident victims, and central pharmacy is a place to store drugs, nurses and doctors may be available, but this one (central pharmacy) if people burnt it... I don’t know what would happen... that was the orientation, the 3 places that need to be secure are those ones.”


For the MoH, it was important to have at least a relatively secure site to plan and organise the response. Since most of the instability and severe damage occurred in Dili, the nation’s capital, it severely affected routine government activities and also undoubtedly affected the government’s capacity to respond and plan interventions. When a crisis occurs outside national capitals, the response team can have time and space to plan.

The crisis not only displaced ordinary people but also government employees, including health managers and health workers. The MoH building was also located in a danger zone, opposite the headquarters of the Dili District Police, which was in conflict with the Army. Therefore, the National Hospital was used as an alternative venue for coordinating the emergency health response. This continued for a month until the MoH site was secure.

“Before the situation began to become worse so the Minister, Vice-Minister and me we decided to look for one alternative place to concentrate together in order to maintain our job. The Ministry of Health chose the National Hospital as a base for us to maintain our jobs...at 4 pm in the afternoon there must be a meeting at the national hospital to get information and to take decisions.”

– Permanent Secretary 2003-2008.

The National Hospital and SAMES not only continued to function during the crisis, but both places also offered shelter to health workers and their families and to general IDPs.

By the end of July 2006, the security situation was much improved and some IDPs were able to move around, even going to their homes during the day and returning to the relative safety of IDP camps at night. The improved security situation led the MoH to decide to reduce the number of 24-hour fixed health clinics which had been set up in a number of IDP camps. In certain IDP camps where it was insecure for travel, the services were maintained. However, mobile clinics continued to be undertaken. This decision was made to encourage IDPs to use health services available at CHCs, which were functioning from July 2006.

The decisions and initiatives taken early by the MoH were considered a strength which kept the MoH functional and allowed health services to be provided effectively during the crisis.

“So they had already taken that initiative very early on and I think that was one of the strengths within the Ministry – it was early in taking a lead role and organising themselves – from top level.”

– An international NGO worker who later became an adviser to the MoH.

In the words of a WHO country representative regarding why the health sector remained functional during the crisis, one big advantage was because “health professionals are professionally running [the] full show, people know their jobs”. This observation reinforces the view of the Minister of Health himself who highlighted his pride in the ability of his team to operate effectively during this time of crisis [Zwi et al. 2007].
Establishment of the Health Working Group

The Health Working Group (HWG), which functioned as a coordinating structure, was vital to the organisation and execution of actions during the crisis. The HWG was created in late May 2006 soon after the worst violence occurred and was headed by the MoH’s Director of Health Service Delivery.

The HWG played an important role in the organisation and coordination of health response during the 2006 political instability. It allowed all health interventions to be planned and assessed, and health needs to be identified. The HWG consisted of the Ministry of Health, UN agencies and NGOs, the Cuban Medical Brigade, private clinics and health professional associations. More than 30 NGOs, both international and local, were actively involved in the HWG.

The HWG’s main function was to coordinate and oversee the health sector response to address the health needs of displaced persons and the general population during the period of instability. The HWG was also part of the overall humanitarian coordination structure which had six sub-working groups: Medical Assistance, Maternal and Child Health, Nutrition, Health Promotion, Vector Control and Epidemiological Surveillance (Figure 2 below).

The first health coordination meeting took place at the National Hospital on 31 May 2006 and then ran on a daily basis for almost three weeks during the height of the crisis. After that it was reduced to three times a week until mid-July 2006. As security improved, the frequency of the coordination meetings was gradually reduced. By September 2007 coordination meetings were held once a fortnight.

FIGURE 2. HEALTH WORKING GROUP CREATED TO RESPOND THE EMERGENCY NEEDS DURING THE 2006 POLITICAL VIOLENCE

Source: Timor-Leste Health Sector Resilience and Performance in a time of instability [Zwi et al. 2007].
The task of the HWG was to ensure that the 24-hour fixed clinics, the mobile clinics and health promotion and prevention interventions were operational; which could only be possible when HRH were adequate to deliver those services. The HWG worked closely with Site Liaison Support (SLS) officers, camp managers and NGOs to deliver services.

Coordination not only took place at health coordination meetings but, more importantly, it was continued by ensuring that the decisions they made were acted upon in the field. This ensured equitable distribution of agencies providing health services and avoided duplication of services. As the MoH Emergency Response Coordinator simply put it: “Don’t do duplication, the medical assistances should not be overlapping”.

The smooth coordination during the crisis was attributed to the pre-existing relationship of the MoH and its development partners, as described by one of the key development partners from the NGO sector: “I think it has to do with our pre-existing relationship, our understanding that we were going to stay here, that we’re here for long term”.

The coordination was a learning process for actors involved as reflected by an NGO worker tasked with helping the coordination meetings:

“It (coordination) was a way of putting people together again and starting to understand the situation because we didn’t know the situation and I think it was an evolving process really. We learn how to do it at the same time we were doing it in health and in the inter-sectoral coordination group.”

2. HRH strategies by the Ministry of Health

Delegating decision making on technical issues to the mid-level managers and keeping high level decision makers informed

A contributor to the success of the emergency response was delegating decision making powers on technical matters, including coordination issues with development partners, to mid-level managers. This provided leverage for quick decisions and quick action on the ground. They only communicated with the Minister and Vice Minister on high-level issues and/or issues that had political implications.

Given the centre of the crisis was in Dili, the Head of Dili District was given the responsibility of coordinating activities at an operational level, ensuring all IDPs had access to health services. This also sent a message that the role of those in charge in districts was respected and their responsibilities were not taken over; rather, they were given authority to act and coordinate their responses.

“...and in health we appointed Ana Isabel because she is the Interim Director of Health Service Delivery in which she was in contact with almost everybody on a daily basis, the directorate that work with basic services in health, this directorate is really big. Because of this we selected her, and because this crisis happened in Dili definitely the Head of Dili District Health had to coordinate all health assistance to the IDP camps, with huge support from International NGOs [and] UN agencies.”

This delegation of responsibility to the mid-level managers proved to be working effectively, which enabled the response to be undertaken and demonstrated that MoH was in control.

“I think when we first had the health coordination meeting I think that gave us the impression that you know we are still in charge and things are moving and ... even bigger satisfaction for me was that it was not me doing that but the mid-level directors and the Permanent Secretary were taking up that responsibility and managing, solving the problems, and if you like, it’s very good ‘cause you know you don’t need to go and do the work ... It was very rewarding after all these years of working with these people.”
– Minister for Health.

“He’s a good Minister, he knows what he’s doing ...he delegates a certain level of authority to them [mid-level managers] to take decisions and I find even during the crisis he delegated tasks to the head of service provision, her name is [Ana] Isabel. He delegated this part of coordination for Dili and the service provision for the IDP camps.”
– UNFPA Staff.

Delegating decision making to a lower level was important from management perspective because it demonstrated that leaders had a trust in their subordinates (mid-level managers) to execute
organisational functions and that the subordinates had capacity to undertake those delegated tasks.

**Mobilising and retaining health workers during the crisis**

The MoH strategy to mobilise and retain health workers during the period of instability was undertaken through the following “ad hoc strategies”:
- Mobilising the Cuban Medical Brigade
- Flexible policies on displaced health workers
- Some temporary arrangements within health facilities

Prior to describing this, it is worthwhile to present the MoH staff profile before the crisis and the circulation in and out of the displaced health workers during the crisis period (Table 5 below). At the time of crisis, the MoH already had approximately 2000 health staff comprising doctors, nurses, midwives, managers, public health officers, and administrative and support workers.

**TABLE 5. MOH STAFF PROFILE PRIOR TO THE 2006 POLITICAL INSTABILITY AND THE CIRCULATION IN AND OUT OF THE DISPLACED HEALTH WORKERS**

<table>
<thead>
<tr>
<th>Ministry of Health Central Office</th>
<th>Total number of staff prior to the crisis in 2006</th>
<th>Displaced out (Health staff displaced from their permanent workplace to other districts)</th>
<th>Displaced in (Receiving temporary displaced health staff from other districts or MoH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health Central Office</td>
<td>101</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>National Hospital</td>
<td>330</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Institute of Health Science</td>
<td>34</td>
<td>4</td>
<td>No displacement</td>
</tr>
<tr>
<td>National Laboratory</td>
<td>11</td>
<td>2</td>
<td>No displacement</td>
</tr>
<tr>
<td>SAMES</td>
<td>No displacement</td>
<td>No displacement</td>
<td>No displacement</td>
</tr>
<tr>
<td>DHS Aileu</td>
<td>73</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>DHS Ainaro</td>
<td>85</td>
<td>No displacement</td>
<td>No displacement</td>
</tr>
<tr>
<td>DHS Baucau</td>
<td>135</td>
<td>No displacement</td>
<td>23</td>
</tr>
<tr>
<td>DHS Bobonaro</td>
<td>89</td>
<td>No displacement</td>
<td>3</td>
</tr>
<tr>
<td>DHS Covalima</td>
<td>75</td>
<td>1</td>
<td>No displacement</td>
</tr>
<tr>
<td>DHS Dili</td>
<td>123</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>DHS Ermera</td>
<td>93</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>DHS Lautem</td>
<td>96</td>
<td>No displacement</td>
<td>5</td>
</tr>
<tr>
<td>DHS Liquica</td>
<td>71</td>
<td>2</td>
<td>No displacement</td>
</tr>
<tr>
<td>DHS Manatuto</td>
<td>98</td>
<td>No displacement</td>
<td>No displacement</td>
</tr>
<tr>
<td>DHS Manufahi</td>
<td>59</td>
<td>5</td>
<td>No displacement</td>
</tr>
<tr>
<td>DHS Oecusi</td>
<td>98</td>
<td>No displacement</td>
<td>No displacement</td>
</tr>
<tr>
<td>DHS Viqueque</td>
<td>119</td>
<td>No displacement</td>
<td>12</td>
</tr>
<tr>
<td>Regional Hospital Baucau</td>
<td>47</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Regional Hospital Maliana</td>
<td>35</td>
<td>No displacement</td>
<td>No displacement</td>
</tr>
<tr>
<td>Regional Hospital Maubessi</td>
<td>Not yet functioning</td>
<td>Not yet functioning</td>
<td>Not yet functioning</td>
</tr>
<tr>
<td>Regional Hospital Oecussi</td>
<td>43</td>
<td>1</td>
<td>No displacement</td>
</tr>
<tr>
<td>Regional Hospital Suai</td>
<td>48</td>
<td>1</td>
<td>No displacement</td>
</tr>
<tr>
<td></td>
<td>1992</td>
<td>63</td>
<td>63</td>
</tr>
</tbody>
</table>
As seen in Table 5 (page 17), all 63 health workers displaced from their posts continued to be accommodated in the system. The district of Baucau accommodated the highest number of displaced health workers, while both DHS Dili and National Hospital had the highest number of their staff being displaced.

Dili National Hospital accommodated more than 30 displaced health workers, mostly clinical staff, at that hospital. These health workers were provided with tents and camped inside the hospital compound [personal communication]. The Bairo Pite Clinic (BPC) had 13 displaced health workers within its compound while also housing about 1200 IDPs on its grounds [personal communication].

Flexible policy on displaced health workers by continuing to engage them to support health services

Some health workers were displaced at IDP camps and to districts as a result of the crisis. The MoH was aware of that situation and also aware that the displacement was not a fault of the health workers. Therefore, the MoH issued a flexible policy to allow these displaced health workers to continue to perform their duties. This was done by allowing:

• health workers and their families to move to hospital grounds;
• displaced health workers in districts to be temporarily accommodated in those districts; and
• health workers in districts who felt insecure to be transferred to either MoH or other places.

As shown in Table 5, some workers were displaced from their original workplace to other districts (mainly districts of their origins), some from districts being displaced to the capital Dili, and some requested to be temporarily transferred. The MoH response to this particular situation was to allow them to move to places where they felt secure and requested them to continue to perform their duties.

“Now there are some nurses and doctors have become IDPs for themselves which they also felt threatened with the issue of East and West. Some of them also fled to mountains, mostly nurses but we already gave them orientation. In the Ministry and Districts [we asked them] to identify nurses or health workers which became IDPs and displaced to districts, they can be accommodated in the system, activate them in hospital or health centres or health posts so that they continue to perform their duties as health workers and they continue to be on payroll on the basis of the reports from head of districts, director of hospital or director of health centres or at the national level (MoH) ... some abandoned their work and ran away to Baucau, we thought that this not their faults to leave their works, this is not because of their own intentions.”


In order to maintain these displaced health workers in the government’s payroll system, they needed to submit their attendance list certified by the head of district confirming their attendance.

“...the important thing is that they have to fill the attendance form because if they don’t fill the attendance form they will not get their salary, because as a Servant Civil they have to work eight hours per day. Even in war. So they have to list their name and give to the Chief of District and when they are going to get their payment the Chief of District have to sign or give the recommendation. They could choose any district that they feel comfortable to go.”

– Permanent Secretary 2003-2008.

Allowing health workers to stay at service areas such as in the National Hospital and SAMES grounds can be seen as a strategy to retain them in vital health facilities in order to keep the facilities functional. The Bairo Pite Clinic, a private, not-for-profit clinic in Dili, also allowed some health workers to stay at its compound enabling it to continue to function and provide services.

“During the initial time a lot of our staff members decided they’d sent their families away to the districts and they decided to stay and they stayed at the Bairo Pite Clinic so they could keep working which is amazing ... They wanted to stay here and work. They said ‘we’re doctors, this is what we do, this is where we’re needed and want to be here and we want to be working’. I think they were also quite brave as well.”

– Bairo Pite Clinic program manager.
There were also some health workers displaced in the IDP camps in and around Dili; they were requested to assist to provide health services to IDPs in camps where these health workers became IDPs themselves (see Box 4, page 25 and Box 6, page 28). They worked collaboratively with Cuban doctors and other health workers from government and NGOs in the 24-hour fixed clinics and mobile clinics.

“[At] Seminario Maior [Camp], by coincidence one of our staff was also displaced there [at that camp], this colleague of ours displaced there, so she was on standby there.”
– Manager of one CHC in Dili.

“[They] provide some medicines in a small box and I put in my tents so I give them medicines every afternoon, this was every afternoon. So they come to my tents and I give medication, I give medical examination there every afternoon.”
– A Timorese doctor who was displaced in an IDP camp and provided consultation from his tent.

Temporary arrangements within health facilities

The National Hospital also encountered a human resources shortage as some of its health staff fled to districts or were unable to come to work. The National Hospital managed to cope with the staff shortage by redeploying staff from non-essential wards and outpatient departments to the wards that most needed staff.

“Things that not too important at that time like physiotherapy, we cancelled it and all of the staff come to help and also from the outpatient department, we needed them to cover all in wards.”

Staff from the CHCs that had been temporarily closed were pooled at DHS Dili headquarters (sharing the same building with CHC Centro) to assist with medical services at the 24-hour fixed health clinics and the mobile clinics that were operational. Technical coordination on medical assistance and deployment of resources on this aspect, including deployment of CMBs, was based at Centro CHC/DHS Dili.

Interestingly, despite the human resources shortage facing the National Hospital, some Timorese doctors working there were also drawn in to help provide medical assistance to people at IDP camps.

... leadership was crucial for getting things moving in crisis settings and allowing anticipative actions to be taken in preparation for the worst.

“From April until July, we were involved directly in this crisis situation. This is our own initiative … At the beginning we were delivering health services together with MoH. MoH picked us at Hospital Nacional Guido Valadares for running Mobile Clinic. First, on May 23 and 24, we were delivering health services at IDP Camps, such as, Tasitolu, Airport, Canossa, Bombeiros, Farmacia Central, F-FDTL Caicoli, Hera, Metinaro, Dare and Motoel Church. During our mobile clinic, we coordinated with Ministry of Health in collaboration with Dili District Health Services, but we met a lot of difficulties because we did not have transportation facilities.”
– President of the Timorese Medical Association.

The Timorese health workers, CMB and NGO workers were the backbone of human resources for health during the crisis response.

Sustained leadership from MoH

The senior MoH officers continuously followed all aspects of the health response, making themselves available via telephone, and often calling managers while they were on duty. In difficult times, they continued to be present in most meetings. For example, during the height of the crisis, the Minister, Vice-Minister, and Permanent Secretary chaired coordination meetings held in hospitals. This sustained leadership and continued guidance not only played out at a national level but also penetrated to the district level.

This demonstrated that leadership was crucial for getting things moving in crisis settings and allowing anticipative actions to be taken in preparation for the worst. This kind of quality of the leadership was what most staff (subordinates) expected, as was recalled by the emergency health response coordinator “...what
Sustained leadership required leaders to make themselves present or at least to be contactable and accessible during the difficult time. This was indeed put into practice by the MoH leaders at that period. Such leadership and experience was felt by managers who managed health services in districts and hospitals.

“Our minister, for me I think he has a good leadership ... because this ministry has already a good leadership so everything running well ... during the crisis, first time when the Minister called me, I was surprised. I didn’t know who call[ed] me but he said ‘me, Dr Rui just want to ask about the health situation’, he told us to maintain our job and ‘if there is any problem please contact me soon, if I can’t, you can talk to [the] Vice Minister, or Permanent Secretary’. Both of them we frequently contacted every day. I myself appreciate with the Minister, especial in the difficult time in which most people looked stagnated but he always give the spirit of work, he made us feel strong in difficult time.”

“The leadership of the Minister was good ... I always [had] contact with him and also he always [had] contact [with] us here, even three times in one day, to ask about the progress, and the situation.”

“In crisis times the coordination was very good, better than in normal times. I managed to pass through Dili 22 May [2006], I handed over the duty to [the] deputy, I was in Dili for about a week. I met Minister on 23 May 3 pm. From Dili I helped coordinating the evacuation of victims (wounded) to Maliana hospital. I called Minister and Vice Minister to seek their advice during the crisis.”

Leadership was among many other key factors that sustained the MoH’s function and allowed it to carry out its mandate during the difficult times. Factors operating at individual levels (managers), which highlighted the importance of leadership displayed by each individual manager, added a strength to the MoH’s capacity as an institution (see Boxes 1 to 3, pages 21, 22 and 24).
Ms Ana Isabel de Fatima Sousa Soares (AS) was born in Viqueque on 29 March 1966. She was the National Director of Health Service Delivery MoH-TL and was appointed as the overall coordinator for health sector response during the 2006 political instability. AS is currently doing her PhD at Charles Darwin University in Darwin, Australia. She completed her undergraduate studies in public health at the University of Airlangga, Surabaya, Indonesia and Masters of Public Administration. She graduated from Dili Nursing School in 1986 as a nurse and became a teacher for this Nursing School during Indonesian times from 1989-1999, as well as a lecturer for the Nursing Academy.

During the United Nations Transitional Administration for East Timor (UNTAET) period, AS was the team leader for the Nursing School and a lecturer for the Nursing Academy. She then joined the Interim Health Authority as a member for the Cabinet of the Health Policy Group. When the MoH was established in 2001, AS became the head of Health Promotion Department where she remained until 2005. She was elevated to National Director of Health Service Delivery, MoH-TL in 2005, a position she held to 2007. She was also a part-time lecturer at the Faculty of Public Health, Universidade da Paz.

Her last post in the MoH was very instrumental as it dealt with ensuring that health service delivery and programs were delivered and implemented. With her experience in health services, she was entrusted by the MoH to lead and coordinate health sector response during the 2006 political instability.

During the political instability, AS’s house was burned down and she took refuge at the National Hospital, but due to strong determination and with a principle to serve other people (and their health needs), she accepted the MoH’s decision to take up the lead and coordination of the health sector response during the crisis.

She said leadership is crucial for any challenging task, describing “leadership” in her own words as: “We have to be impartial. As a leader, like National Directors, we don’t say: I come from East or West. Leadership, leadership, we need a brave person, brave to take initiatives and decisions at anytime in whatever situations, [when] we are needed to go down [to field], we have to, keep calm and in control, listen and consider to our partners and ignore the rumours... and need to coordinate and be brave... I believe that God protects and guides me. Moreover another critical aspect is to assess and prioritise the most important problems to address during the situation like this”.

She also added that another important ingredient which prompted her to accept this responsibility was the sense of ownership to the institution where she belongs: “I lost my house and belongings. If I don’t have the sense of ownership, the ownership should be there, the sense of ownership to institution and to people who we manage. If at that moment I didn’t care about the work, I didn’t care about the situation of many people, I could pack my belongings and put them in car and take them to Viqueque, to secure my stuff there, but I didn’t think like this”.

With these values, AS was able to execute the responsibilities given to her perfectly well, given the circumstance at that time, and she earned praised and recognition from the Minister for Health and the development partners for this well done job.

AS’s story demonstrated the value of leadership, sense of ownership and personal resilience in accepting a responsibility despite personal loss and insecurity. These values motivated her to face the challenges, and kept health services running and the MoH functioning.
Mr Macario Faria da Silva (MS) was born in Dili on 6 December 1949. He completed his nursing study at the Portuguese Nursing School in Dili in 1968 and began working as a nurse at the Surgery Department of Portuguese Hospital in 1969 through to 1975. During Indonesia time, he worked with ICRC from 1979-1989 and moved on to work a Church-run Motael Clinic from 1989-1999. During the UNTAET period, he was a member of the Interim Health Authority. He was appointed as the head of Dili District Health Service in 2001 through to 2008. Currently he is on staff at the MoH central office.

As most of the instability and severe damage occurred in Dili, his area of responsibility, he was actively involved in the emergency response and was in charge of the medical assistance sub-working group. His main responsibility was to ensure that community (both IDPs and non-IDPs) had access to health services through CHCs, the 24-hour fixed health clinics and mobile clinics. With support from the Cuban Medical Brigade, MS did an excellent job.

The word of appreciation for MS’s role came from the Minister for Health: “The Dili District Health Services Signor MS, and the others. He was doing an outstanding job .. even though, even though, at one point particularly after the Congress of FRETILIN because he was also a delegate, an active delegate of the Party, some of the members of the party were targeted but he remained very calm and continued to organise the services and make sure that the service was delivered and the bulk of the work organising the services to the IDPs was done by Dili District Health Services and the Head of the Dili District Health Service I think there has a credit on him.”

MS also said that MoH was functional partly because DHS Dili was able to maintain its functions and responsibility, with support and coordination from the Cuban Medical Brigade. He acknowledged that what drove him to work and coordinate health services to the population was that, as a Timorese and a health professional, he did not want to see his fellow Timorese being abandoned or being denied their access to health service, or their dignity being let down. He said he was already afraid to perform his duties and responsibility but he got encouragement from the Cuban Medical Coordinator as well as the MoH, which enabled him to regain his morale and strength to respond to people’s health needs during the crisis.

At a time when the tension between (ethnic) communities was high, there were casualties requiring ambulance assistance. Mr MS applied a pragmatic approach to allow medical assistance to reach those who needed it. This was done by deploying health workers from the same ethnic background. He said: “If you know that the area or trouble area is mostly populated by people from west, you should use an ambulance driver from west. Likewise if the trouble area is mostly people from east, you should use driver from east”.

MS’s message to today’s generation, particularly health workers, is that the young generation are well informed and better qualified, and therefore they are well prepared to face any crisis that might reappear. He added that he would like to see the young generation own the spirit of caring for others and to take it forward.
Making cash available

One of the key decisions made by the MoH senior leadership was to give the Vice-Minister about US$100,000 in cash during the period of instability. This decision proved to be important in facilitating the MoH’s health system to operate during the crisis period. This enabled mid-level managers to use this fund to pay for operational costs, e.g. fuel and meals for staff on duty.

“When during the peak and two three days after the peak where it was not very easy to travel around we even decided to ask the Vice Minister as the one who hold some cash in terms of money so that the districts would come and then pick up cash from him instead of coming here because this whole area were a very uhh kind of war zone area here so the ... the anticipation of making things that logistically the service were all supported, I think also contributed to the overall performance of the [Ministry of Health]...”

“Even myself during the crisis I went around with a bag full of money to support health services not only for the national level, fuel for ambulance, but also for districts to guarantee health services to continue functioning. I was like a treasurer, many people said I was hiding but they don’t know I hid with money and everybody was looking for me to receive the money, I was a refugee at [Central] Pharmacy for one or two nights there, luckily people did not know I had the money, if they knew and came after me, that would be a big problem, despite all this the work continued to function.”

The usefulness of this anticipative approach was not only echoed by those at the decision-making level, but was also confirmed by those at the implementation level who agreed that the strategy was indeed helping to facilitate the MoH emergency response, as reflected below:

“And for the money to support things, the Minister said that there had to be [people] like the Vice-Minister have to keep cash in hand. So when we are in the emergency time and difficult to find our finance we can easily take money from them to buy necessary sometime. At that time all of our districts and sub-district were still functioning, so they needed money to support their work ... It was good thing to help our work, because with this division of tasks can help us.”
– MoH’s coordinator for the emergency response.

Continuous reminder message on professionalism and impartiality

Since the start of the crisis, the Minister himself and MoH senior officers always reminded health workers to be impartial and professional. Health workers were reminded to live up to their professional oath which obliged them to serve humanity without differentiating race, creed, ethnic, religious and political affiliations.

“We had regular meetings particularly when the crisis was seemingly out of control. I called meetings with few of the staff who turned up every day. We have meetings at the hospital with the management team at the hospital and at one stage with some of the staff. We had meetings with people from the ambulance services to convey the message and make it clear to everybody that ... the professionalism of the health care should be upheld. No-one could jeopardise that ... but also give the message that everybody is free if they feel that they are not safe in performing their duties they can make their choices ... you have to be very impartial, I and the [other senior MoH officials] we conveyed that to each other.”

“I myself convened one meeting with all of them to say to them, no nurse had lost their professional values, there is no East nurse and no West nurse, if there some other people said we are East or West, we accept it, but we must not say East or West between us, we have to contribute to eliminate this issue, we have to kill this issue, we must not contribute to make this issue become bigger, from the beginning we had meeting twice or three times with them I always talked about this in order to boost their morale because many of them lost their houses, burnt everything which can make them losing motivation to work.”

The message of upholding professionalism was reiterated by mid-level managers from both government and private clinics by emphasising that
all staff working in an institution are family and that there should be no room for ethnic identity to influence their duty to serve.

“Yes, professionalism value, but we need to show that [the value of professionalism] ... I gave instructions to them [SAMES staff], here we are one big family, no East no West here. We have to show them that, we should not stand for this one or that one.”


“He [Dr Dan] made a very strong point during the conflict to say ‘we are one people there is no Lorosae/Loromonu, we help everyone, we’re doctors, this is what we do’.”

– Bairo Pite Clinic program manager.

“...as health professionals, we should not leave our duties; we have to attend the sick people. If we all run away, then all sick people will die, because there is no access to health.”

– CHC Comoro Manager.

A couple, both nurses from East and West who got married during the instability, were threatened but they were not afraid to stay in Bairo Pite Clinic and continued to work. One of them said “Oh I could go to the districts, I could be a farmer but I’m not, I’m a nurse and I am going to stay here and keep working”.

Mr Antonio Caleres Junior (AC), one of the most senior health professionals in the health system, is a very experienced worker in three different administrations from Portuguese colonial to Indonesian occupation and to Independence. He was born on 26 November 1947 and graduated from the Academy of Nursing School in 1970. He had his first job as head of the school health program until 1971 and was then elevated to Director General of the District Hospital in Ainaro from 1972 to 1975.

During the Indonesian period, he held several important positions including as the Head of the Nursing School in Dili. During Independence, he took part in the Interim Health Authority and Division of Health Service. He was appointed as National Hospital Director from 2004-2008 and currently serves as Health Inspector.

He played a crucial role during the instability running the hospital and looking after approximately 4000 – 5000 IDPs sheltering in the hospital. He was very instrumental in keeping the hospital running and, at some point, he also prevented tension among health workers in the hospital. He was able to undertake this task because he was trusted by most of the health workers, or as he put it: “they all trust me because of most of them were my students, even though [they were] not my students but I also worked as a civil servant in Indonesian time. Most of them called me Pai [meaning father in Portuguese], so they trust me”.

AC and his staff at the National Hospital also successfully managed to reduce tension between families, relatives and colleagues of wounded victims admitted to the hospital from both the Army and the Police forces. A war of words and threats between followers of the two forces had taken place in the hospital grounds. This imminent fighting between the members of the two forces was prevented by AC and his staff by calming them down and reminding them about the duty of the hospital to serve humanity regardless of political affiliation.

Their effort allowed care for both patients to be continued and peace was maintained in the hospital grounds. This was just a small example of how health workers can play a role as a “peace maker” and “conflict preventer” in conflict settings.
Box 4. The story of Vita de Oliveira Santos
A midwife at the National Hospital

Ms Vita de Oliveira Santos (VO) is originally from Lospalos, Lautem district, on the far eastern tip of Timor-Leste. She was born on 9 February 1969, graduated from Nursing School in 1991, and completed a one-year midwifery course in 1992. She was immediately posted to Quelicali Community Health Center, Baucau, on the north coast, in the centre of the country, for about 6 months and moved to work as a village midwife in Osoala, Baucau until 1999.

During the transition period she worked with the International Committee of the Red Cross. VO was officially recruited as a midwife in 2001 and was posted at the maternity ward, Dili Hospital National Hospital until 2009. In 2010, she was doing her Diploma 3 in Midwifery at the Institute of Health Science.

During the crisis in 2006, VO was displaced a number of times. First she and her daughter sought refuge for 2 weeks, due to instability, in the United Nations compound known as Obrigado Barrack, while her husband and her son tried to stay on hoping the situation would return to normal. As the situation deteriorated, her husband and son were unable to join them at Obrigado Barrack but instead ran away to their place of origin in Baucau. With the help of a priest, she and her daughter were taken to Baucau to join the rest of the family.

VO and all other health workers who were displaced to Baucau were requested to report to the District Health Services (DHS) in Baucau. According to the MoH instruction, the DHS issued a temporary assignment letter to them to allow them to work in Baucau. VO was assigned to work at the Baucau Regional Hospital and she was placed in the Operating Theatre. She worked at this hospital for about 2 to 3 months before returning to Dili.

She said as a civil servant she had to work and added that going to work was also helping them to get over their own family stresses. She did not know why the MoH posted her to the Operating Theatre as this was new to her and she needed to adapt herself. However, she learned new things from her new workplace and managed to transfer some skills to hospital staff in Baucau. She acknowledged that she was not as energetic as the other workers already at the site; and described her new colleagues as very friendly, supportive, and that they worked together very well.

As the situation seemed to have stabilised, the family decided to come back to Dili. VO’s husband was an MoH staff member. In Dili, they did not have a place to go to because their house had burned down and their usual neighbourhood was insecure. With help from the MoH staff, VO and her family were provided with a tent and were allowed to camp in the National Hospital grounds. They camped together with about 4000-5000 IDPs in this hospital.

The hospital management in Dili posted her to her old workplace, the maternity ward. She received a warm welcome from her friends and they helped her to be “at home” at the maternity ward. She described living in a tent as very tense and miserable, explaining that their camp came under constant attack from rival gangs operating in that area. She acknowledged that this insecurity affected her during the performance of her duties because she had to think about the safety of her family and her belongings. They had to carry their belongings in and out of the tent all the time.

Camping at the hospital site was the longest period they had ever spent in a tent. They camped until the hospital camp was closed by the government around July 2008. They stayed in a temporary camp at Unital Becora for a few months before finally leaving the IDP camp and moving to their current house.

When asked how she treated patients with different ethnic background, VO said: “I am a midwife, I know there are Lorosae and Loromonu but I know that he/she is a sick patient, I need to save his/her life. I knew before undertaking my profession I also took oath (professional oath). I cannot differentiate them, this is Lorosae or this is Loromonu, I know that people come to hospital because they are sick. I serve them according to what I know and according to skill I have…We cannot say this is Lorosae or Loromonu. We feel sorry if we had to say this, when they (patients) come to hospital, who is going to provide health service to them?”
In times of crisis, motivation from leaders is important because it can help staff/workers overcome their fears and enable them to perform their duties in difficult situations. This high motivation to work regardless of the security situation was noted.

“Nurses were not afraid, doctors were not afraid because they believe that what they do is humanitarian mission. Because of this their motivation increased more and even in the difficult times in which gun fires were heard everywhere ... and I in my capacity as the President of Nurse Association conducted a special meeting all nurses at Guido Valadares National Hospital to re-emphasise our motivation to work, it needs to be stronger in difficult times, in difficult times in which many people were worried that they would lose health assistance, we need to motivate ourselves to provide health assistance much better, in spite of some nurses, many have their house burnt, destroyed, some became of victims of Ambonese arrow, got stoned and hospitalised, however, the motivation was not dead and they continued to carry on their health duties, something that I noted very important in difficult times.”

In short, leaders and individual health workers themselves all played a part in cultivating the spirit and motivation to work in difficult environments. Leaders should continue to boost the morale of health workers and be available to work side-by-side directly and indirectly. They should lead by an example which can be followed by their subordinates and front-line health workers.

3. External HRH support:

Continued support from development partners

One cannot credit everything to Timorese MoH, the engagement of the development partners was just as important as the local engagement. Donors created a Flash Appeal Fund to seek funding to assist the emergency response and they also participated actively in the health coordination meetings, which were very crucial for maintaining the provision of health services.

“One cannot credit everything to Timorese MoH, the engagement of the development partners was just as important as the local engagement.”

– MoH’s emergency coordinator.

“Above all firstly the MoH is a well-organised ministry, everybody has his/her roles, this is good, there is also good orientation between directors, directors and head of departments, between programs. Furthermore, maximum support from NGOs and international agencies like UNICEF, UNFPA, WHO, Care International, TAIS, Church’s clinics, we see that everybody is passionate to cooperate with health because we have strong organisation, there are of course some people that were not so active, that is a minor thing.”

Support from development partners not only took place formally at coordination meetings, it also penetrated down to individual relationships between national and international actors on the ground, which turned out to be a crucial factor for strengthening coordination at the implementation level. At the height of the crisis, where Timorese staff were too scared to travel, it was through personal friendships that had developed over time that the international staff came to help. They went down to the field to assess the situation and would give feedback to the national staff in coordination meetings for decision-making.

“During the emergency time the NGO peoples could walk freely but not for us East Timorese. The Malae [foreigners] could freely go anywhere to give the [assistance] but it was difficult for us. So at that time I found a friend – her name is Sarah Moon, she is Malae. I told Sarah please help me just to check if you could go to the field to see the situation around during the emergency and to see about the service going on at that time and to tell me what was happening and what were the difficult things.”
– MoH’s emergency coordinator.
Mr Joaquim Soares dos Santos (JS) and Mr Jose da Costa Maher (JM) are ambulance drivers. They have been working as ambulance drivers since the establishment of the national ambulance service. There are six ambulances drivers, five national staff and one for Dili district. The 12 districts also have one ambulance driver each. So, in Dili alone there were six ambulance drivers.

JS and JM told their stories and difficulties including threats they faced in their duties during the 2006 political instability. They both were chosen on purposive and convenient basis, but their stories generally reflected what the ambulance drivers experienced in the Timor-Leste crisis. They both were high school graduates and had some training on ambulance service and first aid.

They said that the ambulance service was operational for 24 hours during the crisis; many times they had to sleep at the ambulance headquarters and did not go to their homes just because the work required them to be ready to evacuate patients and accident victims, including gunshot victims, anytime and anywhere.

According to them, if the ambulance service was operational and they did not perform their duties during the crisis, they could not imagine what would happen to patients and victims. There would be many patients and gunshot and slingshot victims left unattended. They always managed to respond to the call-outs and went to the sites of troubled areas to collect the victims, as well as to IDP camps and homes to collect patients. They faced many threats to their personal safety and even four of their ambulance vehicles were stoned. All windows and the bodies of those four cars were severely damaged.

They commented that the worst situation they faced was the fights between easterner and westerner gangs, and the fights between the martial arts groups. They said the fights between the Armed Forces and the Police Forces were not so dangerous because people from these two institutions already recognised them and because they already had working relationships before the crisis. However, with ethnic gang fights and martial arts groups it was very dangerous because they did not recognise the ambulance.

JM described how he was once threatened by a martial arts group who thought he was from another martial arts group. He managed to convince them that he had come to evacuate one of their fellows who was wounded. He was allowed to take this wounded victim, but he was told he would be killed if he did not obey their order to take this patient to Bairo Pite Clinic and not to the National Hospital. During the crisis, in Dili, only the National Hospital and the Bairo Pite Clinic became the referral points. Asking what they did to respond to those threats, JS said: “Before the crisis, we had a role, when we evacuated a patient, we took him/her straight to hospital” but during the crisis they just followed what people said and chose “if they chose to go to hospital, we took them to hospital, if they said to go to Lanud we took them to Lanud”. “Lanud” referred to Bairo Pite Clinic, the actual location of this clinic.

Asking what motivated them to continue to work despite their personal safety risks, JM said that it was their motto, “Fo neon fo laran ba moras no kanek – Give hearts and minds to the sick and the wounded”, that elevated their spirit to continue working in difficult times. This was reinforced by his colleague JS who added “our spirit as what is written in our motto, we hold on to this firmly, so if we did not go down, who else would be able to go? As I said when we drove in the city, we saw only dogs and cats that crossed the streets, who else would be brave to go out, apart from us. So, in the crisis situation, like or not, we had to be ready, as said in our motto”.

Both JS and JM gave messages to other health workers, JM’s message was that as health professionals providing health services during a difficult time, the key was that there should not be favouritism of one group over the other, there should not be favouritism to family. He stressed that their mission was to save lives and that they were always ready to help whoever was in need of their help. They had a unanimous message to leaders: that the crisis should not be allowed to happen again because they witnessed for themselves some horrific things. They also had their personal concerns: they had worked hard during the crisis, sometimes sleeping at the ambulance office to work for 24 hours just to evacuate patients and victims who needed emergency services, but sadly they had not received any reward or any overtime payment for their work.
Box 6. The story of Luisa da Costa
IDP Seminary Maior, Fatumeta

Ms Luisa da Costa (LC) was born in Dili, from Uatucarabau father and mother Remexio, Aileu. She completed Nursing School in 1992 and was posted to CHC Malao, Dili, from 1992-1999. Previously, since 1985, she had worked as a Nurse Assistant. During the transition period, she worked at Bairo Pite Clinic from 1999-2001. She was recruited as a civil servant and posted to CHC Comoro from 2001-2009. Luisa is now doing D3 at ICS Dili.

LC and her family were displaced to IDP camp Seminario Maior once the worst violence broke out on 23 May 2006, when the government soldiers were attacked by rebels. This IDP camp housed about 7000 to 8000 IDPs. The Cuban doctors had provided medical assistance since this IDP camp was established.

At that time LC was still able to go to work at CHC during the day, while at night she attended sick people who needed emergency health services. She became the point of contact between the IDP camp and the ambulance and the national hospital. In June 2006, when there were increasing gang fights, she was asked to provide a health service at this IDP camp until the camp was officially closed in December 2008. The 24-hours fixed clinics went on until December 2006 when the Cuban doctor and LC provided health services. From January 2007 to December 2008, the Cuban doctor still provided medical services on a daily basis, and LC continued to provide health services day and night. She reported to CHC on a weekly basis. When the Cubans did not come she provided services alone. With Cubans, sometimes patients were afraid to go to them because of language difficulties.

LC said that she was able to provide clinical work at the IDP camp because it was “a duty of profession, as a nurse I should help people at good and bad times” and she also added “it was my responsibility as a staff (government worker), so instead of sitting around doing nothing at camp, I helped people”. She received support from her husband and her superiors to do her work.

She said one time, when she and her husband were outside camp, there was a call from the IDP camp about a patient needing immediate medical assistance. She was called to go quickly to the camp. While they were riding the motor bike on the way to the IDP camp, they were stopped by gangs who threatened to kill her. They talked with their attackers and told them that she was a nurse and that she was called to help a patient inside the IDP camp. Finally she and her husband were allowed to proceed, but she said it was a very scary moment. In difficult times her husband always gave her encouragement and moral support by saying “when we did not commit wrong things, we should not be afraid”.

Seminarians also provided support to her.

The clinic at the IDP camp was also very busy, attending to around 200 patient in the daytime and around 50-80 at night. Health services were not only provided to IDPs inside the camp, but surrounding communities also came to seek help. Major health conditions encountered at the IDP camp were upper respiratory infections, malaria, diarrhoea and skin diseases. LC recounted an incredible story in which she and Dr FB helped remove “rama ambon – a metal arrow which gangs used to fight each other” from a patient. At that time the fighting was very intense, an ambulance was called but didn’t turn up. So she and Dr FB had to perform surgery to remove the “rama ambon” on the veranda of Dr FB’s house. As Dr FB had since passed away due to sickness, LC could not hold back her tears when she told this story.

She said that she was proud because although the environment at the IDP camp was not as conducive as in the CHC, because the space was so small and lacking equipment and drugs, she was able to help people. Asked how she treated patients from different a ethnic background, Luisa said: “I treated patients without differentiating them because I treated them as patients”.

She received encouragement from Mr MS (Head of DHS Dili at that time) and also from the Minister’s message on radio and TV. These types of supports and encouragements helped her to perform duties in difficult situations. LC is proud of what she did because she could help many people and could also practice her profession. She could help IDPs and her family and relatives.
The Cuban Medical Brigade - availability of additional foreign health workers

The presence of the Cuban Medical Brigade (CMB) in Timor-Leste in 2006 was vital and proved to be very important in assisting the health response at the time of instability. At the time of crisis, the CMB in Timor-Leste had 210 doctors, 22 nurses, and 35 health technicians (radiologists, laboratory workers, electro medical workers, anaesthetists and pharmacists). Cuban doctors were placed at hospital, district and sub-district levels. During the crisis 30 Cuban doctors were called from districts and redeployed into Dili to help provide medical services at IDP camps.

Among more than 60 IDP camps, 13 had 24-hour fixed clinics while the others were regular mobile clinics. Big camps with 10,000 or more IDPs were usually equipped with 24-hour fixed health clinics.

The placement of Cuban doctors in IDP camps was jointly discussed by the MoH, CMB coordinator and the DHS Dili district. The presence of CMBs in this particular situation provided surge capacity to enable the health sector to quickly provide medical assistance to IDPs in camps and contributed to the overall performance of the MoH. During the height of the conflict, most medical staff present in the IDP camps were from the CMB.

“I think daily presence strengthened a lot the capacity to service delivery and the IDPs both in quantity and in quality as well because if we didn’t have enough amount of Cuban doctors to support us we were going to rely on the Timorese doctors and nurses and midwives who we have to underscore this, at the peak of the incident and also in the time surrounding that area were very emotionally affected by fear ... so going to an IDP as an East Timorese was not very easy at that time ... so I think the presence in terms of numbers were very helpful and I would not say that this is because they are Cubans even if for example we have a big contingency of let’s say American or Australian doctors here during the crisis they would do the same thing obviously because the tensions and the conflict was mainly between Timorese and to some extent it spared the expatriates, the expatriates were not targeted and therefore they were not afraid to go to the camps and provide services and helping the people but one particularity is that there was also good coordination with the leadership of the Cuban medical team. They have a leadership in the group and the coordination was really good, the coordination was very good.”

The importance of the CMB presence in big numbers in facilitating the emergency response was also echoed by the Vice-Minister and a senior MoH adviser.

“It is not good if I just comment only Cuban doctors, because not only Cuban doctors deliver the services, but I can say that the big numbers, the big numbers are from Cubans, also from their formal training, they are well coordinated... [about] 50% doctors from districts came to give support in Dili here.”

“I think the medical assistance, clinics and perhaps more the set-up of that was very successful and there are two factors on that. One was that it was given the responsibilities were distributed and in this case it was the Head of the Dili District Health Centres, Mr M who was in charge of that and we have the opportunity to mobilise the Cuban doctors and that was extremely useful and they have done a marvellous job, dedicated with participation working throughout.”
– Senior MoH adviser.

Other development partners engaged in the emergency response also noted the valuable contribution from the Cuban Medical Brigade:

“There were the head of the Cuban who was leading, he coordinated a lot with the Ministry of Health which was great. They responded very quickly and they had 24-hour health service in many larger camps which is amazing.”
– Bairo Pite Clinic program manager.

“I found government did excellent job, at all levels but particularly in health sector, they were probably managing the situation and with the Cuban doctors that participated in the organisation, with UNFPA, with the organisations that are working in health.”
– UNFPA.
CHALLENGES AND CONSTRAINTS

Apart from the MoH’s commendable early planning, and the decisions and actions which were facilitated through HWG’s regular meetings, there were some contextual factors that constrained the emergency response. The major challenges were: the magnitude of violence, the fact that the security forces were involved in conflict with each other, the ethnic identity attached to health workers, the displacement of health workers and the focus of the crisis in the capital city. Pre-existing inadequate human resources and financial and materials resources further aggravated the crisis situation.

The magnitude of violence and the chaotic situation it created was beyond any expectation, so the country did not have the capacity to respond. The National Hospital Director described it thus: “at any point, we never thought that people would shoot each other or kill each other but we just thought of people fainting or hungry, that was our preparation.”

The instability occurred in the capital of the country where government power was located. This reduced the capacity of various institutions to respond because of the disruption to central governance activities, including those in the MoH. Consequently, the insecurity impacted on the health managers in carrying out their duties. MoH and MTRC were the only two government ministries functioning throughout the crisis.

“I think that to some extent in the whole crisis here it has been a certain concentration on Dili here. Basically [it is] here is Dili that they do a lot of events coming and going and where there had been a lot of insecurity so we talk about the whole crisis. Yes, it has been a national crisis with a lot of dimensions from the political and different areas and there has been a feeling that it was a true failure of the state that it was a breakdown of the public sector. There was a complete breakdown of credibility.
– Senior MoH adviser.

State security branches were part of the conflict and this no doubt intensified the climate of insecurity. In Timor-Leste’s crisis in 2006, the army and police became part of the conflict, peaking with an incident where some armed forces opened fire upon unarmed police, killing nine and injuring 27. In many conflict settings, the armed forces and the police are used to neutralise or contain the conflict and would be the first elements/forces to be mobilised to respond to communal conflict or natural disasters. However, as the army and police became involved in the conflict themselves, they had difficulties fulfilling their normal roles.

“After 28 of April the situation became better, but on 25 of May the technical preparation was going well, but at that point we didn’t think about the two big institutions would go against each other (PNTL vs FFDTL), we didn’t think that.”

Staff displacement was an important issue affecting the emergency response because it reduced the capacity of institutions to respond to the crisis, more so in a health system with pre-existing HRH inadequacies.

The crisis had unintended ramifications along ethnic lines between East and West Timor. Health workers and senior staff of the MoH belonged to one or the other of these two ethnic groups. The main concern of MoH leaders was to make sure health workers were not getting drawn into the issue. In most respects, the MoH managed to overcome this potential very well, but there were some verbal arguments between staff in the National Hospital and in one CHC. The MoH leadership was aware of these isolated incidents.

“Closely related to the ethnic identity of each one because it’s a small environment, people know each other, people know that this nurse, this doctor, this midwife, is from the East, for example, or is from the West and may be targeted. I’m not saying that this group of people were really part of dealing with the conflict but the impression, the fear, of oneself, about this reality was there ... so that affected a little bit of the performance.”
There were also heroic examples where health workers acted as peacemakers to prevent fighting between army and police; when injured personnel from both forces were admitted to the National Hospital. Health workers and senior managers in the hospital did their best and finally convinced the two factions not to fight in the hospital, to lay down their guns and obey the advice from health workers. Health workers reminded both sides that the hospital’s duty was to serve humanity, to serve all people, and that it was a place to care for the sick and not a place to fight.

“When it happened we came to think that it was like a big Home Work for us [it was constantly on our minds] because from [the] Police Force, there was many police members got wounded and were sent to surgery wards for females, there we put two nurses to attend them and two other nurses to wait outside the window to maintain the security, if there was any one wanted to go in they had to write their name and needed to ask first whether he/she could be received or not. Then the next group from F-FDT also came, we put the wounded troops in the VIP ward, so that they can stay far away from each other, and also we put two nurses to look after them and two other nurses to maintain the security from outside. The police people or their relatives said to the F-FDTL’s relatives “kill the assassins”, from the F-FDTL part, they said to police relatives “those traitors must be killed”. So we don’t know which one we can trust, which one was true. So we told them that you all come here as wounded people or victims so you have to leave this thinking outside, and forget it. In generally those who are victims didn’t say anything, just their family, the big mouth, usually women, even the children spoke this kind of thing, some families came in drunk condition, some of them rolled up their shirt sleeves. In the beginning we seemed to be confused but then we set up the meeting to make things working… So in wards we had to organise,

“I always say this: all incidents will test our vocation as health personnel… despite one small thing, small thing happened in CHC Comoro, but we immediately resolved it, we made a declaration and informed them that they must not say things like that [in the] workplace.”

There were also heroic examples where health workers acted as peacemakers to prevent fighting between army and police; when injured personnel from both forces were admitted to the National Hospital.

even in the door of the wards had to be organised as well. The problem is about the visitors and the journalists – we needed to limit them. We could not give the information, we chose one doctor as spokesperson for the victims. To talk about the private problem of victims we had to wait until the doctor agreed, and he/she had to accompany the victim going to the special room and then ask the victim whether he can respond or not.”
INNOVATIONS AND EMERGING LESSONS

Responding to emergency needs during a conflict situation is a humanitarian call to provide basic minimum standards of care to affected populations. This grew out from a simple humanitarian action shown by Henry Dunant, who witnessed the suffering of wounded soldiers in the battlefield in the aftermath of the Battle of Solferino between Franco-Sardinian allies and the Austrian Army in 1859. This led Dunant to establish the International Committee for Red Cross, to provide impartial care to people affected by wars and disasters [MacQueen et al. 1997]. In addition, the Geneva Convention 1949 defined standards for humanitarian treatment of the victims of war.

From there, humanitarian response has evolved to include food, shelter, health and water and sanitation [McConnan 2000; The Sphere Project 2004]. To deliver an effective minimum standard of health care for a population during a conflict requires adequate material, financial and human resources. It is not uncommon that during conflict, resources, including human resource, are limited; therefore, they must be allocated in such a manner that provides the greatest benefit to the greatest number of people. This echoes the importance of prioritising public and primary health interventions [Brennan & Nandy 2001]. One of WHO’s six building blocks for strengthening health systems in fragile states is human resources [Health & Fragile States Network 2009].

In the Timor-Leste experience, the crucial points which enabled the health sector to function and execute its responsibilities in the 2006 crisis were making early decisions on intervention planning; the delegation of decision making to mid-level managers; coordination with development partners, the existing Timorese and Cuban health workers available at the time of crisis; the use of displaced health workers; and the continuous support and message of impartiality and professionalism from MoH leaders.

Those supporting factors described above can be broadly grouped into five “enabling” themes:

1. Leadership
2. Coordination
3. Timely available expatriate health workers in large numbers
4. Innovations in utilising available human resources in the country
5. Values that boost staff morale high to enable them to continue working in difficult environments.

These ‘enabling’ factors are paramount for a health system to function and for health workers to continue their professional duties at such times; thus enabling continued access to health services by all parties in difficult settings.

As seen in Timor-Leste, by building on the respect they have in communities due to their professional roles, health workers can gain the community’s trust, enabling them to be a useful asset for conflict prevention and peace-building. The following discussion focuses on the analysis of the ‘enabling’ factors and health workers’ role in conflict prevention and peace-building.

1. Leadership

In this analysis, two definitions of leadership are used. First, “leadership is a process whereby an individual influences a group of individuals to achieve a common goal” [Northouse 2004]. The second is “leadership is ultimately about creating a way for people to contribute to making something extraordinary happen” [Kouzes & Posner 2007].

The former describes leadership as a process and an influence that takes place in the context of a group with an objective to achieve a common goal. It basically entails the power relationship between leaders and followers.

In the latter definition, leadership is the ability of an individual to create an enabling environment which allows other individuals, presumably in a group or organisation, to contribute maximally to produce an extraordinary outcome. In other words, an extraordinary thing would not be achieved without an inspiring leader.

These two definitions are best suited to describe the leadership of the MoH senior officials during the crisis in 2006, as they played a crucial part in influencing health workers to continue work under difficult circumstances (an extraordinary environment).

This strong leadership from the MoH also facilitated coordination and positioned the MoH at the head of the overall coordinated health response. Without
strong leadership coordination can be ineffective and/or be taken over by other actors. If this happened, it would undoubtedly undermine the capacity and the legitimacy of government.

Examples of weak government legitimacy and/or the absence of a legitimate government that prompted international actors to take over leadership and coordination in responding to population needs in conflict settings have been observed in many settings, such as in Cambodia [Lanjouw et al. 1999], El Salvador [Borgh 2005] and to some extent Timor’s own experience during the post-referendum violence in 1999 [Alonso & Brugha 2006].

During the 2006 crisis, leadership was about making anticipative decisions to avoid and/or to confront the worst; this happened when the MoH made a decision as to which sites needed to be secured and kept functional at all cost.

Leadership was also important in keeping the spirits of health workers up, so they could continue to work in difficult circumstances; by reminding them that the very essence of being health workers is to serve others who need health assistance.

At the height of the crisis, Timorese people were polarised by the East-West issue and were aware that local health workers were from both places. Without strong leadership from the MoH, the East-West issue could also have easily divided health workers, putting health service delivery at risk and potentially leading to the collapse of the health service. So the MoH’s leadership was invaluable in influencing health workers not to be influenced by any divisive issue and enabling them to continue to undertake their duties in serving the whole population of the country.

Timor-Leste’s experience clearly demonstrated the core essence of leadership: the ability of a leader to exert his/her influence over his/her staff to create an environment where staff could work through difficult conditions to achieve a common goal (the survival and functioning of an organisation) and/or to achieve an extraordinary objective (delivering health service to IDPs while risking their own safety).

the qualities that a leader should possess to confront challenges in difficult settings.

One important point that also needs to be noted is that all health workers, including those displaced to districts and IDP camps, continued to have their salaries paid. This demonstrated that leadership even in crisis time, still continued to pay attention to their staff’s welfare.

2. Coordination

The Cambridge English Dictionary defines coordination as “the act of making all the people involved in a plan or activity work together in an organized way” [Cambridge University Press 2008]. Coordination in humanitarian action is needed to ensure people affected by conflict have access to health services.

In practical terms, coordination should be a sharing of responsibilities to prevent a duplication of effort [Martins et al. 2006], so that resources can be equally allocated and used effectively to address the needs of the affected population. In 2006, coordination was also one of the key factors that contributed positively to the overall performance of the health sector in responding to that instability.

Coordination and leadership go hand in hand. It was strong and attentive leadership and the continued guidance from senior MoH leaders that enabled coordination with development partners (UN agencies, NGOs, UNMIT, international forces, private...
The availability of the Cuban Medical Brigade contingent was crucial in keeping the health services operational, particularly at the height of the violence when local health workers had to face the East/West issue.

clinics and professional associations and others) to take place. Leadership helped remove barriers which otherwise might have contributed to ineffective coordination, leading to poor provision of health services and, in a worst case scenario, coordination could have been taken over by other actors, which could be damaging to the functioning and image of legitimate government.

Coordination can sometimes be difficult to undertake. As Brabant put it: “everyone wants co-ordination but no one wants to be co-ordinated” [Brabant 1997] which, if allowed, would adversely affect the humanitarian response. Several factors contribute to the potential for effective coordination, such as the different mandates of each organisation, different target groups, the desire to maintain independence and identity, or simply poor leadership [Brabant 1997].

Coordination requires those involved to have the authority to make decisions and to understand the political environment in which humanitarian action during a crises takes place [Borton 1996]. That was what occurred in the HWG in which the MoH coordinator was given the authority to make decisions on coordinating multiple actors in planning, organising and implementing the emergency response.

3. Timely available expatriate health workers in large numbers

The availability of the Cuban Medical Brigade contingent was crucial in keeping the health services operational, particularly at the height of the violence when local health workers had to face the East/West issue. The CMB was called in from districts and re-deployed in Dili at short notice. They were assigned to run the 24-hour fixed health clinics and the mobile clinics in camps in and outside Dili. Some CMB were also redeployed into the National Hospital.

The conflict was an internal conflict between Timorese; therefore, foreigners (including Cubans) were not the target of the conflict and could move around freely. This provided a neutral health workforce to attend to the needs of people at a time when suspicions among Timorese society were very high.

Therefore, the presence of the CMB during the 2006 instability in Timor-Leste was very fortunate and useful in terms of providing a surge capacity that enabled health services to be delivered to the affected population when local health workers were unable to be rapidly mobilised. Their presence also reinforced government’s existence at that time and reassured the people that the government was still able to meet its responsibility to provide health services to the IDPs and the general population.

If there was no CMB in Timor-Leste at the time of conflict, health authorities would have faced a serious problem in maintaining the delivery of health services to the IDPs in camps, the national hospital and health centers around the capital. The 24-hour fixed clinics in camps may not have been established particularly at the height of conflict.

If this had happened, it would have had serious implications on population health, for example, people who needed health services may not have been attended to and the risk for potential disease outbreaks may have been increased. It would also reduce the trust in the government by people who were affected by conflict at that time which could potentially have worsened the conflict or triggered new conflicts.

4. Innovations in utilising available human resources in conflict settings

It has been documented in many settings that armed conflicts may cause a sudden and dramatic loss of human resources due to people being displaced, killed, kidnapped and/or migrating to other countries [Betsi et al. 2006; Borgh 2005; Macrae 1997; Pavignani & Colombo 2001].
Conflicts and complex emergencies can also destroy training institutions, which will have implications for future HRH development [World Health Organization 2005]. On the other hand, human resources in emergency response are extremely necessary to allow health services and programs to be delivered.

In the Timor-Leste crisis in 2006, several important innovations related to HRH were used to assist in the emergency. These innovations included: allowing health workers to stay at the service area, utilising displaced health workers in camps to assist with service delivery, allowing displaced health workers to go to districts to report for work and accommodating them in the nearby health facilities and health offices, and making cash available where necessary.

Allowing health workers to stay in the service area, most notably in Dili National Hospital, SAMES grounds and in Bairo Pite Clinic, was crucial to keep these health facilities operating during the crisis. These health workers sheltered in the hospital grounds with their families while also continuing to perform their normal duties. This was one of the factors that allowed the National Hospital to remain functional and to offer health services during the period of instability. This was an innovative way of retaining health workers at health facilities and to keep them operational during conflicts.

However, there were also some downsides from accommodating IDPs and displaced health workers in the hospital compound. It undoubtedly placed enormous strain on resources, particularly water and sanitation, created an “insecure” environment for patients and hospital staff, and affected the overall function of the hospital.

Accommodating hospital workers and IDPs had also occurred in a hospital in Northern Uganda, during the civil conflict and Ebola epidemics. The displaced health workers in that hospital continued to work and supported the functioning of the hospital [Hauck 2004].

Some displaced health workers in IDP camps in Dili also voluntarily came forward to offer their services in the IDP camps. They worked side-by-side with Cuban doctors, Timorese and DHS staff from Dili District, and with NGOs to deliver health services in the IDP camps. The duration of services offered by displaced health workers varied from weeks to months depending on how long they stayed in the camps (see Boxes 4 and 6).

As some health workers were displaced to districts (most to districts of their origins), the MoH issued a policy to ask these displaced health workers to report to health authorities in the respective areas. They were requested to work temporarily in those areas until the security situation permitted them to go back to their original posts (see Box 4). The announcement was made through local media (radio, TV and newspapers) and also through normal MoH communication lines.

Providing cash, without good faith and accountability, to a person in a crisis situation can be risky. However, Timor-Leste’s crisis proved that the cash made available to a senior MoH official was also a key to facilitating the running of the MoH system during the emergency period. It allowed the emergency response team to purchase items urgently needed, including buying fuel and meals for staff. It also helped the DHSs to function; districts were unable to submit and request normal petty cash because there was no staff to process claims. With this cash available from a MoH official, districts could directly request the amount of money they needed to meet their immediate needs.

An unofficial but pragmatic approach of using health workers based on their ethnic background to deliver services to their ethnic population, in an extremely tense situation of ethnic tension, can be an effective strategy to respond to emergency health needs, such as the evacuation of patients.

A strategy was applied by field managers, for example, if an area was populated by people from one ethnic origin and there was a request for an emergency victim evacuation, it would be sensible to send an ambulance driver from the same ethnic background. This would avoid unintended risk for the

In the Timor-Leste crisis in 2006, several important innovations related to HRH were used to assist in the emergency.
One important element that enabled the health sector to survive and to execute its mandates in meeting the needs of IDPs during the period of the instability in Timor-Leste in 2006 was the values that existed in both individual health workers and the MoH ...

ambulance driver and also for the safe evacuation of the victim. However, this practice should not be condoned in normal security situations as it can be seen as discriminatory and may aggravate the widening division in a community where ethnic division already exists.

5. Values that boost staff morale to work in difficult environments

As discussed earlier, health workers can become victims of violence by warring factions and often they are deliberately targeted, either being killed or kidnapped, as has been observed in many conflict settings in Africa and Latin America [Borgh 2005; Pavignani & Colombo 2001]. This can diminish the motivation of health workers and can prevent them from performing their duties in difficult environments.

One important element that enabled the health sector to survive and to execute its mandates in meeting the needs of IDPs during the period of the instability in Timor-Leste in 2006 was the values that existed in both individual health workers and the MoH. This became a source of resilience to help the health system to withstand the crisis. Resilience is the ability of an individual or an institution to withstand and rebound from crisis and adversity [Froma 1996; Ungar 2005].

The values displayed were professionalism, neutrality, impartiality and upholding professional oaths to serve humanity. These values rest within the individual health worker, are nurtured by individuals and associations of professionals and by the employer, the MoH. When these values are upheld they help individuals and/institutions to overcome adversity and to undertake tasks in challenging difficult environments.

During the crisis, senior MoH leadership always reminded health workers on every occasion that they should remain impartial and not take sides in performing their duties; they should carry out their duties as health professionals. They should live up to their professional oaths to perform their duties by respecting patients’ dignity without discrimination based on ethnicity, race, religion, social and economic status, and political affiliation. They should carry out their duties to serve humanity and respect people’s right to life and access to health care.

These values were introduced to every health worker as part of their education as health professionals. Neutrality and impartiality are crucial factors for enabling humanitarian actors to get access to populations across battlefield lines and to operate in the midst of violent conflict without becoming party to it [Buhmann et al. 2010]. For these values to grow and to become an inseparable identity of a health worker or an institution, they need to be nurtured.

Stories drawn from the experience of individual health workers demonstrated the strength of these values in guiding them in their determination to act in difficult times. The values and strengths which emanated from health workers and health managers were a contributing factor for the health sector to maintain its functions. Without these values, health managers and health workers may not have been inspired to assume their responsibilities, which could have led to the collapse of the health system.

6. Health workers contribution to conflict prevention and peace-building

The involvement of health as an element for peace-building is a relatively new approach, dating back to El Salvador in the 1980s when UNICEF and the Catholic Church negotiated warring government and rebel factions to agree to the “days of tranquility” which enabled the halting of fighting from 1985 until peace accords in 1992 to allow for the immunisation of children [MacQueen & Santa-Barbara 2000]. This was the beginning of the WHO PAHO’s health for peace initiative known as “Health as a Bridge for Peace (HBP)”. On the basis of experience in El Salvador, the initiative was extended into Angola,
Bosnia-Herzegovina, Croatia, Haiti and Mozambique in the 1990s [Rushton & McInnes 2006].

Health can also contribute diplomacy and peace-building, and can achieve what might have been difficult or impossible for other sectors to undertake. This can be seen in the cooperation between Israeli and Palestinian and Jordanian health professionals [Jabbour 2005; Skinner & Sriharan 2002].

Often, health workers have a well-respected position in the community; sometimes they are the first ones to detect discontent and/or signs of conflict [Bunde-Birouste & Zwi 2003]. This can place them in a position to contribute to reducing the source of the conflict and thereby to help avoid or reduce violence, and build peace in society. This experience also occurred during the political instability in Timor-Leste.

Other authors suggest that health providers are uniquely qualified as lobbyists and advocates in determining humanitarian priorities without discrimination [Burkle 1999]. In the Timor crisis, indeed, health workers did display these qualities particularly in relation to their impartiality and not being influenced by their ethnic identity in providing health services to people affected by the instability.

The MoH as an institution had also played its part in preventing conflicts and/or at least preventing conflicts that could be generated by the lack of access to health services and/or avoiding conflict from getting worst. Had the MoH not been able to provide health services to the affected populations, potentially new instabilities could have been generated.

The position taken by senior leaderships at the MoH in ensuring health workers would not be influenced by their ethnic identity had the effect of keeping health services functional throughout the crisis period. This also prevented possible internal conflicts between health workers.

As described by some authors, despite health workers opting for a ‘neutral position’ in a violent conflict, not all people are able to see beyond ethnic identity [Buhmann et al. 2010]. This certainly is an issue that can emerge in ethnic conflicts and the MoH leadership was fully aware of such views. Some isolated incidents of verbal fighting between health workers could have led to divisions and conflicts, but were peacefully resolved by the leaders in the health system.

At international level, health contribution to peace-building has been recognised, with the award of the Nobel Peace Prize to ICRC (1917, 1944 and 1963), MSF (1999) for their work and dedication to serving humanity in conflicts and disasters, and to the International Physician for the Prevention of Nuclear War Prevention (IPPNW) in 1985 for its work campaigning against nuclear war in the 1980s and preventing potential nuclear wars during the Cold War [MacQueen et al. 1997]. These awards not only demonstrated recognition for their work and dedication to alleviating the suffering of people affected by wars, conflicts and disasters, but also their contribution to peace-building.
POLICY ISSUES AND IMPLICATIONS

This case study clearly revealed factors that enabled health workers and health systems to continue functions and to exercise their responsibilities to meet the health needs of populations affected by political instability.

These factors were leadership, coordination, timely availability of expatriate health workers, innovations in utilising human resources, and values that kept the morale of health workers high to enable them to perform their duties in difficult settings. Health workers should be neutral, impartial and professional in performing their duties. They should uphold their professional oath to serve humanity without discrimination.

This case study also highlighted that health workers are not merely needed to perform their duties to enable people to continue to have access to health services, but they (health workers) can also play an active role in preventing conflicts, thus contributing to peace-building. Figure 3 (page 39) was developed on the basis of evidence derived from this study and demonstrates how health workers can play their part as conflict preventers and peace-builders.

The challenges that health workers faced in the 2006 crisis in Timor-Leste arose from a conflict that had multiple dimensions ranging from political, military and ethnic to martial arts gang rivalry, creating general insecurity.

For the MoH, the main challenge was to ensure that health workers were not influenced by ethnic identity and, indeed, the MoH achieved this objective which contributed to the overall functioning of the health sector during the crisis.

This raises several policy issues as to how to support health workers to assume the responsibility to provide health services to populations in difficult environments. These include policy options ranging from education, training and establishing a disaster unit to providing recognition and rewards.

This case study offers four policy options.

Firstly, it is important to make sure that future health workers possess the values related to their professions. This can be done by incorporating ethics and the values of the profession into the curricula if there are none, and/or enhancing them if they are already in the curriculum. For current health workers, training and refresher courses could be provided on the ethics and values for health workers, and how to position themselves in conflict settings, in order for them to draw strength from their professional values. Individual strengths will ultimately contribute to institutional strengths.

Secondly, the MoH should also develop its own strategy to respond to conflicts and disasters, and define clearly the roles of individuals and agencies involved in such situations. These cover resource mobilisation, deployment of human resource and allocation of logistical resources to support essential interventions. The line of coordination authority needs to be defined, as do ways of making coordination work.

The crucial factor to make values, strategies and coordination work is to have a strong leadership. Under the current MoH structure, there is no department or unit assigned responsibility for responding to conflicts and natural disasters.

Therefore, it is recommended that a department or a unit should be created to prepare for and respond to these issues. The immediate task for such a unit is to prepare plans and strategies for prevention, preparedness, mitigation, response and recovery (including providing regular training on disaster response) for the system to be ready to respond if any conflict or disaster emerges.

Thirdly, the fact that health workers can be well respected by their community and they can earn the community’s trust needs to be recognised. Their position and the people’s trust in them can be a very valuable asset for involving health workers in peace-building initiatives. Health workers should also be involved in efforts to prevent further conflicts and to build peace in settings previously affected by conflict.

Lastly, we recommend that government consider the potential for providing a reward to honour outstanding health workers who have demonstrated leadership, dedication, and self-sacrifice to care for others in unthinkable dangerous settings. Rewards can be provided as incentives, such as a certificate acknowledging their roles, promotion in ranking, monetary rewards or an opportunity to pursue further training. Rewarding such health workers will set an example for other and future health workers to follow.
FIGURE 3. HEALTH WORKERS CONTRIBUTION TO CONFLICT PREVENTION AND PEACE-BUILDING

Health workers contribution to peace-building

Enabling factors
Leadership
Coordination
Availability of neutral workforce
Innovations
Values

Health workers working in conflict settings

Health system functioning

People having access to health services

Conflicts prevention & peace-building

Inhibiting factors
Insecurity
Personal fear
Absence of enabling factors

Direct involvement in mediating conflict through health initiatives and/or advancing humanitarian reasons
REFERENCES


### APPENDIX 1.

#### TABLE 6. MOH STAFF PROFILE 2005

<table>
<thead>
<tr>
<th>Category of post &amp; personnel</th>
<th>MoH</th>
<th>DNH</th>
<th>Referral Hospital</th>
<th>Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MoH</td>
<td>DNH</td>
<td>Referral Hospital</td>
<td>Districts</td>
</tr>
<tr>
<td></td>
<td>Bcu</td>
<td>Min</td>
<td>Mbs</td>
<td>Ocs</td>
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<tr>
<td>Population numbers (000s)</td>
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</tr>
<tr>
<td>Census 2004</td>
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<td></td>
</tr>
<tr>
<td>Population %</td>
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<td></td>
</tr>
<tr>
<td>Doctors/DMOs</td>
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<td>2</td>
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<tr>
<td>Dentists</td>
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<td>Environmental/Public Health/TB</td>
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<tr>
<td>Educators</td>
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<td></td>
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<tr>
<td>“Other” Health posts including admin/support</td>
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<td>75</td>
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<tr>
<td>“Contracted out” Posts</td>
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<td>34</td>
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<tr>
<td>Total posts in Health</td>
<td>101</td>
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<td>137</td>
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### APPENDIX 2.

#### TABLE 7. MOH STAFF IN 2007

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<th>Category of post &amp; personnel</th>
<th>MoH</th>
<th>DNH</th>
<th>Referral Hospital</th>
<th>Districts</th>
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<td>MoH</td>
<td>DNH</td>
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<td>Mln</td>
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<td>2006 population numbers (000s) from 2004 census projections</td>
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<td>43.2</td>
<td>58.6</td>
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<tr>
<td>Population %</td>
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<td></td>
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<tr>
<td>Doctors/DMOs</td>
<td>25</td>
<td>71</td>
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<td>10</td>
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<tr>
<td>Dentists</td>
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<td>0</td>
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<tr>
<td>Midwives</td>
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<td>Nurses</td>
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<tr>
<td>Techn (Lab/ Pharm/Dent)</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Educators</td>
<td>-</td>
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</tr>
<tr>
<td>“Other” Health posts including admin/support</td>
<td>107</td>
<td>75</td>
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<tr>
<td>“Contracted out” Posts</td>
<td>27</td>
<td>68</td>
<td>26</td>
<td>10</td>
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<tr>
<td>Total posts in Health</td>
<td>159</td>
<td>477</td>
<td>148</td>
<td>50</td>
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</table>
APPENDIX 3

RESEARCH QUESTIONS

- What have been the HRH challenges documented from Timor-Leste’s 2006 crisis in responding to health needs of the population affected by the instability?
  - How did the MoH mobilise human resources to coordinate the response and to actually deliver the response?
  - How did the development partners, particularly the Cuban Medical Brigade, support the human resources which enabled that services continued to be delivered during the heightened conflict?
  - What factors drove the health workers to continue working in the times of instability?
  - What are the possible risk factors that can hinder health workers to carry out their roles in period of conflict? And how can these possible risks be mitigated?
  - Was there any innovative strategy/idea that was used to maximise the existing available human resources at that time to respond to the crisis needs?
THE KNOWLEDGE HUBS FOR HEALTH INITIATIVE

The Human Resources for Health Knowledge Hub is one of four hubs established by AusAID in 2008 as part of the Australian Government’s commitment to meeting the Millennium Development Goals and improving health in the Asia and Pacific regions.

All four Hubs share the common goal of expanding the expertise and knowledge base in order to help inform and guide health policy.

**Human Resource for Health Knowledge Hub**  
*University of New South Wales*  
Some of the key thematic areas for this Hub include governance, leadership and management; maternal, newborn and child health workforce; public health emergencies; and migration.  
www.hrhhub.unsw.edu.au

**Health Information Systems Knowledge Hub**  
*University of Queensland*  
Aims to facilitate the development and integration of health information systems in the broader health system strengthening agenda as well as increase local capacity to ensure that cost-effective, timely, reliable and relevant information is available, and used, to better inform health development policies.  
www.uq.edu.au/hishub

**Health Finance and Health Policy Knowledge Hub**  
*The Nossal Institute for Global Health (University of Melbourne)*  
Aims to support regional, national and international partners to develop effective evidence-informed national policy-making, particularly in the field of health finance and health systems. Key thematic areas for this Hub include comparative analysis of health finance interventions and health system outcomes; the role of non-state providers of health care; and health policy development in the Pacific.  
www.ni.unimelb.edu.au

**Compass: Women’s and Children’s Health Knowledge Hub**  
*Compass is a partnership between the Centre for International Child Health, University of Melbourne, Menzies School of Health Research and Burnet Institute’s Centre for International Health.*  
Aims to enhance the quality and effectiveness of WCH interventions and focuses on supporting the Millennium Development Goals 4 and 5 – improved maternal and child health and universal access to reproductive health. Key thematic areas for this Hub include regional strategies for child survival; strengthening health systems for maternal and newborn health; adolescent reproductive health; and nutrition.  
www.wchknowledgehub.com.au
Human Resources for Health Hub

Send us your email and be the first to receive copies of future publications. We also welcome your questions and feedback.

HRH Hub @ UNSW
School of Public Health and Community Medicine
Samuels Building, Level 2, Room 209
The University of New South Wales
Sydney, NSW, 2052
Australia

T +61 2 9385 8464
F +61 2 9385 1104
hrhhub@unsw.edu.au
www.hrhhub.unsw.edu.au
http://twitter.com/HRHHub

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