



**DEMOCRATIC REPUBLIC OF TIMOR-LESTE  
MINISTRY OF HEALTH**

# **NATIONAL STRATEGIC PLAN**

**for Human Resources for Health (NSPHRH)**

**2020 - 2024**

**National Directorate for Human Resources**





# **Motto**

**There are no good and bad workers**

**There are well motivated and well oriented people**

**Also, disoriented and demotivated people**

**Our mission is to manage and improve them step by step.**



## PREFACE

The Ministry of Health, National Directorate for Human Resources has for the first time developed a "National Strategic Plan for Human Resources for Health 2020-2024", (NSPHRH) with the aim of accelerating Timor-Leste's progress for the delivery of health services in accordance with the Constitution's commitment to "provide universal health care in a sustainable manner" through a decentralised public health care system, in accordance with the RDTL Constitution, article 57 aligned with the national vision for "Healthy Timorese people in a Healthy Timor-Leste".



In order to achieve the above vision, the Ministry of Health continues to prioritise the fundamental area of human resources, in order to ensure the availability human resources for the health development plan, with adequate numbers and professional staff categories, distribution and skills, performance and quality standards and offering service delivery to the population in an ethical, professional and safe manner.

In the last few years, Timor-Leste has been able to achieve significant improvement in health indicators, including access to health, reduction of the maternal, new-born and child mortality rates, increased immunisation coverage, birthing in health facilities, reduction of malaria, access to treatment for tuberculosis, benefits from antiretroviral treatment for HIV/AIDS and others.

Going forward, the Government is concerned with the provision of sufficient quality services for the entire population. Attention is focussed on strengthening and improving the health system in this country, particularly for the National Health Services.

This strategic plan, has been developed to respond to the challenges that the Ministry of Health continues to face. With these challenges, going forward, the Ministry of Health will be making efforts to improve services in the areas of human resources, their distribution, professional career development, skills/capacities, career promotions, for those entering into the public services from the general and special career regimes and for those reaching the age of retirement.

This plan is ambitious but also essential for Timor-Leste to be able to maintain and improve the quality of services and improve health outcomes.

In order to bring benefits to our population, all of us - the Government, partners, community and civil society are determined to unite our forces for the successful implementation of this strategic plan. We (will) always face significant challenges, but using our knowledge and resolve, we will achieve our goal.

  
**Drª Élia A. A. dos Reis Amaral, SH**  
**Vice-Minister for Primary Health care and Acting Minister of Health**



## **Message from his Excellency the Vice Minister of Health for Strategic Health Development Issues**



With the grace of God, I am very happy to introduce the National Strategic Plan for Human Resources for Health for 2020-2024 for the first time.

This strategy, is a framework to respond to and strengthen the health system through human resource development in order to ensure efficient and effective health delivery at all levels.

The Ministry of Health faces challenges due to the lack of balance in distribution of health workforce between urban and rural areas and deployments that are not yet aligned with priorities, needs and areas of specialisation. According to the World Health Organisation standard there should be a ratio of health professionals (meaning doctors, nurses and midwives) of 44.3/10,000 persons.

This Strategy is properly aligned with existing legislation regarding human resource development, and the principles foreseen in public service human resource management and the program of the Government of the 8th Legislature. Everything must have a plan that is viable, sustainable, integrated and comprehensive so as to dispel any concerns.

This Strategy has been guided by a great deal of input from Directors, Heads of Departments, and Staff in the Ministry of Health, Development Partners and all stakeholders, through consultative workshops, specific sessions to hear the opinions of members of the Ministry of Health National Directions Council and particularly hearing from the Vice-Minister for Primary Health Care Matters and Interim Health Minister and from the Vice-Minister for Strategic Health Development Matters of the 8th Government Legislature.

The active participation of those whose names are not mentioned here have provided contributions of great value, especially I give my thanks and appreciation to the Director General of Cooperative Services, the National Director of Human Resources, Department Heads, National Directorate of Human Resources Advisor, WHO Human Resource Expert, the WHO-European Commission - Health System Strengthening for Universal Health Coverage Partnership programme, who have worked very hard throughout the entire process to bring this plan to reality.

Lastly, I present the NSPHRH 2020-2024 which the Ministry of Health will manage with fairness, transparency and with credibility for the entire population.

  
**Bonifácio Mau Coli dos Reis, Lic.SP**  
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## List of Abbreviations

NAAAA	National Agency for Academic Assessment and Accreditation
AT-ENBC	Advance Training -Essential New Born Care
BOR	Bed Occupancy Rate
C-NBH	Community New Born at Home
DNHR	National Directorate for Human Resources
FAT	Functional Analysis Team
EMOC	Emergency Obstetric Care
HCFD	Human Capital Development Fund
SWOT	Strengths, Weaknesses, Opportunities and Threats
GDP	Gross Domestic Product
HMIS	Health Management Information System
IIP	Immunization In Practice
IMCI	Integrated Management Child Illness
INAP	National Institute for Public Administration
INS	National Health Institute
IPC	Inter Personal Communication
CSC	Civil Service Commission
PHC	Primary Health Care
MSA	Ministry of State Administration
MoE	Ministry of Education
MoH	Ministry of Health
NCD	Non Communicable Diseases
SDG	Sustainable Development Goals
WHO	World Health Organisation
CHSAP	Community Hygiene & Sanitation Action Plan
FP	Family Planning
CSB	Clean and Safe Birthing
GDP	Gross Domestic Product
NHSHRSP	National Strategic Plan For Human Resources for the Health Sector
NHSSP	National Health Sector Strategic Plan
SOP	Standard Operating Procedures
HHS	Health Human Resources
NHS	National Health Service
CHC	Community Health Centre
SP	Health Post
TOT- ENBC	Training of Trainers - Essential New Born Care
UNTL	Universidade Nasional Timor –Leste
USAID	United States Agency for International Development
WHO	World Health Organization
WISN	Workload Indicator for Staffing Needs

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## EXECUTIVE SUMMARY

This National Health Sector Workforce Strategic Plan (NHSWSP) seeks to accelerate Timor-Leste's progress through the commitments of the constitution's provisions to "provide free, universal health care through a decentralised public health care system" Article 57) in accordance with the national vision for "Healthy Timorese people in a healthy Timor-Leste." The overall goal is to ensure the availability of a health workforce in accordance with the National Health Sector Strategic Plan (NHSSP).

The Health Workforce in Timor-Leste has already registered substantial improvements over the past 15 years, particularly in relation to availability and production capacity. The total supply of health staff in Timor-Leste may be more than 7,000. Of the 5,000 Ministry of Health workers, half (2480) have graduated from three or four year training courses in the professional careers of nursing, midwifery, and allied health professions; one fifth (920) are doctors; around one quarter (1290) are administration and management staff; and 5% are nurses aids.

Six nationally accredited institutions provide health training courses for in-country pre-service candidates. The great majority of health staff are educated with the final objective – and implicit assumption – of absorption in to the public sector. However, non-formal mechanisms link health workforce production with health sector needs identified and expressed by the Ministry of Health. If the current trends for health staff production by education institutions continue into the future, and a relatively low (2-3%) annual attrition rate is assumed, considering the youthful age structure of staff and the low rate of overseas migration, the number of health workers is projected to increase substantially in the coming years to more than 17,700 by 2030. At the current production rate, the health labour market may be approaching the point of saturation, as evidenced by unemployment amongst the most recent batch of graduates.

The NHSSP establishes requirements for staffing for a range of health facility types and these are expected to be achieved by 2030. In 2004, the MoH reviewed the norms for recruitment to primary health care facilities. These standards establish an ambitious vision for health care delivery profile in the country and for infrastructure. In addition, there is no long-term certainty in growth of the oil and gas sector and correspondingly for Government receipts, and so it is not possible to guarantee the sustainability of the rapid growth trajectory for public health sector expenditure in the medium to long term. Planned expansion of the health workforce foreseen in the NHSSP 2030 and PHC 2014 policies gives rise to higher forecasts than the available resource envelope in the short and long term. It is important to maximise the impact from current human resources instead of

continuing down the expansionary path, in order to maintain a financially sustainable health workforce.

Consequently, this NHSWSP proposes to review staffing levels that maintain an orientation to PHC and align with the objectives of the Home Visits initiative, while at the same time maintaining targets for the mid-term financial limitations context, and giving consideration to underutilisation of staff at health posts and Community health Centres, resulting in a cumulative need of 6,056 health workers (vs an estimated need of 11,912 health workers in the NHSSP 2030 or 13,319 health workers in the PHC 2014 standards).

At the health workforce policy and governance level, current challenges that are highlighted include a need to strengthen planning, monitoring, management and skills at all levels; limited use of evidence and data for plans and strategies; lack of adequate liaison between the centre and periphery regarding health workforce management practices: lack of balance of quality pre-service education and lack of standards and mechanisms for accreditation and licensing; inefficient mechanisms for postings and staff transfers; poor performance and low levels of productivity, particularly at peripheral facilities; poor attitude of health staff/workers during interactions with clients and teamwork; unclear career pathways; lack of balance in mixed skills and challenges for rural deployments and retention.

Therefore, this plan provides recommendations and policy options in various domains including:

- 1) Training/Education: align health workforce production by the education sector to health sector needs; rationalise the scholarship scheme; invest in improving training institution faculties and infrastructure; complete a review of pre-service training curricula.
- 2) Motivation, performance and retention: implement standard operating procedures for staff recruitment, deployment and transfers; providing regular, integrated in-service training with supportive supervision for all public health sector workers; offer opportunities for merit based career advancement; implement a rural retention incentive scheme comprised of financial and non-financial incentives.
- 3) Regulation and licensing: strengthen accreditation for education institutions; establish a professional licensing board based on health workforce competencies; regularise private sector education and dual public-private practice.
- 4) Leadership and management: re-focus the Health HR Directorate on strategic and high level management functions; establish an inter-sectoral health

workforce working group; build the capacity for routine management functions within municipal administrations.

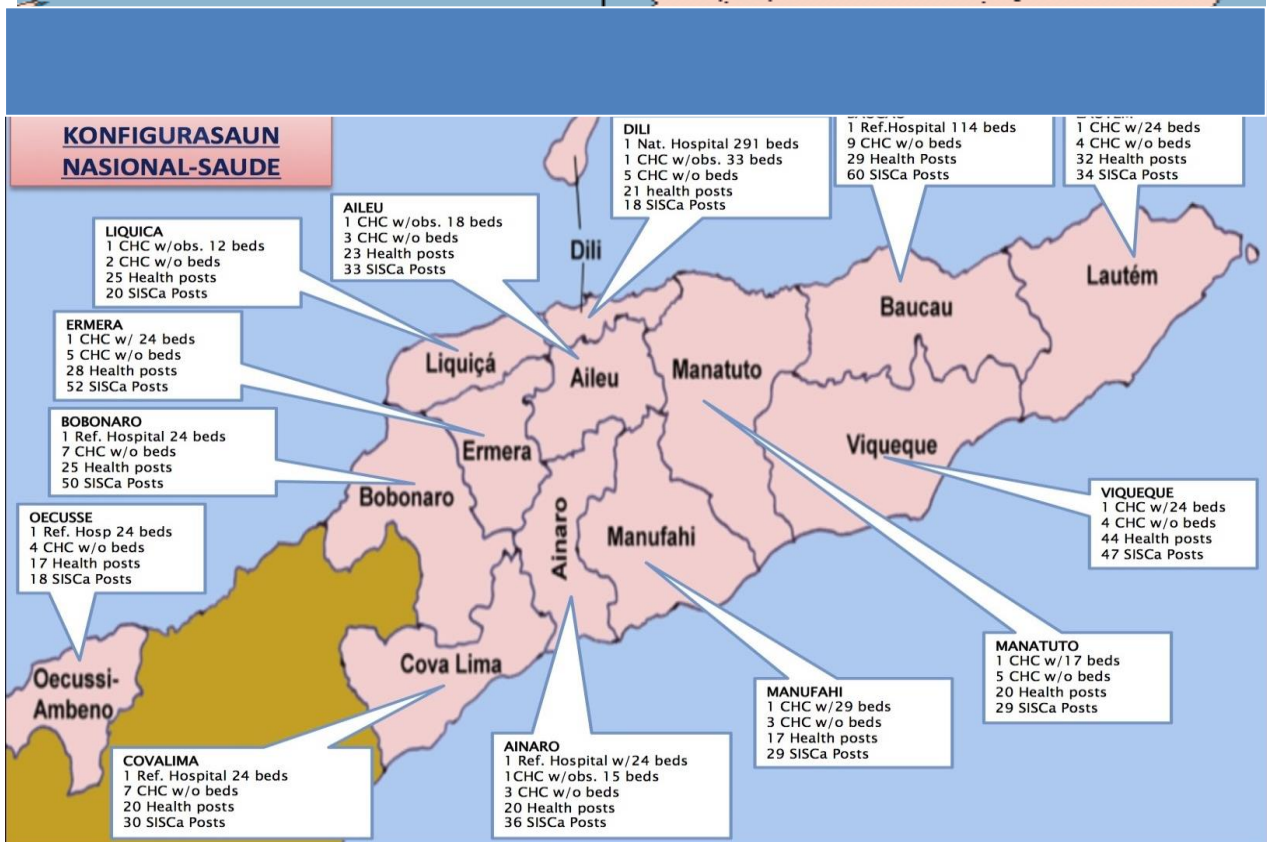
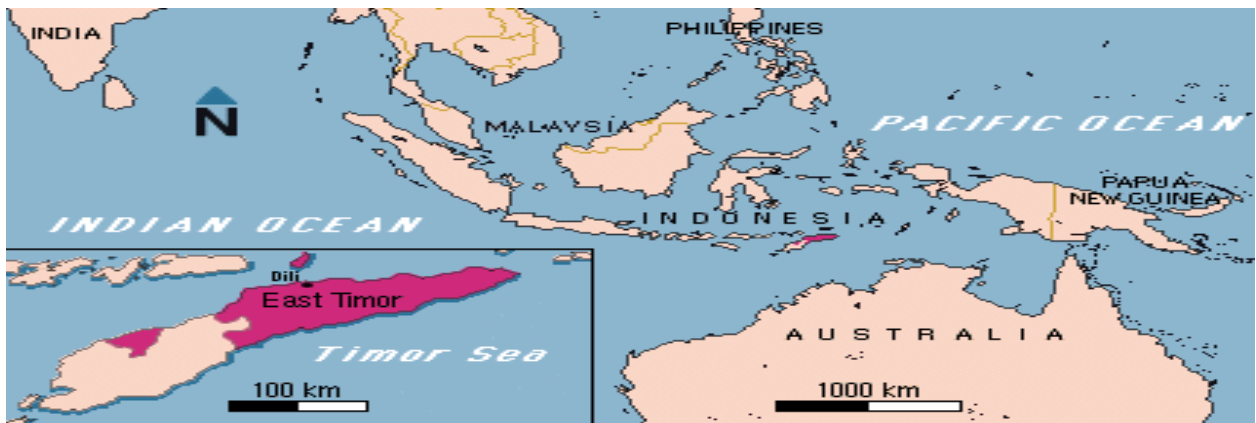
- 5) Human resource information system: Develop an electronic platform to consolidate all HRH related data and evidence from a range of data sources, (including all health staff in the country) in to a single database. This will have the capacity to create timely reports about the quality, composition, distribution, employment status, and demographic characteristics of the health workforce, including gender and age, in order to facilitate effective planning and contribute updated information on a regular basis to the national health workforce register.

The health HR Directorate will be responsible for coordinating the implementation of this plan, attributing clear roles, responsibilities and accountability for its execution, linking funding to its activities and the annual budget cycle, seeking partnerships that incorporate long-term technical assistance and ensuring regular plan monitoring.



*As health professionals, ready to work with professionalism, integrity and ethics, to contribute to progress, social harmony, fair and balanced development to achieve the national goals..*

## SECTION I: INTRODUCTION TO THE TIMOR-LESTE NATIONAL CONTEXT



## **SECTION I: INTRODUCTION TO THE TIMOR-LESTE NATIONAL CONTEXT**

### **1. Introduction**

Timor-Leste is a small nation in Southeast Asia, essentially occupying the eastern half of the island of Timor with West Timor being part of the Republic of Indonesia. The population in 2016 was estimated at 1,167,242 with a life expectation of 62 years. Fertility levels and trends indicate that the population will increase from its current number to 1.9 million in 2025 to 3.2 million by 2050.

More than 70% of the population live in isolated mountainous rural areas with roads in poor condition making access to health services a challenge. With 60 percent of the population under the age of 25, Timor-Leste has one of the youngest populations in the world. Various languages are spoken within the country; Tetun is the most commonly spoken language and the first of the official languages. Portuguese is the other official language, but not many people speak it, while English and Indonesian are more important working languages. Timor-Leste is divided into 12 municipal administrations, the Special Administrative Region of Oecusse-Ambeno, 65 Administrative Posts, 442 sucos and 2,225 aldeias. The capital Dili is the largest city and the main port, while the eastern city of Bacau is the second largest city.

The government's Strategic Development Plan 2011-2030 offers a vision, targets and indicators for the next two decades and establishes three important pillars, one of which, social capital includes health, education and social protection. The other two pillars are infrastructure development and economic development. Ensuring that Timor-Leste's youthful population is educated, healthy, employed and productive is the biggest development challenge faced by Timor-Leste in the coming decades.

In recent years the Timor-Leste government has made significant efforts to develop and distribute adequate numbers of skilled and motivated health staff, essential to achieve the national health goals. The Ministry of Health has made constant progress over the past decade to achieve the vision of "Healthy Timorese in a Healthy Timor-Leste" and improvements to key health outcomes, especially the training and deployment of doctors, nurses, and midwives to the municipal level, and placement of staff in rural and remote areas.

## 2. Economic growth forecast

Timor-Leste is a middle-low income nation, with a Gross Domestic Product (GDP) of 1.4 billion or per capita GDP of 1,134 USD/year.<sup>1</sup> The nations dependency is strong on oil income (78% of GDP comes from the petroleum industry) which is closely linked to the oil market price fluctuations (currently at lower prices) and to its oil reserves (which have already passed their peak).

Consequently, while incomes continues to be based on oil, economic prosperity can be seen as a challenge in the mid-term.<sup>2</sup> Average growth of GDP was 5.85% from 2001 to 2015,<sup>3</sup> however, considering the above factors, the economic outlook is more conservative based on forecasting proposed by this development plan.

As well as community based agriculture and small-scale home industries, remittances from Timorese labour migrants from Australia, the UK and other locations will continue to be the most important single source of income for the nation. The service network for provincial cities and the capital will probably see the government continue as the main employer providing salaries and supporting small service industries.

## 3. Population status, demographics, health, health service coverage for essential indicators.

Timor-Leste's population is 1,183,643 (2015 Census), and has continued to increase by 2.3% annually, with a fertility rate of 4.2 live births per women between 2010 -2015. A great success story of the Timor-Leste Ministry of Health is being able to reduce the malaria incidence rate significantly from 104.2/1000 population in 2010 to 5.3 in 2012; gradually reducing to less than 1/1000 population for the next three years and finally reducing to 0.03/1000 population in 2017 (and receiving an award from the WHO for Excellence in Public Health).

Maternal and new-born tetanus have been declared as eliminated as has leprosy (although this latter remains endemic in two municipalities). One survey shows that, while half of all children under one year of age have complete immunisations, one-quarter have not received all vaccinations.

The progress of detection of tuberculosis cases in all municipalities has increased from 51% in 2016 to 60% in 2017, (compared with the CDR standard target of 90%).

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<sup>1</sup> World Bank, 2015

<sup>2</sup> *The Economist*, May 2017

<sup>3</sup> <https://tradingeconomics.com/east-timor/gdp-growth-annual>

Low levels of agricultural production have created a burden of chronic food insecurity – contributing to the high rate of chronic malnutrition. 10% of babies are underweight at birth; more than one-third under the age of five years are underweight. Stunting and wasting are the highest in the region and one-quarter of women have a low body-mass index. There are micronutrient deficiencies and two-thirds of children under the age of five suffer from anemia. In relation to the issues of anemia and nutrition noted above, nearly one-third of children aged 7 to 16 (29%) have soil-transmitted worms and one-fifth (18%) have serum prevalent lymphatic filariasis. There are cases of scarlet fever.

Maternal mortality has reduced from 889/100,000 live births in 2003 to 218 in 2016.<sup>4</sup> Ante-natal care (ANC1) shows an average of 79% while ANC 4 shows 53% of visits conducted in 2017. According to the Ministry of Health HMIS 2018, the magnitude of the HIV incidence has shown a detection of new cases from 7 in 2005, rising gradually to 83 cases in 2017. The number of deaths has also risen slowly reaching 12 deaths in 2017.

One in 20 Timorese have mental illness with one-quarter suffering from psychotic distress.

The national retirement age is 60, which is also the current average life expectancy. Care for the aged and those who live in the most difficult to access places, is considered to be inadequate. Importantly, Timor-Leste is in position 11 of nations considered to be at most risk of natural disasters (specifically high-winds, flooding, wild-fires and landslides). It is considered to be vulnerable to climate change.

#### **4. National Policies**

Starting from the restoration of Timor-Leste's independence on the 20th of May 2002, a democratic, multi-party regime has been in force in this country, building solid political stability and peace in civil society. Timor-Leste is a semi-presidential republic. Timor-Leste held its fourth election for the President of the Republic in 2017, and has held 5 elections for the National Parliament, the last of which resulted in the formation of the 8th Constitutional Government in 2018.

The Program of the 8th Constitutional Government is the primary policy instrument for the next five years; reflects the aspiration of Timorese people and also declares priority measures for sustainable development (as defined in the National Strategic Development Plan 2011-2030). This executive, during its mandate, will continue to contribute to the transformation of Timor-Leste, from a low middle-income country to a high-middle income country with a population living safely and that is healthy, educated and prosperous.

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<sup>4</sup> WHO, Global Health Observatory <http://apps.who.int/gho/data/node.main.15>

The Government Program incorporates “the United Nations Agenda 2030 for Sustainable Development”, with its goals and priorities in line with the “Sustainable Development Goals (SDGs)”, in order to achieve concrete progress and sustainable development. This Global Agenda has 17 SDGs, which seek to respond to the needs of people, to ensure that no individual is left behind, to guarantee a better future for Timorese people and for the entire world.

## **5. Partnerships**

There are many stakeholders supporting the improvement of human resource management in the health sector. Development Partners, including UN Agencies, bilateral partners, INGOs and NGOs play an important role in the health sector. The MoH recognises the importance of all partners and considers the guiding principles of partnership important for national health development.

These include but are not limited to, the provision of financial contributions for ongoing training of the health workforce, improving governance, management and the quality of health service delivery. Furthermore, development partners are considered as complementary to the public health sector in terms of increasing geographic access to health services and the range and scale of services provided.

There is a need for a clear strategy and implementation plan to define roles, including joint planning, monitoring and implementation by key partners.

## **6. National Health System**

The Ministry of Health, as the central organ of Government, is made up of Consultative and Coordination organs including: the National Health Council, the Health Ministry Guiding Council, and the Health Ministry Consultive Council. Central Service activities are led by two Director Generals and supported by four Offices, 8 National Directorates, the Litigation and Legal Support Unit and the Liaison and Support Unit to the Municipal Health Services. The roles and function of the central level are the development of policy and health regulations, establishing health service standards, determining priorities, planning and the national health budget, donor coordination, national program management, health system monitoring and evaluation and equity safeguards through human resource allocation mechanisms including cross-subsidisations.

The National Health System in Timor-Leste, is divided into hospital services and community services..

Hospital services include one regional hospital and four referral hospitals (with the capacity to provide some surgical services including appendectomy and caesarians). The central hospital for referrals is the Guido Valadares National Hospital in Dili.

There are 72 Community Health Centres and 302 Health Posts, linked directly with 600 SISCa Posts and home visits.

The Central Ambulance System serves the municipal populations - multifunction vehicles, on rotation to the Administrative Post level, carry patients coming from the municipalities to the municipality centre - from where ambulances carry them to Dili.

Municipalities face many problems at the infrastructure level, where ambulances are unable to get to locations and air transport must be used. Australian contracted small aircraft transport patients from Suai and Viqueque to Dili, and there is a boat linking Atauro with Dili. There are also 50 horses spread throughout the country that carry patients across rivers and places where there are no roads for motorbikes.

For tertiary care, Timor-Leste has a patient transfer agreement with Singapore, Malaysia, Australia and Indonesia. In Indonesia there is collaboration with three hospitals, one for treatment of veterans and the others for the treatment of the general population.

Since the Ministry of Health has a shortage of specialist resources for the technical and human capacities to provide high quality tertiary health services, the path ahead in the short term is to continue overseas referral of patients while promoting private investment in tertiary health care.

## **7. Infrastructure for health care delivery**

The provision of health care is organised through a network of services for outreach services, health posts, community health centres at the municipal and administrative post levels and referral hospitals at the regional and national levels (Table 1). Health care includes universal, free, family care through a service network of over 500 health care professionals – doctors, qualified nurses and qualified midwives – health post services situated in approximately half of the total of 433 sucos (the lowest administrative unit of the state administration).

Since the launching of the Comprehensive primary care Package in 2015 and the later adoption of the Family Health Program, health post infrastructure and the distribution and size of teams has remained fluid. Services at the next level, with the same number – or more – health staff and now including allied health professionals is the service network for health centre, at least one for each Administrative Post division, each delivering services to 5-10 satellite health posts. They, in turn, refer to a hospital (of which there are five in the country outside of Dili) or a municipal health centre with a current total capacity of nearly 500 beds (Table 2). The service network is managed by municipal authorities, with a health

workforce – numbering close to 5,000+ in the middle of 2017 – through the Health Ministry Central Services (MoH).

**Table 1: Existing health care facilities**

Facility	Number (existing)					Observation
National Hospital	1					HN Guido Valadares, Dili
Regional Hospital		1				Baucau, covering the eastern part of Timor-Leste
Referral Hospital			4			In Oecusse, Maliana, Maubisse and Suai
Health Centre (large/ inpatients)				7		Coverage area: municipality
Health Centre					65	Coverage area: Administrative Posts
Health Post						302 Coverage area: all sucos (or part of)

Source: 2018 Infrastructure Mapping, DNALP-MS

**Table 2: Estimated number of hospital beds in public sector health facilities**

Hospital	Total beds
Baucau	75
Maliana	24
Covalima	24
Dili	291
Maubessi	24
Oecussi	24
<b>Total</b>	<b>462</b>

Source: DNSH, MS, 2019

To ensure accessibility, especially for citizens in remote, mountainous and difficult to access locations, the MoH would like for each suco or population coverage area of 1500 people or sucos where health facilities can be accessed walking on foot within 2 hours – to have their own health post. In order to achieve this, 120-140 health posts will be added to the existing service network. Going forward the NHSSP foresees the updating of health centres at the municipal level to municipal hospitals (where the municipality does not already have a regional referral hospital).

## **8. Private health provider/facilities**

Information about the availability of private sector facilities is limited. Private providers are not seen as a large component of the health sector at this time, and the available health finance data indicates that only 10% of total expenditure on health is privately financed. In 2010, the MoH estimated that the private sector provided 25% of health services throughout the country. Complete data of the private health workforce is not available at the time of this review. However, the two largest non-profits alone employ 130 health staff. In 2016, the MoH conducted registration of 52 private health facilities – for profit and not-for-profit – at various levels from the state registry, the majority in Dili.

Private pharmacies and for-profit medical clinics are distributed throughout Dili. There is no large for-profit Diagnosis Centre. Some health staff, particularly medical specialists and general practitioners, provide services in the public sector but outside of working hours provide services in the private sector. Traditional birth attendants who receive national payment, continue to assist the majority of births. Information on the private not-for-profit sector is poorly documented; these are mainly financed by international development organisations.

## **9. Legal framework and national policy**

Article 57 of the RDTL Constitution solicits the State to provide free, universal health care through a decentralised public health care system. The Civil Service Law (altered in 2009) establishes general protection and the role of all public servants. The Civil Service Career Regime (2016) specifies, amongst other items, pre-requisites for general civil service. In relation to the sub-item on public servants which includes the health workforce which provides health services, the previous law for Career Regime for Health Professionals, Decree-Law 13/2012 7th of March, specifically regulates health professionals. This includes the Special Regime (for health professionals) and the General Regime (for non-health professionals). Further detail about the legal framework for management of health staff is available in Annex 1.

The National Health Sector Strategic Plan (NHSSP) (2011-2030), aligned with the National Strategic Development Plan (2011-2030), the RDTL Constitution and the health Policy Framework (2002), outlines five pillars, the third of which is related to the health workforce, recommending the establishment of a human resource plan to link needs and health staff demand, support pre-service education and continuing professional development, licensing and certification, staff management and working conditions, occupational health and safety. The NHSSP, the subsequent Comprehensive Package for Primary Health Care,

launched in May 2015 and the recent Essential Services Package 2019 all provide detailed staffing norms proposed for each level of the health system in Timor-Leste (health posts, CHCs, municipal hospitals, referral hospitals, and the national hospital).

## **10. Methodology**

The framework for supply and demand in the market is used to contextualise the needs identified in the NHSSP, the Comprehensive Package for PHC and the Essential Service Package to anticipate the likely trends against any proposed policy options.

Private sub-sector services (not yet considered a player in Timor-Leste) are considered as a market for overseas employment opportunities (also more limited). Looking ahead, health graduates available in the country (i.e. supply) when compared with the anticipated need and absorption capacity of health employers (e.g. demand) suggest the possibility of a significant imbalance – with supply exceeding need.

The implications of these will need to be assessed and solutions sought through consultation with expert stake-holders within and outside of the MoH. Relevant literature and national policy documents have been used to inform the interpretation of results and identification of appropriate recommendations. Policy options and recommendations are aligned with the relevant national policy frameworks, including the NHSSP, the Essential Services Package 2019, informed by international best practices and reflected in the WHO Global Strategy regarding the Health Human Resource: Workforce 2030

## SECTION II. HEALTH HUMAN RESOURCE CURRENT SITUATION ANALYSIS



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### 1. Supply, composition by cadre and distribution by geographic area

The health workforce numbers in practice have increased substantially over the past 15 years, doubling in the past five years alone. The state has made great efforts to increase production, recruitment and deployment of the health workforce, resulting in early achievement of the important milestones for health workforce availability identified in the health workforce plan 2005-2015.

Collaboration with the Government of Cuba has been particularly instrumental in the rapid increase in education and deployment of doctors. Initial progress was slow in increasing education and production of other cadres, leading to an imbalance in the skills-mix. Table 3 presents a summary of the essential cadre groups and the corresponding duration of pre-service education.

**Table 3: Cadre group used in the NDHHR - MoH**

Official Name	English language Equivalent	Qualification/ Training	Observation
<b>Medico Especialista</b>	Medical Specialist	6 Levels/ Years + 3-4 years post-basic	Senior Clinician
<b>Medico Geral</b>	General Doctor	6 levels/years	
<b>Aliados</b>	Allied health Professional	Various/ 3-4 years	Include pharmacy technicians (at level 5), Lab Technicians, Nutritionists, physiotherapists
<b>Parteira</b>	Midwife	Diploma IV (4 years) or Diploma I (1 year)	Dip I (course already closed) is particularly for those with experience. Including Nurse/Midwife. Excludes Traditional Birth Attendants.
<b>Enfermeiro</b>	Nurse	Diploma IV / 4 years	Includes Dental Nurses and (occasionally) Public Health Specialists (4 years)
<b>Assistente Enferm</b>	Nurses Aid	Certificate/Less than one year	Minimum training, nurse practitioner, pre-service training for those cadre that no longer exist
<b>Regime Geral</b>	General Regime	Various/From A (senior) – H (auxiliary)	All admin/management levels. Including Administrative and Technical

**Source: Dep. JP-NDHHR, MoH**

The total supply of health personnel in Timor-Leste is over 7000. Given the absence of proper data from professional councils, this figure has been estimated by combining data from a range of sources and obtained from interviews with key informants: those who are currently working as civil servants at the Ministry of Health (5000); estimates of those who are registered to be able to work in the private sector (200); doctors recently graduated from UNTL and dentists recently graduated from UNDIL (150); those who are either unemployed or employed outside the public sector; unemployed graduates whose professions

are unknown (estimated around 200); public health level workers from UNPAZ not working at the MoH (1500); traditional midwives (estimated up to 450, based on the assumption of there being one in each suco); 'contracted' auxiliary staff not registered with the MoH (250).

Of the 5000 MoH civil servants, half (2480) have graduated from 3 or 4 year courses in nursing, midwifery, and allied health professions (pharmacists, nutritionists, lab technicians, biomedical scientists, radiographers, etc); one-fifth (924) are doctors, including generalists or specialists; around one-quarter (1290) are administration or management staff; and 5% are nurses aides, sole health providers with elementary training in Timor-Leste.

As public servants, all MoH staff have rights and benefits in all work-sites and includes a commitment to work during their professional career. There are some community health staff (Family Health Promoters – PSF, recently called Community Volunteers) who cover basic primary health care at the community and household levels. The PSF are voluntary members of sucos selected by the community who receive some incentives. They are registered at the Ministry of Health and trained in the necessary skills; however they are not integrated in to the national system, and only limited information is available regarding their true numbers.

Health workforce personnel are appropriately distributed through the entire country in gross terms. While in the Municipality of Dili – where one-fifth of the population and also one-third of the human resources represent an apparent imbalance, outside of Dili, human resources are distributed more or less uniformly with most staff allocated to the largest municipalities of Baucau and Ermera. For the other ten municipalities, each with a population between 50,000 to 75,000 the remaining health workers are distributed uniformly.

Distribution within municipalities, however shows that there is a disproportionately higher number for the quota allocated to the administrative posts from the larger cities. Furthermore, the most remote sucos are under-staffed within the administrative posts. Overall, less than half of all MoH staff (42%) are health professionals working outside of Dili at the primary and secondary levels and lower than the expected quota considered appropriate for rural Family Health service delivery as identified nationally.

The health workforce in Timor-Leste is predominantly made up of professional health staff (doctors, nurses and midwives) and other cadres recognized as allied health professionals (including physiotherapists, pharmacy technicians and

laboratory technicians). Training for Nurses aides, trained for less than a year, has been discontinued now. Table 4 presents a summary of the latest available public health sector workforce composition. There is no separate data available for the private sector health workforce.

**Table 4: Public sector health staff Timor Leste, August 2017**

<b>Cadre group</b>	<b>Available number</b>
Medical Specialist	35
General Doctor	889
Allied Health Professional*	648
Midwife	618
Nurse	1267
Nurse's Aid	230
Administration & Support Staff	1224
<b>Total</b>	<b>4911</b>

\* includes pharmacy & lab technician, nutritionist, physiotherapist, etc.

\* Source: MoH-HDHR Staff Management Department, August 2017. Not including RAEOA- OéCusse

Some data is available regarding the geographic distribution across a range of municipalities showing substantial variation (Table 5).

Crucially, there is no systematic data regarding poor distribution within municipalities.

With reported higher concentration in larger cities, some CHCs have more than 30 staff, while others have less than five.

Poor distribution of health staff can also be attributed to personal preferences of postings/locations; research results from 2014 show that Health Posts are the least attractive of all postings/locations.

As part of human resources, distribution data is available across hospitals and specialised institutions (medical warehouse, training institutes, MoH) in table 6

**Table 5: Distribution within all municipalities excluding hospitals (March 2017)**

Municipalities (West to East)	Oecusse	Covalima	Bobonaro	Liquiça	Ermera	Ainaro	Aileu	Dili	Manufahi	Manatuto	Viqueque	Baucau	Lautem	Total
Specialists	0	0	0	0	0	0	0	3	0	0	0	0	0	3
Doctors	40	33	48	50	63	33	46	163	46	52	63	84	58	739
Allied Health Professionals	19	24	31	25	32	19	27	139	27	30	27	35	41	457
Midwives	20	27	31	31	30	21	27	111	28	42	44	60	26	478
Nurses	29	53	61	42	61	42	40	139	37	56	106	84	49	770
Nurses Aid	16	16	5	5	16	6	7	20	14	20	20	21	25	175
Admin List	51	47	56	55	57	49	37	506	50	27	47	72	56	1110
<b>Total</b>	<b>† 175</b>	<b>† 200</b>	<b>† 232</b>	<b>208</b>	<b>259</b>	<b>170</b>	<b>184</b>	<b>1082</b>	<b>202</b>	<b>227</b>	<b>307</b>	<b>356</b>	<b>255</b>	<b>3857</b>
Population (000s)	68	65	97	71	125	63	48	277	53	46	76	123	65	1183
Combined Health Workforce /pop	2.4	3.1	2.4	2.9	2.1	2.7	3.8	3.9	3.8	4.9	4.0	2.9	3.9	3.3

Source: Database, Dept Staff Management, National Directorate for Human Resources -MoH 2019

Population Source: Population Record 2015, National Directorate of Statistics.

† Excluding Health Workforce based in Hospitals in these municipalities

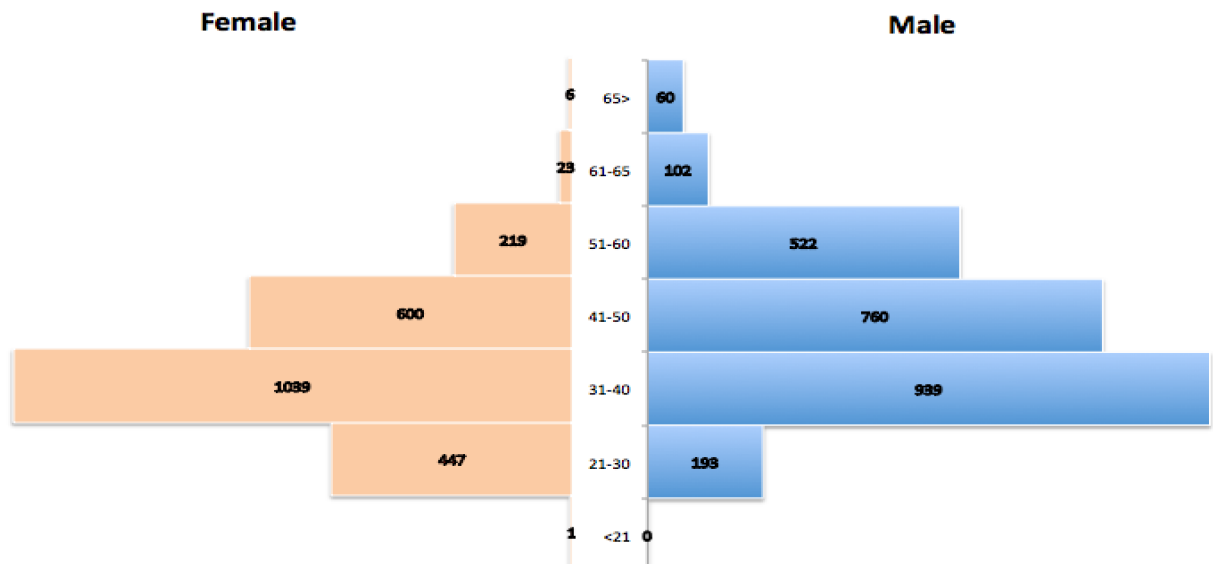
**Table 6: Distribution amongst hospitals and national level entities (August 2017)**

Municipalities West to East	Oecusse Hospital	Covalima Hospital	Bobonaro Maliana Hospital	Maubisse Hospital	Baucau Hospital	National Hospital	INS, Lab Nas, Medical Warehouse	GAJC, AGS, GECQ	DG for Corporate Services	DG Service Delivery	Total
Specialists	0	0	1	0	2	28	0	0	0	1	32
Doctors	9	16	11	12	25	86	1	3	0	32	195
Allied Health Professionals	16	21	22	24	37	83	56	0	0	22	281
Midwives	12	15	17	12	25	71	0	1	0	2	155
Nurses	38	40	38	30	99	291	3	1	2	17	559
Nurses Aid	7	6	6	8	13	22	0	0	0	11	73
Admin List	22	14	13	14	43	71	109	36	143	136	611
<b>Total</b>	<b>104</b>	<b>112</b>	<b>108</b>	<b>100</b>	<b>244</b>	<b>652</b>	<b>169</b>	<b>41</b>	<b>155</b>	<b>221</b>	<b>1906</b>

Source: Database, Dept Staff Management, National Directorate for Human Resources -MoH August 2019

The gender balance of the current general workforce is almost equal, and the workforce is relatively young, with 35% between the ages of 31 and 40. Importantly, 97% of doctors are under 40; 42% of midwives are between 41 and 50, while nurses are in the age group 21 to 30 (table 7). This has implications for future health workforce planning.

**Figure 7: Age distribution for the workforce 2016, by gender**



Source: MoH HR Database, August 2016

## 2. Health Education and Training/Production Capacity

### 2.1. Pre-service training.

Six institutions with national accreditation provide health training/education for pre-service candidates in the country. From these sources, more than 1309 health professionals are ready to enter the health system each year (table 7).

Education institutions determine their entry and outputs based on directives from the Ministry of Education, with instructions to increase output without considering the employment opportunities in the health labour market.

Unlike other countries where the private sector represents a significant contributor to health sector employment, in Timor-Leste the largest number of health personnel are educated with the ultimate aim – and implicit assumption – of absorption into the public sector.

However, there is no formal mechanism linking health workforce production to existing health sector needs, as identified and expressed by the MoH.

**Table 7: Output from Accredited Health Training Institutions**

Institute	Cadre produced	Annual average Output	Cummulative output to date
<b>UNTL (public)</b>	Specialist Doctors (through partnership with Cuba)	10	n/a
	General Doctors	60	900
	Nurse	95	400
	Midwives	80	197
	Nutritionists	30	0
	Pharmacy Technician	30	0
	Biomedical Scientist	30	0
<b>UNITAL (private)</b>	Nurse	100	32
	Public health specialist *	10	0
	Nutritionists	15	0
	Biomedical Scientist	35	0
<b>UNPAZ (private)</b>	Public health specialist *	455	1730
<b>UNDIL (private)</b>	Dental therapist	50	150
<b>Inst Superior Cristal (private)</b>	Nurse	15	n/a
	Midwives	15	n/a
<b>Inst Ciencias de Saude (private)</b>	Nurse	45	0
	Midwives	150	0
	Nutritionists	24	0
	Pharmacy Technician	60	0
<b>Total</b>		<b>1309</b>	<b>3409</b>

Source: UNTL, Private University, 2016

\* Public health specialists typically obtain other qualifications and undertake this course as additional training. Thus, they do not adjust the total output of new graduates.

While the establishment of the faculties of medicine, nursing, midwifery, pharmacy and nutrition at UNTL have increased output and provided key cadres, the supply and capacity of local educators and clinical tutors is insufficient to meet training requirements.

Trainees are also sent to referral, regional and national hospitals for hands-on training; this is also included to increase faculty, supplies and additional equipment, including teaching rooms and contact hours with patients (or deliveries in the case of midwives).

The quality of education programs show room for improvement, with many recent graduates lacking practical clinical skills needed in the work-place, and many perceptions of poor attitudes from the major cadres of health personnel towards patients.

Regarding the development of national curricula for the Schools of Medicine, Nursing and Midwifery, and Health Technology in the Faculty of Medicine and Health Sciences, at UNTL, there are a number of initiatives to develop and review their curricula in recent years, however the process is not complete.

Evaluation and accreditation of all six local training institutions for health professionals has been conducted by the National Agency for Academic Evaluation and Accreditation. However there is no formal mechanism or body to conduct standardised national examinations or a system of licensing based on competencies of individual health staff.

In addition, through the Human Capital Development Fund (FDCH), 3.7 million USD in 2017 – the government has financed or part-financed 689 pre-service scholarships overseas to supplement cadre strength as in table 8.

Through bilateral agreements and other operational arrangements, additional students undertake pre-service education in Fiji, Papua New Guinea, Portugal, China, Australia and Mozambique. New graduates while expected to take up immediate employment in the public sector following graduation, in fact may have to wait for up to two years before being employed in the public sector.

**Table 8: MoH Pre-service Scholarships Program 2014-2019 & 2017-2021**

No.	Study Program	University / Nation	Total Scholarships	Training Duration
1	Biostatistics Medical Specialists	La Habana University / Cuba	2	2017-2019
2	Masters in Pharmacology Epidemiology	La Habana University / Cuba	2	2017-2019
3	Med. Specialist Endocrinology	La Habana University / Cuba	2	2017-2020
4	Med. Specialist Cardiology	La Habana University, Cuba	4	2017-2020
5	Med. Specialist Radiology	Villa Clara University Cuba	2	2017-2020
6	Med. Specialist Nephrology	La Habana University / Cuba	3	2017-2020
7	Med. Specialist Neurology	La Habana University / Cuba	2	2017-2020
8	Med. Specialist Oncology	La Habana University / Cuba	3	2017-2020
9	Med. Specialist Gynecology and Obstetrics	Padjajaran University, Bandung, Indonesia and Villa Clara University Cuba	4	2014-2019 no 2017-2021
10	Medical Specialist Anaesthesia	Padjajaran University, Bandung, Indonesia and Fiji National University	3	2014-2019 no 2017-2021
11	Medical Specialist Surgery	PNG National University and Fiji National University	3	2014-2019 no 2017-2021

12	Medical Specialist Intensive Care & Emergency	La Habana University / Cuba and PNG National University	6	2014-2019 no 2017-2020
13	Medical Specialist Internal Medicine	Universidade Indonesia	1	2014-2019
14	Dental Medicine	IIK BW Kediri, Indonesia	65	2011-2018, 2013-2019 no 2014-2020
15	General Medicine	Universidade Nasional Timor Lorosae (UNTL)	65	2013-2019 no 2014-2020
16	Batchelor of Midwifery	Universidade Nasional Timor Lorosae	2	2018-2022
17	Batchelor of Human Resource Management s	Dili Institute of Tehnology	19	2017-2020
18	Diploma 3 Pharmacy	IIK BW Kediri, Indonesia	1	2014-2017
19	Diploma 3 Medical Records	IIK BW Kediri, Indonesia	1	2016-2019
20	Diploma 3 Physiotherapy	IIK BW Kediri, Indonesia	1	2014-2017
21	Diploma 3 Analyst	IIK BW Kediri, Indonesia	1	2015-2018
<b>Total</b>			<b>192</b>	

Source: NDHR Department of Planning, 2019

## 2.2. In-service training

The National Health Institute (INS) works with a large group of national and international partners to conduct and coordinate in-service training for selected professionals in Dili and at the municipal level. From a limited budget, its functions are strongly supported: in 2017, the INS received USD 150,000 from the FDCH (3% from the last budget) for delivery of in-service training for 180 members of the health workforce, or 4% of the workforce. Based on this average, and assuming no repetition or expansion of the workforce, the health workforce can expect there to be one episode of in-service training every 25 years only.

However, from 2017 the INS conducted 15 training initiatives including Training of Trainers and Advanced Training, with a total of 2,894 trainees comprised of 1043 doctors, 696 midwives, 733 nurses, 393 allied health professionals and 28 managers and administrators, with a total of 1327 men and 1566 women trained. In 2018 there was a total of 27 training sessions for 1183 trainees. These trainings received technical and budget support from a range of development partners. Training numbers are presented in table 9.

**Table 9: Participation in in-service training, by cadre, 2017-18.**

No	Training Type	Professionals trained					Total	Support
		Doctor	Midwife	Nurse	Allied health	Manag / Admin		
1	ToT-IPC			1		14	15	GAVI
2	IPC	47	35	91	38	7	218	GAVI,JSI
3	PF	42	73				115	UNFPA JSI KOICA
4	ENBC	54	50	31			135	KOICa Child Fund
5	TOT-ENBC	4	2	1			7	KOICA
6	AT-ENBC	7	6	4			17	KOICA NKBRI
7	C-NBH	42	26	33			101	UNICEF, Child Fund
8	IMCI	23	24	30			77	UNICEF KOICA JSI
9	TOT-IMCI	16	2	4		1	23	KOICA,KBRI
10	AT-IMCI	4		5			9	KOICA,KBRI
11	PMS	69	60	7			136	UNICEF CF KOICA JSI
12	TOT-PMS	5	6				11	KOICA
13	SOP EVM	17	11	20	12		60	UNICEF
14	IIP	12	17	19		1	49	GAVI
15	TOT -EMOC	4	10				14	UNFPA
16	EMOC -St	2	21				23	UNFPA WHO UNICEF KOICA HAI JSI
17	PAKSI	1	2	23	12	16	54	UNICEF
18	TB-Lab	29					29	Fundu Global
19	SR-STI/AIV-SIDA					3	3	DFAT
20	Prontu-simulationi	2	18				20	HAI
21	Non-CD	1		1			2	WHO
22	School Health			2	1	33	36	SHAREE
23	Child Health				1		1	TAICA
24	J-leadership		3	3	1	3	10	FDCH
25	J-Finance					2	2	UNFPA
26	Health Management					13	13	SJG
27	Audit Management					3	3	Unicef,WHO, UNFPA
	<b>Totál</b>	<b>381</b>	<b>366</b>	<b>275</b>	<b>65</b>	<b>96</b>	<b>1183</b>	

Source: INS-MoH Report 2018

The INS also has responsibility for coordination of health and medical research activities in the country. The facilities of the INS represent a significant national resource with considerable unexplored potential, that requires additional investment in the necessary equipment, technology and faculty.

Health staff participation in in-service training recorded by events, instead of being recorded by persons trained means that some health professionals receive multiple training while others have very few or none,, leading to an imbalance in participation. Dependent for its funding supply from vertical programs and lacking proper resources, the INS in-service training is not sufficiently balanced to cover all cadres. Recent graduates working in urban centres obtain additional training while staff who have been working for a long time in remote locations do not.. Additionally, since half of the workforce were recruited before the introduction of the Comprehensive Package and Family Health initiative, they may not have received in-service training for these important initiatives..

No needs assessment has been conducted to identify the relevance and appropriateness of in-service training content. In addition, there is no systematic mechanism for post training follow-up which is useful for both participants and facilitators.

### **2.2.a. Additional health training**

Career progression through additional training continues to be poorly defined. In order to increase its in-service training role, the INS anticipates being able to provide 15-months update courses for Nurse's Aids, including short courses for midwifery Diploma I, 9-month course for X-Ray technicians and 9-month post-basic course on anaesthesia for nurses.

## **3. Policy and governance mechanism for the health workforce**

Health workforce governance, planning and performance management is centralised at the level of the National Directorate for Human Resources. Mechanisms to develop individual job descriptions and supportive supervision programs, the process of municipal monitoring and evaluation, planning and budget processes at the central and municipal levels and national monitoring and evaluation frameworks are not yet established or only partially implemented.

Recently, there have been improvements in the reliability and availability of health workforce information and the 2016 data is available regarding supply, distribution, and characteristics for the public sector health workforce. However,

data generated through the MoH Staff Management Department in the HR database is not consistently used by the National Directorate for HR to determine discrepancies for NHSSP targets, including informing planning and decisions regarding recruitment and deployment of annual health workforce outputs. Health workforce density data have been integrated into the MoH Health Management Information System and are used to report on human resource indicators in the National Monitoring and Evaluation Framework.

The supervision system implemented in 2016, collects information about staff availability at health post and community health centre levels. However, supervision visits are of a non-supportive nature and are limited to verify compliance with check-lists about the availability of equipment and working conditions. However, health workforce data that has been collected is now being compiled, analysed, interpreted and used for planning and action.

The National Agency for Academic Evaluation and Accreditation (ANAAA) provides accreditation for health training institutions, and although there are professional associations for doctors, nurses, midwives, dental health staff and public health, there is no regulatory entity with the legal mandate to regulate or issue professional licenses, resulting in a gap in procedures and mechanisms to guarantee the quality of education for the workforce and professional practice. There is no professional council in the country; the majority of regulatory functions at present are performed by the MoH Office of Health Quality Control. This entity has explored options for the establishment of one or more health professional councils, and has put mechanisms in place to monitor compliance with guidelines and procedures for service delivery.

#### **4. Current staffing norms**

NHSSP (2011 – 2030) has established requirements for staffing of various types for health facilities that are hoped to be achieved by 2030. In 2014, the MoH reviewed staffing standards for primary health care facilities (PHC 2014). These new standards proposed 47 staff for health centres based in each of 7 municipalities (the 6 other municipalities have hospitals in their coverage areas); 38 staff for each health centre which serves other administrative posts; and 10 staff for each health post in sucos (Annex XXX).

If these staffing requirements are to be achieved, there must be a substantial increase in the production of health professionals and adequate budgetary allocation/space for the recruitment, deployment and management of these additional staff. However the key results from functional analysis for the MoH found that staffing norms have not yet been reviewed or adjusted to reflect the

service delivery needs that have been developed and there are not enough funds to absorb the numbers projected by the NHSSP or PHC 2014. Considering these realities and limitations, the MoH may need to review health workforce staff targets in the NHSSP and PHC 2014 and consider whether the health workforce requirements projected in the 2019 Essential Service Package (ESP) described later in this document remain valid and appropriate.

## **5. Current salary scale for health staff in the public sector**

Public sector health staff are remunerated according to the national salary scale (table 10). Salary levels are competitive in relation to other public servant categories, and for remuneration levels in nations at similar levels of socio-economic development.

These factors, together with fiscal limitations, relatively large numbers of health staff available to meet domestic demand and limited competition from private sector employers currently point to the fact that salaries are substantially adequate for the Timor-Leste reality.

The rural posting/placement incentive scheme (which foresees an incentive up to 40% above basic payments for the majority of remote locations), while not yet implemented, may represent an important element as part of the establishment of a more comprehensive strategy to encourage rural deployments.

**Table 10: MoH NDHR basic salary scale (2019)**

<b>Cadre</b>	<b>Monthly Salary (USD)</b>
<b>Specialist Doctors:</b>	
Specialist Doctor - Junior 1	1000
Specialist Doctor - Junior 2	1025
<b>General Doctors:</b>	
General Doctor - Junior 1	610
General Doctor - Junior 2	625
General Doctor - Senior 1	700
<b>Allied Health Technicians:</b>	
Allied Health Technician - Basic 1	300
Allied Health Technician - Basic 2	310
Allied Health Technician - Basic 3	320
Allied Health Technician - Basic Junior B1	405
Allied Health Technician - Bachelor Degree Junior B1	405
Allied Health Technician - Bachelor Degree Junior B2	415
Allied Health Technician - Bachelor Degree Junior A1	510
Allied Health Technician - Graduate Degree Junior A1	510
Allied Health Technician - Graduate Degree Junior A2	520
Allied Health Technician - Graduate Degree Senior A1	610
<b>Midwives :</b>	
Midwife D 1 (Junior B1)	450
Midwife D 1 (Junior B2)	460
Midwife D 1 (Junior B3)	470
Midwife D1 (Junior A1)	510
Midwife D3 (Junior B3)	470
Midwife D3 Juinor A1/ Midwife Graduate (Junior A1 )	510
Midwife Graduate (Junior A2 )	520
<b>Nurses :</b>	
Nurse Basic 1	350
Nurse Basic 2	360
General Nurse Basic 3	370
Nurse Bachelor Degree D1-D3 (junior B1)	450
Nurse Bachelor Degree D1-D3 (junior B2)	460
Nurse Graduate Degree Junior A1	510
Nurse Graduate Degree Junior A2	520
Nurse Graduate Degree senior A1	610
<b>Assistants (Nurse, Midwife, other Technical staff):</b>	
Assistant 1	250
Assistant 2	260
Assistant 3	270
Assistant 4	280
<b>Administration Technical Staff (General Regime)</b>	450
<b>Cleaner, auxiliary and other support staff *</b>	150

\*Ancillary staff are normally recruited on a contract basis and are not public servants

## **6. Labour market assessment**

Comprehensive data assessment of the health labour market are not available; however key informants identify unemployment amongst recent doctor and nursing graduates, reaffirming that, at the current rate of output, the health market may be close to saturation. Together with vacancies (e.g. sanctioned and funded postings that not been filled), the most common interpretation of this phenomenon according to key informants is that recruitment is slow and inefficient, instead of a lack of willingness from health staff to accept the terms and conditions of public sector employment.

Recruitment and deployment for some rural and remote areas is very difficult. There is no evidence available about the prevalence of dual practice, but at present this is seen as limited to faculty and senior specialists.

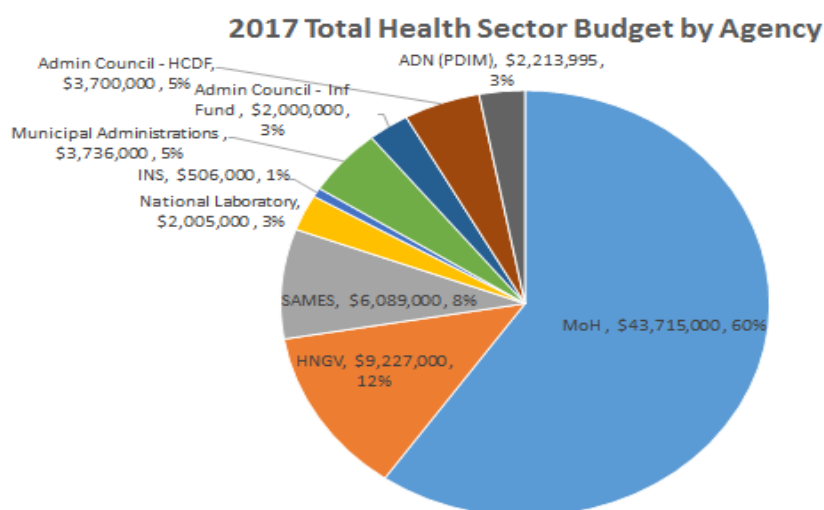
## **7. Health Workforce Financing Assessment**

The period of growth coincides with a period of gradual increase in government expenditure on health.

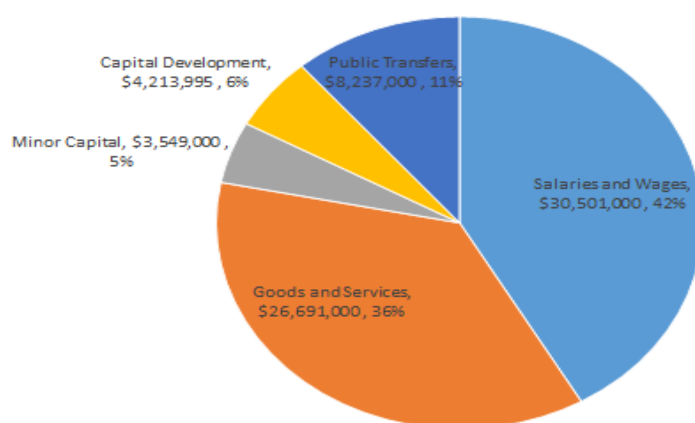
The health sector budget as a percentage of the total State Budget has increased from 4.4% in 2016 to 5.4% in 2017 (highest of the last 3 years). Within this, salaries increased as a proportion of the total sector budget (from 34% in 2015 to 42% - around 30 million USD - in 2017) as seen in Figure 2.

However uncertainty in long-term economic growth regarding the oil & gas sector and the corresponding government receipts do not guarantee a sustainable increased growth trajectory for public health expenditure over the medium to long term.

**Figure 2: Health sector budget allocation by agency and budget category**



**2017 Total Health Sector Budget by Budget Category**



### 8. Current problems and issues

The health workforce in Timor-Leste has been substantially increased over the past 15 years, particularly in relation to availability and production capacity. The current challenges include a need to strengthen planning, monitoring, management and skills at all levels; limited use of evidence and data for planning and strategies; lack of adequate liaison between the centre and the periphery regarding health workforce management practices; unequal quality of pre-service education and lack of standards and mechanisms for accreditation and licensing; inefficient mechanisms of staff postings/placements and transfers; poor performance and low productivity, particularly at peripheral facilities; poor attitude and communication from health staff in interactions with clients and team members; unclear career pathways; imbalance of mixed skills and challenges for rural deployments and retention.

In the future, challenges may include: 1) increasing salary costs, unsustainable under current macro-economic conditions, and unnecessary relative to health care service network needs and population, with potential to put great pressure on the health sector budget; and 2) unregulated proliferation of private, for-profit education institutions, increasing health staff production beyond need and the realistic absorption capacity of the Timor-Leste health system.

## **9. Distribution**

The geographic distribution of the health workforce in the general and special regimes at hospitals and facilities, by municipality and suco are presented in tables 11 to 14 below. Inequitable distribution of staff is a key concern that arises in many review documents and from interviews with key informants. Going forward the NDHR needs to improve the distribution of staff at all facilities and particularly for specialists in the regional and referral hospitals.

A key challenge for the nursing and midwifery workforce identified through informant interviews and recent HR and EIS data is that its distribution is inclined towards hospitals and CHCs. As table 11 and 12 below show, only 44.5% of Health Posts have one midwife, 37% of sucos have one midwife and 50% have one nurse, while some urban CHCs and hospitals have many more staff relative to their workload. For example, of the 615 midwives available in the country, almost 150 are based at hospital and health facilities in Dili.

There is an imbalance between the various service delivery levels too; as indicated in table 11, just 44.5% of Health Posts have one midwife and 7% have a pharmacist compared with 81% at CHC and other facility types; some CHCs have more than 30 staff, while others have less than five.

**Table 11: Percentage of selected key staff available at facilities 2018**

HR	HP	CHC	All Health Facilities
% of posts with doctors	96%	96%	88%
% of posts with Midwife	44.5%	85%	88%
% of posts with Nurse	50%	92%	82%
% of posts with Pharmacist	7%	81%	82%
% of Pharmacists available at all facilities	10%	43%	90%
% of Lab Technician working in municipalities and hospitals	0%	46%	82%

Source: MoH HR Data Base 2018

**Table 12: Professional staff distribution by Suco**

Distribution	Number of sucos	%	Ga
Total number of sucos with one professional	342	77	100
Total number of sucos with one staff doctor	335	76	107
Total number of sucos with one staff	162	37	280
Total number of sucos with one staff nurse	195	44	247
Total number of sucos with one nurse's aide	152	34	290

Source: \*JAHSR 2014 p. 38\*

There continues to be an imbalance within some facilities. For example, during the workload assessment conducted by the FAT (Functional Analysis Team), it was found that some departments at the Dili National Hospital were understaffed while others were overstaffed.

**Table 13 : Distribution of staff throughout referral hospitals 2016**

Grade	Dili National Hospital	Baucau Regional Hospital	Maliana Referral Hospital	Maubisse Referral Hospital	Suai Referral Hospital	Total
<b>General Regime</b>						
<b>A</b>	0	0	0	0	0	0
<b>B</b>	0	0	0	0	0	0
<b>C</b>	2	0	0	4	1	7
<b>D</b>	13	3	3	1	3	23
<b>E</b>	34	3	6	5	2	50
<b>F</b>	20	11	4	1	8	44
<b>G</b>	4	26	0	2	0	32
	73	43	13	13	14	156
Cadre	Dili National Hospital	Baucau Regional Hospital	Maliana Referral Hospital	Maubisse Referral Hospital	Suai Referral Hospital	Total
<b>Special Regime</b>						
<b>Specialist Doctor</b>	28	2	1	0	0	31
<b>General Doctor</b>	86	25	11	12	16	150
<b>Midwife</b>	71	25	17	12	15	140
<b>Nurse</b>	291	99	37	30	40	497
<b>Nurse's Aid</b>	•	•	•	•	•	•
	22	13	6	8	6	55
<b>Allied Health</b>	•	•	•	•	•	•
	83	37	22	24	21	187
<b>Total</b>	<b>581</b>	<b>201</b>	<b>94</b>	<b>86</b>	<b>98</b>	<b>106</b>

Source: \*MoH HR Database, March 2016\*

Other factors that contribute to staffing imbalances are the number of health facilities in the country. RAKSS 2014 noted that there had been an increase in the number of facilities since 2009, with Health Posts increasing from 216 in 2009 to 320 in 2018.

**Table 14: Distribution of staff by Municipality**

General Regime													
Grade	Aileu	Ainaro	Baucau	Bobonaro	Covalima	Dili	Ermera	Lautem	Liquica	Manatuto	Manufahi	Viqueque	Total
<b>A</b>	0	0	0	0	0	0	0	0	0	0	0	0	<b>0</b>
<b>B</b>	0	0	2	1	1	1	0	1	1	0	0	1	<b>8</b>
<b>C</b>	0	1	1	0	0	1	0	0	3	1	1	0	<b>8</b>
<b>D</b>	7	8	11	6	11	11	9	6	7	5	12	9	<b>102</b>
<b>E</b>	4	4	4	7	5	3	4	7	2	2	4	4	<b>50</b>
<b>F</b>	12	21	26	24	15	30	19	17	27	11	11	16	<b>229</b>
<b>G</b>	14	15	28	19	15	21	28	25	16	8	25	17	<b>231</b>
Total	<b>37</b>	<b>49</b>	<b>72</b>	<b>57</b>	<b>47</b>	<b>67</b>	<b>60</b>	<b>56</b>	<b>56</b>	<b>27</b>	<b>53</b>	<b>46</b>	<b>628</b>
Special Regime													
Cadre	Aileu	Ainaro	Baucau	Bobonaro	Covalima	Dili	Ermera	Lautem	Liquica	Manatuto	Manufahi	Viqueque	Total
<b>Specialist Doctor</b>	0	0	0	0	0	3	0	0	0	0	0	0	<b>3</b>
<b>General Doctor</b>	45	33	84	48	33	12	63	58	50	52	46	63	<b>697</b>
<b>Midwife</b>	27	21	60	31	27	10	30	26	31	42	28	44	<b>475</b>
<b>Nurse</b>	40	42	84	61	53	11	61	49	42	56	37	10	<b>746</b>
<b>Nurse Aides</b>	7	6	21	5	16	9	16	25	5	20	14	20	<b>164</b>
<b>Allied Health</b>	27	19	35	31	24	60	32	41	25	30	27	27	<b>378</b>
Total	<b>14</b>	<b>12</b>	<b>28</b>	<b>17</b>	<b>15</b>	<b>41</b>	<b>20</b>	<b>19</b>	<b>15</b>	<b>20</b>	<b>15</b>	<b>26</b>	<b>2463</b>

Source: MoH HR Database, August 2018

EIS data regarding the number of births compared with the staffing level was examined to obtain a more in-depth picture of the distribution of doctors, midwives, and nurses at different municipalities and facilities. As shown in table 15 below, the CHC at Ver Cruz has 15 midwives and a total of 54 births per month, almost three births per midwife per month. In other locations, the Maliana CHC has 47 births per month, nearly the same as Ver Cruz, and just 5 midwives, or nearly 9 births per month for each midwife and an overall workload greater than that for Ver Cruz staff. Next, data shows that some facilities have midwives but no births, for example, the Ver Cruz 2 & 3 health Posts each have one midwife but did not have any births during the month under review, while others including Health Post Metinaro 1 and HP4 in Cailaco had two and three births

respectively, but no midwife. Throughout the country, health workforce distribution is inequitable and has a negative impact on service delivery and workload for those facilities with lower staffing numbers as evidenced by the data. For example, health professionals for population coverage is lower than one health professional per 1000 persons in Bobonaro but nearly 4 health professionals per 1000 persons in Cailaco.

**Table 15: Number of births and distribution of Doctors, Nurses, and Midwives**

Municipal	Facility	Doctors	Nurses	Midwives	Total Staff	Births per month	Population	Staff per 1000 population ratio
Dili	<b>Vera Cruz CHC</b>	15	16	15	46	54	34,015	1.62
	HP1	1	1	1	3	1		
	HP2	1	1	1	3	0		
	HP3	1	1	1	3	0		
	<b>Total staff</b>				<b>55</b>			
	<b>Becora CHC</b>	13	18	16	47	53	54,936	1.06
	HP1	1	1	1	3	0		
	HP2	1	0	1	2	1		
	HP3	1	1	1	3	0		
	HP4	1	1	1	3	9		
	<b>Total staff</b>				<b>58</b>			
	<b>Metinaro CHC</b>	5	10	3	18	8	4727	4.2
	HP1	1	1	0	2	2		
	<b>Total staff</b>				<b>20</b>			
Bobonaro	<b>Bobanaro CHC</b>	3	4	2	9	9	23854	0.63
	HP1	1	1	0	2	0		
	HP2	0	1	0	1	0		
	HP3	1	2	0	3	0		
	<b>Total staff</b>				<b>15</b>			
	<b>Maliana CHC</b>	5	6	5	16	47	25234	0.83
	HP1	0	1	1	2	0		
	HP2	1	1	1	3	0		
	<b>Total staff</b>				<b>21</b>			
	<b>Cailaco CHC</b>	9	10	5	24	4	9957	3.7
	HP1	1	1	0	2	0		
	HP2	1	1	0	2	1		
	HP3	1	1	0	2	0		
	HP4	1	0	0	1	3		
HP5	1	1	1	3	1			
HP6	1	1	1	3	0			
<b>Total staff</b>				<b>37</b>				

Source: \*Taken from EIS 2016 based on sample selection for facilities from Dili and from Bobonaro \*\*

## **10. Projected Health Workforce Needs by Scenario**

In order to undertake relevant health workforce planning, it is important to have calculations of health workforce projections, based on the current characteristics of staffing and health workforce allotment norms.

Staffing norms were first established in the NHSSP Policy. Subsequently, the PHC 2014 established an ambitious vision for the nation's health care delivery profile and infrastructure. Fiscal space limitations drafted in the last section and in the section below "Demand projections for 2030", show that their complete achievement will not be feasible in the short or medium term. Further, the level of utilisation of health services at the health post and CHC level is not guaranteed, at least in relation to current trends, for the staffing levels recommended in this policy document. In addition, an Essential Services Package (ESP 2019) is being developed to provide high quality, comprehensive primary health coverage to provide Universal Health Coverage (UHC) and meet the health related targets of the SDGs. Consequently, the HRH projections and estimates in this strategy are based on 3 possible staffing scenarios:

One based on the NHSSP staffing norms;  
The second based on PHC 2014 staffing norms;  
The third based on the essential services package (ESP) 2019.

The revised staffing norms in ESP 2019, maintain a strong orientation for PHC and are aligned with the objectives of the Family Health initiative, while at the same time maintaining targets in the context of medium term financial limitations and giving consideration to the under-utilisation of staff at health post and CHC levels, (where despite lower numbers for staff availability are at present under-utilised). Considering all these factors, ESP 2019 suggests a cumulative need for 6,056 health workers (vs. 11,912 in the NHSSP and 13,319 in the PHC 2014) (table 16).

The revised norms must be considered as an interim target for ESP 2019 (time line for this health workforce plan); at this point, if a new assessment of the medium term fiscal space identifies conducive conditions, then, an increase may be considered to move forward the standards foreseen in the PHC 2014 and the NHSSP, providing that there are indicators for performance and facility level and workload analysis to justify the need for this expansion.

**Tables 16 Comparative overview of staffing norms and cumulative health workforce needs according to the NHSSP, PHC 2014 and essential services package 2019 (ESP).**

Cadre	NHSSP						PHC 2014						ESP 2019							
	Health Post	Community Health Center	Municipal Hospital	Referral/Regional Hospital	National Hospital	Cumulative Needs	Health Post	Health Center (sub-district)	S Health Center (district)	Municipal Hospital	Referral/Regional Hospital	National Hospital	Cumulative Needs	Health Post	Health Center (sub-district)	S Health Center (district)	Municipal Hospital	Referral/Regional Hospital	National Hospital	Cumulative Needs
Medical Specialist	0	0	6	24	94	293	0	0	0	6	24	94	293	0	0	0	2	12	94	148
Medical General	1	2	8	24	70	966	1	2	6	8	24	70	1,018	1	1	2	3	16	50	781
Dentists	0	1	1	2	3	99	0	0	0	1	2	3	26	0	0	0/1	1	2	3	26
Nurses	2	10	60	160	300	3,588	2	7	7	60	160	300	3,369	1	3	6	30	80	200	1,784
Nurse Specialist	0	2	7	9	4	366	0	0	0	7	25	4	220	0	0	0	3	9	16	100
Midwife	2	10	16	40	80	2,115	2	7	7	16	40	80	1,896	1	2	4	6	12	36	801
Alied Health Professional	1	8	22	47	78	1,703	2	4	6	22	47	78	1,879	0/1	2	4	11	19	54	529
Admin / Auxillary	0	0	42	113	220	2,782	3	18	21	42	113	220	4,618	1/0	2	4	20	53	147	1,887
<b>Total</b>	<b>6</b>	<b>33</b>	<b>162</b>	<b>419</b>	<b>849</b>	<b>11,912</b>	<b>10</b>	<b>38</b>	<b>47</b>	<b>162</b>	<b>435</b>	<b>849</b>	<b>13,319</b>	<b>4</b>	<b>10</b>	<b>20</b>	<b>76</b>	<b>203</b>	<b>600</b>	<b>6,056</b>

## 11. Projected Health Workforce Supply from 2021 to 2030

If the current trend in health staff production by training institutions continues into the future, and a relatively small annual rate of attrition is assumed (2-3%) considering the youthful structure of health staff and the low rate of overseas migration, the number of health personnel will increase substantially in the coming years to more than 17,700 by 2030 (table 17).

**Table 17: Forecast (supply and flux) for health workforce availability to 2030**

Cadre	Current			Forecast (supply and flux)		
	2010	2015	2019	2021	2025	2030
Specialist Doctor	9	23	35	93	143	193
General Doctor	75	820	889	1,149	1,233	1,322
Nurse	883	1,139	1267	2,635	3,534	4,359
Midwife	388	533	618	1,782	2,663	3,509
Allied Health Professional	316	440	648	2,466	3,746	4,985
General/Admin Staff	615	1,289	1224	2,090	2,688	3,222
<b>Total</b>	<b>2,286</b>	<b>4,481</b>	<b>4911</b>	<b>10,416</b>	<b>14,185</b>	<b>17,743</b>

Source: \*MoH HR database, 2010, 2015- August 2019\*

## 12. Discrepancy based on projected needs from 2021 to 2030

The needs identified in the NHSSP, PHC 2014 and the 2019 essential services package (ESP) need to be compared with projected growth in supply in order to identify any potential shortfalls or excesses of health staff, whether in aggregate or specifically for individual professional cadres (table 18). At the aggregated level, and if current output trends are maintained, adopting only the 2019 essential services package enables matching with health system needs and projected supply; according to the two alternative needs scenarios (the NHSSP and the PHC 2014 staffing norms), a substantial deficit will persist by 2021 and only in the longer term will it be possible to achieve the necessary levels. Also it is important to know whether the requirements identified through these different approaches for standards based on facilities are actually necessary to delivery services as reported volumes of lower service usage at peripheral health facilities based on the current configuration of staffing implies that substantial expansion of staffing numbers cannot be justified on the basis of any excessive workload at public health facilities at this time.

Examination of the difference between the needs identified in the various scenarios and the projected availability of health staff, it is importante to consider that the aggregate value has an important difference between the different professional cadres: for example, production of Specialist Doctors will be lower

than needs in the short, medium and long term according to the three scenarios being considered.

Reciprocally, for doctors and allied health professional, production will surpass requirements by 2021 in all scenarios: the excess may be moderate for doctors, and for those that will be able to obtain employment in the private sector, while for allied health professionals it is not immediately clear what employment opportunities will materialise. For nurses and midwives, on the other hand, choosing the scenario which is adopted is likely to have the greatest impact: with the NHSSP and PHC 2014 scenarios, there may be a deficit in 2021 and an oversupply by 2030, while the lower needs identified according to ESP 2019 there will be excess numbers of this cadre even in 2021.

Production capacity can be adjusted upwards or downwards by student enrolments, and anticipated future trends can inform future needs. However, health sector needs identified through facility based staffing norms is only a partial element for conducting these analyses, as there are other important factors such as the cost of increasing planned capacity and the economic capacity of the country (whether in the public or private sector) to generate demand for health services, and therefore be in a position to finance health staff.

**Table 18 Shortfall or excess projected in 2021, 2025 and 2030 for important health staff cadre based on 3 different needs scenarios 3 (NHSSP, PHC 2014, ESP 2019).**

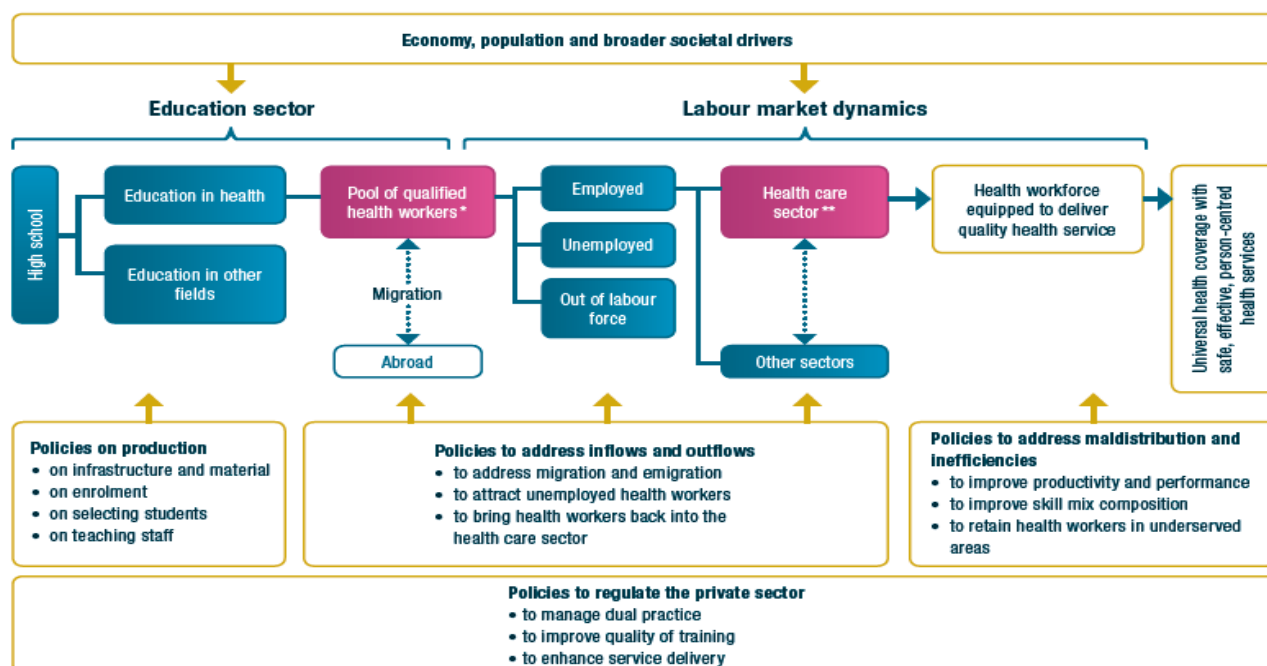
Cadre	NHSSP	PHC 2014	ESP 2019	Projected supply for 2021	Projected supply for 2025	Projected supply for 2030	Shortfall (in negative) or excess in 2021			Shortfall (in negative) or excess in 2025			Shortfall (in negative) or excess in 2030		
	Cumulative need	Cumulative need	Cumulative need				NHSSP	PHC 2014	ESP 2019	NHSSP	PHC 2014	ESP 2019	NHSSP	PHC 2014	ESP 2019
<b>Specialist Doctor</b>	293	293	122	93	143	193	-200	-200	-55	-150	-150	-5	-100	-100	45
<b>General Doctor</b>	966	1,018	689	1,149	1,233	1,322	183	131	68	267	215	452	356	304	541
<b>Nurses (including specialised)</b>	3,588	3,369	1159	2,635	3,534	4,359	-953	-734		-54	165	1,750	771	990	2,575
<b>Midwives</b>	2,115	1,896	702	1,782	2,663	3,509	-333	-114		548	767	1,862	1,394	1,613	2,708
<b>Allied Health Professionals</b>	1,703	1,879	351	2,466	3,746	4,985	763	587		2,043	1,867	3,217	3,282	3,106	4,456
<b>General / Admin Staff</b>	2,782	4,618	1694	2,090	2,688	3,222	-692	-2,528		-94	-1,930	801	440	-1,396	1,335
			4												
<b>Total*</b>	<b>11,447</b>	<b>13,073</b>	<b>4735</b>	<b>10,215</b>	<b>14,007</b>	<b>17,590</b>	<b>-1,232</b>	<b>935</b>	<b>4,285</b>	<b>2,560</b>	<b>935</b>	<b>8,077</b>	<b>6,143</b>	<b>4,518</b>	<b>11,660</b>

### 13. Proposal and target audience for this plan

The aim of this strategic plan is to accelerate Timor-Leste's progress for service delivery in accordance with the commitment in the Constitution to “provide universal health care through a decentralised health care system \*Article 57) aligned with the nation vision for “Health Timorese People in a Healthy Timor-Leste”. The overall goals and specific objectives for this plan are taken directly from the NHSSP.

While the primary target audience for this document include Timor-Leste Government managers, planners and decision-makers (Ministry of Health, Ministry of Education, Municipal authorities), its contents has direct relevance to many actors and stakeholders, including teaching institutions (public and private), health service providers (public and private), professional boards and associations and development partners. The arrangements within it represent a comprehensive set of strategies and policy options to prevent and correct the labour market imbalance (Figure 3). If appropriately implemented, these policy efforts have the potential to improve the conditions and work performance of the labour force in Timor-Leste, and ultimately to benefit the entire population.

**Figure 3. Policy drivers for labour market for health and health workforce**



Source: WHO Global Strategy for the Health Workforce (HRH 2030)

SECTION III : Vision and Goals for the Health Workforce Strategic Plan 2020 - 2024



## **SECTION III : Vision and Goals for the Health Workforce Strategic Plan 2020-2024**

### **1. Vision**

By 2024 Timor-Leste has a qualified and motivated health workforce, with equitable distribution that guarantees the sustainable delivery of quality health care.

### **1. Guiding Principles**

The underlying values of the Health Workforce plan are the basis for the constitutional provision for free universal access to health care and for the goals of the NHSSP and ESP 2019 policy. This plan recognises the importance of:

- Equity of distribution of human resources functioning in accordance with the National Health System network and valuing the development of human resource skills
- The health workforce is not only a fundamental pre-requisite for the success of the health goals, but also a potential contributor to enable opportunities for qualified employment, particularly for women resulting in general economic growth.
- To promote the rights, participation and access of citizens, this plan is oriented to the primary health care approach, emphasising the importance of a mixed skills approach with the balance and needs to ensure the focus on prevention, promotion and outpatient care.
- It underlines the central role of the public sector, while allowing private public partnerships to achieve public policy objectives.
- This plan is also informed by considerations of efficiency and cost-effectiveness, and the importance of guaranteeing quality care through quality of the health workforce.

### **2. Overall objectives**

In accordance with the National Health Sector Strategic Plan 2030, the Ministry of Health projects a service configuration for primary health care to establish Health Posts in each suco and Community Health Centres in administrative posts and for population concentrations in urban centres of between 6,000 to 15,000. With regards to hospital based care, hospitals will be constructed in each municipality along with regional hospitals and a Super-Specialised National Hospital as the national referral centre. In order to achieve the above vision, attention will be given to three fundamental areas: health workforce; health service delivery and health infrastructure.

In responding to this plan, the Ministry of Health needs to ensure a *health sector workforce for Timor-Leste, with adequate numbers, distribution and skills, performance and quality standards able to offer service delivery to the*

*population in a friendly and respectful manner, in the context of appropriate management support and supervision.*

### **3. Strategic Intervention Objectives**

The NSPHRH 2020-2024 is based on the following main health sector strategic policy and planning documents:

- 1) National Health Sector Strategic Plan 2011-2030
- 2) Primary Health Care Program 2014;
- 3) Program of the 8<sup>th</sup> Constitutional Government;
- 4) Decree Law N.º3/2019 of the 5<sup>th</sup> of March, Ministry of Health Organic Law
- 5) Civil Service Human Resource Management Manual;
- 6) Analysis report for the Health Service Workforce 2014/2015
- 7) Essential Services Package 2019

The NSPHRH document covers a period of five years (2020-2024) and will be evaluated and reviewed in 2023 before the end of the five year period.

The National Health Policy has defined the priorities for the Health Workforce as follows:

- 1) Develop procedures for the development of the health workforce, particularly for selection and recruitment, remuneration, professional development and careers, in accordance with the priorities defined in the NHSSP 2011-2030;
- 2) Develop staff management norms and evaluation tools;
- 3) Promote the recruitment and mobility of professionals for the National Health Service, in accordance with the law;
- 4) Participate in the development of staffing in collaboration with the relevant services within the Ministry;
- 5) Comply with applicable legislation for the Public Administration (Civil Service);
- 6) Ensure attendance records and punctuality controls for staff at workplaces at all levels;
- 7) Participate in the development of annual plans for training and specialisations overseas, promote and organise the undertaking of training, ensuring gender equality;
- 8) Promote the review and updating of courses, ongoing training and seminars for Ministry staff;
- 9) Manage the scholarship system, within the Ministry of Health, for graduate courses and vocational training in health areas, in country and overseas, together with the INS and the FDCH;
- 10) Create and manage a health workforce management database;

### **4. Strategic Objectives**

The strategic objectives for this plan are taken directly from the NHSSP and regrouped and rewritten for the progress of the implementation of the NHSSP. The strategic objectives, principles and specific strategies mentioned in this document are the result of workshop deliberations with wide stake-holder

participation from the MoH, the Civil Service and a large number of partners and from face to face discussions with key informants.

The Strategic Objectives for the Health Workforce Strategic Plan 2020-2024 are defined as follows:

#### **STRATEGIC OBJECTIVES**

- 1. Availability & distribution of Health Workforce:** “Ensure the availability and equitable distribution of the Health Workforce for the proper functioning of the health system”
- 2. Training/Education:** “Develop the capacity for training and education institutions for the production of qualified human resources”.
- 3. Performance & motivation:** “Enable a conducive environment to improve work performance and motivation for the existing workforce and new recruits”.
- 4. Governance, Human Resources Management and Regulation:** “Strengthen health workforce management, planning, administration and quality assurance for all health practitioners”.
- 5. Health workforce information system** “Availability of timely, reliable and relevant information for health workforce management”

The NSPHRH 2020-2024 will be implemented and coordinated through health sector structures and management, including the Health Legal and Regulatory Body, the MoH Headquarters at the central level, the National Directorate for Human Resources, Municipal Health Services, Health Institutions, Development Partners and individual Health Associations. There will be specific coordination and implementation functions for stakeholders to implement the NSPHRH. Formulation of strategic objectives and components and their summaries are shown in table 21 with detailed descriptions provided in the following section.

#### IV. STRATEGIC INTERVENTION TABLE

1. Table 21: Summary Workforce Strategic Plan Table

	STRATEGIC INTERVENTION	SUB-STRATEGY	DESCRIPTION
Health Workforce availability & distribution	<b>1. Workforce Availability and Distribution: “Ensure equitable availability and distribution of health workforce for proper health system functioning”</b>		
	Appropriate planning for a rational mix of skills for local needs	Review standards for minimum staffing	Needs evaluation based on the new ESP 2019. The MoH senior manager to facilitate staffing profiles that review all health facilities from the sub-municipal to regional and national levels.
	Redistribution of health workforce	Development of Municipal Health Offices	MoH, through the Human Resource Directorate manager, will strengthen working relationships with HR personnel from the Municipal Health office in order to build their capacity to progressively develop the routine HR administration functions of local officers.
		Distribution within municipalites	Local health managers to adapt and implement a dynamic process to define current staffing for each facility, adjusted upwards or downwards based on the current service responsibilities observed during the most recent time period.
	Promote equitable deployment and retention	Linkages/Legally Binding	MoH will formalise legally binding/commitment scheme for services in rural areas for new graduates from priority professions (including doctors, nurses and midwives).
		Maintain salaries within the “range”	Civil Service Commission will resist requests for future salary increases for health staff.
Health Workforce	<b>2. Heath Workforce training/education: “Develop the capacity of training and education institutions for the production of a qualified health workforce.”</b>		
	<b>Align health workforce production by education sectors for health sector needs</b>	Annual orientation for the MoE	MoH will issue annual guidance for all training institutions, through the ME, regarding its medium-term anticipated health workforce needs, by staff type and locations.
	<b>Strengthen training/education institutions</b>	Accreditation	<ul style="list-style-type: none"> <li>MoH will promote the adoption and oversight of regulations via MoE inspections and an independent accreditation authority for all</li> </ul>

		health training institutions;
	Common Examination	<ul style="list-style-type: none"> <li>For each staff cadre, the MoE in coordination with the MoH, will facilitate a gathering of faculty representatives from participating training institutions to establish and adjudicate a final unified examination (written and practical) for the end of this year until the establishment of a Timorese Examination Board to assume this function;</li> </ul>
	Establishment of a Timorese Examinations Board	MoE with MoH to undertake strong coordination with the MoH, to establish a National Examinations Board for all graduates in health related fields
	Regulation of private sector education	MoH to review, and coordinate with the MoE, regarding existing legislation covering private sector education
<b>Strengthen and update content and modalities for pre-service education</b>	Curriculum review	Education institutions under MoE supervision and with advice from the MoH, to finalize curriculum review for pre-service education for selected health professions.
	Supervision of curricula in accordance with competencies defined for health personnel	The Professional Council established will supervise curricula in accordance with competencies defined for health personnel, including doctor, nurse, midwife and allied health professionals workforce.
	Competency based training	<ul style="list-style-type: none"> <li>MoE, with advice from the MoH, to support training institutions to strengthen their capacities and reorient that training goals for train graduates with all of the competencies need to enter the workplace.</li> <li>Create mechanisms to guarantee ongoing professional development and training</li> </ul>
	Increase practice locations	MoH to facilitate the use of existing health facilities as practice sites for pre-service students and new graduates (interns)
Review of scholarship schemes	Best use of the Human Capital Development Fund and Career Progressions	MoH through the FDCH to rationalise and prioritise scholarship awards for health education
Strengthen Health Workforce cooperation and capacity building	Strengthen cooperation with countries, National and international institutions for Health Sector Workforce capacity building	<p>Develop a training, capacity building and ongoing professional development plan;</p> <p>Create a management training package for managers at different levels in the Ministry of Health;</p>

			Specialized training for educators, professional technicians, for human resource managers in the areas of management, administration, finance, procurement and accountability
Performance & Motivation	<b>3. PERFORMANCE &amp; MOTIVATION: Create a favourable environment to improve work performance and motivation of the existing and newly recruited workforce”.</b>		
	<b>Integrated in-service training</b>	Needs assessment	MoH to support the INS to conduct a comprehensive assessment of needs throughout the entire nation for in-service training
		All staff benefit from in-service training	INS, in accordance with guidance from the MoH, through the Department of Workforce Planning & Development, re-prioritising maintenance of skills and development of the existing health Workforce to establish and launch a program for delivery of integrated in-service training for all public health sector staff at least every five years.
	<b>Supervision</b>	Supportive supervision (mentoring)	MoH to support development of supportive supervision (mentoring) tools and promote ongoing supervision practices at all levels in the system, and provide resources such as transport.
	<b>Rural incentives</b>	Rural benefits	MoH to award a bonus to staff agreeing to placement in suco health posts with lower levels of service.
		Housing	The Director of Municipal Health Services will seek to ensure that individual health workforce personnel accept rural deployments to areas that are not the same as their original residence, with adequate housing, separate from the health facilities, and provide free assistance or at a concessionary rate
			•
<b>4. GOVERNANCE, HUMAN RESOURCE MANAGEMENT &amp; REGULATION: “Strengthen capacity for management, planning and administration of HRH in general, develop and implement mechanisms for registration, regulation and quality controls for all health practitioners”</b>			
<b>Build health Workforce governance capacity at the national and local levels</b>	HR Directorate mandate	MoH to consolidate and strengthen health workforce governance and leadership functions to empower the health workforce Directorate.	
	Re-organisation of the role of the HR Directorate	MoH, through the HR Directorate, to re-orient its role for proactive management in accordance with their role for harmonisation, standards and expectations as the central and municipal level entity;	
	Management and leadership capacity	MoH to facilitate development and acquisition of management and leadership capacity for health professionals at all levels of the health system. Strengthen/build the capacity of Municipal Managers in the	

		<p>áreas of management and decentralisation.</p>
<p><b>Coordination of Health Workforce development and performance</b></p>	<p>HRH Technial Working Group</p>	<p>MoH to facilitate establishment of an intersectoral Health Workforce Technical Working Group</p>
<p><b>Simplify work force management practices</b></p>	<p>Standard Operating Procedures</p>	<p>MoH, through the HR Directorate, to coordinate and monitor implementation of Standard Operating Procedures (SOPs) for merit based recruitments (to fill each vacancy), placement (selection for work station or work posting), deployment (dispatch to posting), transfers (relocations), staff administration and management</p>
<p><b>Regulations and implementation of legislation package regarding health workforce management.</b></p>	<p>Continue to strengthen and improve legislation, in accordance with rules and regulations for professional careers</p>	<p>DNHR to work together with relevant entities to implement: Review the legal diploma for Exercise of Health Professions, establishment of Health Professionals Councils or Orders to supervise curricula, skill and licensing for health staff, including doctors, midwives, nurses and allied health professionals</p> <p>Coordinate witht the CSC with a view to review current legislation regarding health Professionals Careers, in a way that simplifies and makes a more flexible career system; Conduct regular actions to provide clarification of the application of rights and awards, (subsidies, supplements and incentives)</p> <p>Coordinate with the Ministry for Higher Education, Science and Culture for the creation of teaching careers in the health sector;</p> <p>Institute a Performance Evaluation Commission for Health Professionals (PECHP), develop criteria for monitoring and evaluation of health professionals</p>
<p>Regulations for Remuneration Incentives</p>	<p>Continue to strengthen and improve legislation in accordance with the legislation</p>	<p>NDHR to coordinate with the CSC and Minsitry of Finance with a view to:</p> <p>Regularise the situation of civil servants for rights and awards in terms of the current legislation;</p> <p>Implement compensation principles for work in risk áreas, overtime and shiftwork;</p>

			Establish a system of credits for the attribution of subsidies, incentives for professionals and health teams, based on merit, performance, by type of 'health facility' (HNGV, HR, CHC I, II or II, HP)
		Dual Practice:	MoH Legal Officers to review existing legislation which administer regulations for the provision of private health services, including dual private/public practice by those employed in the public health service.
<b>5. Health Workforce Information System “Availability of timely, reliable and relevant information for Health Workforce management”</b>			
	<b>Strengthen the Information System</b>		<ul style="list-style-type: none"> <li>• Creation of a health workforce information system integrated with the HIS;</li> <li>• Creation of planning indicators, follow-up and evaluation of the health workforce;</li> <li>• Creation of a “Health Workforce Observatory” integrated with the “National Health Observatory”;</li> <li>• Completeness/updating of the health workforce information system for public administration of health workforce management needs.</li> <li>• Develop SOP/guidelines for establishment of Health Workforce Information System</li> <li>• Establish infrastructure for IT for Health Workforce</li> </ul>
<b>Preparation for implementation: define responsibilities and accountability arrangements</b>			
<b>Mobilise sufficient financial resources for plan implementation</b>			

## 2. Strategic Interventions

### 2.1 Strategic Objective 1:

**Health Workforce Availability & Distribution: “Ensure equitable health workforce availability and distribution for proper health system functioning**

#### 2.1.1 Appropriate planning for a rational mix of skills for local needs;

**Review minimal staffing standards:** *Needs assessment based on the new ESP 2019 policy. Senior MoH manager to facilitate development of staffing profiles for all health facilities at the sub-municipal, regional and national levels.*

Examine needs identified for human resources for health based on the NHSSP, PHC PHC 2014 and those suggested in the 2019 ESP document comparing these with a review of legislation, including the Health in the Family Policy and Decree-Law (December 2017), review of health facility structures (February 2018), decentralisation legislation and other significant policies.

There will be analysis of standard staffing needs aligned with the Essential Service Package 2019, with complementary updating of costs and service requirements by level, which will also include needs for medication and medical equipment, so as to enable a comprehensive overview of the mid-term needs of the entire health system. There may also be consideration of the existing finance capacity and realistic forecasting of the fiscal space for the next five years.

Therefore, the MoH will define the minimal staffing needs with updating on the bases of health facilities to include all health professionals necessary (defined numbers) and with consideration for health service needs based on the current national health priorities and profile, while reflecting a holistic approach to health service delivery.

There should be a review of the long-term viability of staffing standards to look at weighing up fixed costs, cost effectiveness and clinic appropriation (in terms of the most effective and efficient use of limited resources), and relevance to population needs (as determined on the basis of the baseline data from Health in the Family for individual sucos and outputs and usage figures).

The MoH must decide whether informal staffing by community health staff must be progressively increased or whether they must be formalised and more directly integrated within the health system.

Rationalised staffing profiles will enable a more cost-effective allocation of resources and greater health budget sustainability. Failure to act will result in lack of resources to implement unrealistic staffing profiles and/or result in excessive staff at low workload facilities resulting in reduced productivity and loss of skills.

### **2.1.2 Health Workforce Redistribution, by professional categories, áreas of specialisation for all levels of health facilities**

#### **Development of Municipal Health Office**

The MoH, through its HR Directorate manager, will strengthen working relationships with HR staff from the Municipal Health Office in order to build their capacity to progressively develop routine HR administrative functions of local officers. Through retraining sessions in Dili and regular visits from MoH staff to each Municipality, local HR units will develop their capacity to enable discussion and presentation of evidence about health workforce distribution to municipal directors to promote rational local decision making. Therefore, support and training will be increased for municipal HR officers.

The consequence of this action will be fairer distribution of health workforce responding to local needs; increased awareness and response capacity for local health workforce; allow for early feedback from horizontal-level concerns to the central level; alleviate the work responsibilities of the MoH HR Directorate over the long-term. The consequence of inadequate development of the municipal HR unit is continuing inflexible management and reduced resilience and response capacity.

#### **Distribution within municipalities:**

Local health managers will adopt and implement a dynamic process for defining current staffing at each facility, adjusting the staffing profiles upwards or downwards based on the current workload and recent trends.

The WHO Workload Indicators of Staffing Need (WISN) provide a good methodology and tool for assessing the human resource needs for health facilities based on their workload.

The consequence of this action, will strengthen the capacity of municipal directors to make a health workforce distribution with demographic and geographic balance for operational imperatives, that maximizes accessibility coverage without compromising quality. The consequence of failing to follow the reviewed guidance will result in inappropriate allocation of resources far away from communities, an oversupply at health centres (which will not be utilised).

## **Promote equitable deployment and retention**

**Binding relationship:** MoH will formalise a binding relationship scheme for work in rural areas from priority professions (including doctors, nurses and midwives). The binding placement scheme will involve exclusive work with the government after completion of pre-service education, subject to public sector employment offers.

If implemented together with positive incentives (including improved workplace environment, adequate system support, career scale and financial incentives) this approach will re-inforce rural deployments and retention.

The consequence of not taking action, is increased risk of ongoing challenges arising from not being able to fill positions and peripheral health facilities with the types of health staff required by national policy.

## **Maintain salaries within the “range”:**

**The Public Service Commission will resist requests for general salary increases for health staff.**

The economic arguments (relatively competitive salary scale, higher provisions for health personnel compared with public sector demands, long-term economic outlook insecurity) don't guarantee at this time any adjustment to increase salaries.

The consequence of ever increasing salary levels, will destroy the sustainability of health sector budget and accumulation of other essential recurrent health expenditures, including procurement for medical supplies and supervision, monitoring and coordination activities.

## **Strategic Objective 2:**

**Health Workforce Training/Education: “Develop the capacity of training and education institutions relating to the production of a qualified health workforce.”**

### **4.1. Align Health Workforce Production with Health Sector Needs** **Annual guidance to the MoE:**

*MoH will issue annual guidance to all training institutions via the MoE, regarding its anticipated mid-term health workforce needs, by cadre and location.*

A five year forecast, updated and increased annually, will alert decision makers at health training institutions about the numbers desired for some cadres based on the MoH’s anticipated needs (and for which they are in a position to recruit), to properly allow them to adjust – upwards or downwards – their student intakes. Written guidance can be accompanied with various explanations regarding the rationale, so as to promote action. This guidance will enable channeling of the health workforce (see below) as part of other discussions.

The consequence of these actions will be that, for the MoH, health workforce requirements will be available in the labour market at the necessary time and, for training institutions, successful graduates will quickly enter the workplace to increase the good reputation of institutions (and potential future profit).

For training institutions, and the entire Timorese society, failure to take action will be increased failure to employ graduates, with potential social, economic, and political damage from high numbers of unemployed graduates

### **2.2. Strengthening training and education institutions**

#### **Accreditation:**

MoH will promote adoption and observation of regulations for inspection by the MoE and independent accreditation authorities for all health training institutions.

Increased supervision needs in all training areas, particularly opportunities for practice and preparation of teaching staff skills, will be improved by a review of infrastructure and conditions. A joint inspection of training and practice facilities is recommended. The consequences of this action will be dependable health training providers for the production of the major cadres in accordance with appropriate quality standards, allowing public education institutions to focus

training resources for cadres that are lacking or for post-basic training to the workplace.

### **2.3. Skills Examinations:**

For each cadre, the MoE, in coordination with the MoH, will facilitate a joint meeting with faculty representatives from participating training institutions in order to establish and adjudicate unified final examinations (written and practical) for each year's cohort, until the establishment of the Timorese Examinations Board assumes this function.

The consequences of inaction will be a meaningless variety of documents that ordinary people will not have the capacity to interpret reliably; and the devaluing of all certifications; externally it will have risks to the reputation of Timorese qualifications.

### **2.4. Establishment of Timorese Examinations Board:**

The Timorese Examinations Board will be responsible for conducting examinations for licensing of new graduates to the various health professions, including doctors, nurses, midwives and allied health professionals. Examinations must be written and practical and focus on the evaluation of the necessary minimum competencies. The function of the National Examinations Board must be reviewed once a professional council is functioning to avoid duplication.

### **2.5. Regulations for the private health sector:**

The MoH will review and coordinate with the MoE existing legislation that administers the regulation of private sector education.

Subject to the results of the review, the MoH will consider legislation proposals through Parliamentary Laws that establish the relationship for regulation for private sector education institutions.

The intention is to ensure the application of uniform quality standards for both public and private education institutions.

#### **2.2.3. Strengthen and update content and modalities for pre-service education**

##### **Curriculum review:**

Education institutions, under supervision by the MoE and the MoH council, will finalize pre-service education curricula for selected health professionals.

For example, the MoH and its municipal managers need to be able to ensure that nursing curricula give sufficient attention to the practice workplace demands for

modern community based-nursing (e.g. post-introduction of the Essential Services Package 2019 and Health in the Family Program). For all health staff cadres, it will be important to ensure that education, in order to increase diagnostic, clinical and other skills transfer, also build a conducive professional ethos for respectful care centred on the individual, and a positive attitude to work that provides the foundation for inter-professional collaboration and team-based care.

The consequence of this will be the recruitment and deployment of health professionals to sites where they have the skills to provide appropriate and effective interventions with confidence giving attention to health needs so as to have an impact on national health statistics and increase the population's satisfaction levels.

The consequences of inaction will be the opposite: recruitment and deployment of individuals who are inadequately prepared for the locations where they will not have the skills to make appropriate and effective interventions with confidence, and will not make a positive impact on national health outcomes.

#### **Curriculum supervision according to competencies defined for health personnel:**

The Professional Council established will supervise curricula in accordance with the competencies defined for health personnel, including doctors, nurses and midwives and allied health professionals.

The Professional Council will advise pre-service education institutions, through the MoE, regarding the necessary competencies defined for each professional cadre, with an emphasis on practical exposure for skills development.

The Professional Council will liaise with the MoH to facilitate practical exposure to real situations, and additional laboratory practice.

Competencies will be evaluated for defined needs and become the requirements for registration with the council, therefore the consequence will be ensuring that the minimum curriculum will result in improved skills for graduates.

### **Competency based training:**

The MoE, with the MoH council, will support training institutions to strengthen their capacities and reorient their training goals to train graduates with the appropriate competencies to enter the workforce. This involvement will ensure that performance based on 'know-how' (work-skill readiness in their chosen field) instead of knowing what (having only knowledge).

For skill-based cadres, this will have a correlation with a satisfactory student-teacher ratio (e.g. limited class sizes); adequate facilities and infrastructure for health education institutions; increased opportunities for practice in health facilities and at the community level; relevant and appropriate content, together with seeking feedback from students and student managers; feedback that enables faculty to benefit from advice and requests from students; opportunities for repetition and progression of practical skills (as a consequence of workplace deployments and exposure).

The consequences of this action will be increased user-, employer- and employee satisfaction and improved reputation for institutions. The consequence of inaction will be pressure to increase the numbers of students reducing the opportunities for learning in practice sites that continue to be unavailable, increasing the workload of graduates, increasing the early attrition rate and devaluing qualifications, with a negative impact on the reputation of qualifications amongst other impacts.

### **Increase practice sites:**

The MoH will facilitate the use of existing health facilities as practice sites for pre-service students and new graduates (interns)

In order to ensure appropriate skills development and exposure to real practice setting for sufficient acquisition of competencies (Strategy 2.3.3), the MoH will ensure the availability of Public Health Facilities as practice sites for students and collaboration with MoH staff for practical training for the future workforce. For this proposal, adequate routine accreditation will be established and conducted for health facilities as practice sites

This will allow for the exposure of students to real practices, ensure that graduates are prepared to operate in real contexts, while favouring interactions between students and professionals in the workplace. At the same time, it will strengthen the maintenance of best practice skills for the staff already deployed.

## 2.1. **Review of the scholarship scheme**

### **Best use of the FDCH and Career Progression:**

The MoH, through the FDCH, will rationalise and prioritise scholarship awards to health education.

The best possibility for the health workforce for the Timorese health system is to be trained in Timor-Leste.

Overseas pre-service education scholarships should be stopped for cadres that are already being produced in Timor-Leste. For medical specialists and other cadre with relatively small numbers that make it uneconomical to develop national production capacity, scholarships will be maintained prioritising health workforce needs where supply is lower than the existing or predicted health system needs.

Reform of the scholarship scheme will enable better matching of production with needs, and a more cost-effective use of resources. Lack of action will result in oversupply of some cadres and under-supply of others, while consuming financial resources.

### **2.2.5. Strengthening cooperation for Health Workforce capacity building:**

Strengthen cooperation with countries and international and national institutions for health workforce capacity building. The NDHR to coordinate with relevant entities, develop training, capacity building and ongoing professional development plans.

There is a need to create a management training package for different levels of managers in the Ministry of Health that have not been given attention or prioritised. Training for specialisation as trainers and educators, technical professionals, for human resource managers in the areas of management, administration, finance, procurement and accountability will be developed.

### **2.3 Strategic Objective 3:**

**PERFORMANCE & MOTIVATION: “Create a favourable environment to improve workforce performance and work motivation”**

#### **2.3.1 Integrated in-service training**

##### **Needs assessment:**

The MoH will support the INS to conduct comprehensive assessment of needs for in-service training of health workers.

A comprehensive assessment of training needs will be undertaken in order to guide the development of an appropriate in-service training package;

This must include all levels of facilities, all existing cadre types and all municipalities. This will guide the development of training modules that realistically translate into workforce motivation while adapting existing health professionals for new developments and the introduction of new policies.

In-service training must respond to identified professional development requirements so that weaknesses in existing practices can be objectively identified and also to augment the skills proposed for the introduction of changes.

The consequence will be the development and delivery of training that responds to existing needs (including self-assessed needs), so as to increase motivation.

##### **All staff will benefit from in-service training:**

The INS, with guidance from the MoH, through the Department of HR Planning and Development, HR Directorate will prioritize the maintenance of existing skills and health workforce development in order to build and launch a program for provision of integrated in-service training for all public sector health staff at least every five years.

Unexplored potential of the INS can be fully exploited through the allocation of additional resources from the FDCH, following rationalization of the scholarship scheme.

In-service training activities can first derive from needs assessment (Strategy 3.1.1), and be provide in part on site and in part at the central level at the INS.

Repeated devliery of a 10-day integrated in-service training package, combined with on-site supporting supervision visits intended to target the health workforce in rural locations has the potential to achieve multiple outcomes, which include: incentivize and motivate those in remote locations; provide collective feedback essential for managers (those that don't have the capacity to reach all facilities);

Increased opportunities for career advancement through enabling evidence-based promotions; promoting vertical integration of programs and development of integrated follow-up care; contribute through delivery to more equitable in-service training coverage; capitalizing on earlier investment by the government in these health workforce trainings; development of skill and behaviour changes in preference to the acquisition of knowledge; and enabling individual performance reviews conducted in the context of on-site in-service training activities.

In-service training activities will start with a focus on integrated care, ethics for health practice, appropriate attitudes towards patients, inter-professional collaborations and team-based approaches to care and other cross-cutting elements; over time they will progressively strengthen greater incorporation and greater attention to service needs – or illness-specific training.

Opportunities for more regular web-based training modules via smart-phones and other information and telecommunications technology can also be explored.

The consequence of extended gaps in in-service training is the rapid increase of staff lacking in skills; disassociation between providers and managers; health workforce concerns that remain unresolved; initial investment expenses and difficulty in identification of promising junior managers.

### **2.3.2 Supportive supervision.**

#### **Supportive supervision:**

The MoH will support the development of supportive supervision tools and the promotion of ongoing supervision practices at all levels of the system.

The design of supportive supervision tools that focus on health professional performance and provide support to identify challenges for development will

facilitate periodic performance assessments that motivate and influence professional action.

Tools must be adapted to different facility levels and focus on integrated services, with a vision for teamwork in specific sites. Capacity building of supervisors through positive feedback and encouragement rather than punishment – is an essential requirement for successful supervision.

The association of performance assessment results with special recognition (e.g. bonuses or early recognition and commendments) will boost motivation and performance. Supervision tools must be aligned with other existing tools – e.g. health in the family – while supervision visits can be combined with other activities for maximum efficiency.

The consequences of these actions will be increased motivation and improved performance; supervisors will obtain greater knowledge of performance from levels under their responsibility, facilitating decision making and skills.

They will also need to be able to update their skills and knowledge to be able to support those being supervised adequately. Inaction will lead to individualized and fragmented services and de-motivation of staff in remote areas.

### **2.3.3 Rural incentives**

#### **Rural benefits:**

The MoH will award a rural bonus for staff who agree to locate to health posts in sucos currently lacking adequate manpower.

Classification of existing postings based on their distance can be reviewed to identify remote and difficult posting sites. This must consider also the types of work, responsibilities and other variables including isolation, in order to ensure support for various health professional cadres, based on the requirements of new policy (e.g. health in the family). This may stimulate interest amongst staff to accept remote postings.

It is a fact that the choice of sucos has not received attention as a criteria for what is considered to be rural. The bonus will recognize additional workloads that are involved in establishing relationships and delivery of services.

Other recognition mechanisms will be implemented, including commendations and rapid promotion opportunities for health staff with good performance in remote rural areas.

The consequence of this actions will be to revive the expansion of the health service network. The consequences of inaction will be continued attraction to urban locations and inadequate comprehensive and equitable coverage of essential health services.

**Housing:**

The Director of Municipal Health Services will seek to ensure that individual members of the health workforce posted to areas that are different to their usual residence are provided with appropriate housing, separate from health facilities or at concessionary rates.

Following a survey of housing needs, municipal directors can liaise with the municipality, suco or municipal authorities to determine a plan for each facility identifying individual resource contributions. As a condition for the expansion of the service network, new health posts in sucos that previously lacked attention must be provided with appropriate utilities, such as water and electricity, and accompanied with housing for health staff. In order to respect cultural norms, male and female health staff will live in separate housing.

## **2.4 Strategic Objective 4:**

### **Human Resource Governance, Management and Regulation:**

*“Strengthen the capacity for health workforce management, planning and administration in general, and particularly, take appropriate steps to continue to strengthen and improve legislation, in accordance with laws in relation to professional careers and quality assurance in professional service, including for decentralisation of health professionals management skills”.*

#### **2.4.1. Build the capacity for Health Workforce governance functions at the national and local levels**

##### **HR Directorate Mandate:**

The MoH will consolidate and strengthen health Workforce governance and leadership function in order to strengthen the HR Directorate.

The HR Department must refocus its mandate and be able to take responsibility for coordination of implementation and monitoring of this Health Workforce Strategic Plan, with responsibility for Health Workforce planning, development of national standards, policies and regulations, coordination with other sectors and constituencies, determination of appropriate work conditions and remuneration, monitoring of quantitative trends and policy implementation, in compliance with relevant international obligations, support policy dialogue in order to provide capacity building and backstopping for municipal health HR units.

During the initial phase, technical support strengthened by development partners may facilitate the necessary capacity building activities. In order to build capacity sustainably, it will be critical to maintain some institutional stability, including through retention of MoH staff who have progressively obtained skills and competencies in health workforce strategic management.

Strengthening the HR Directorate will enable the MoH to be the main driver of the national health workforce development agenda. The consequence of inaction will be limited progress and lack of satisfaction with the implementation of this plan.

### **3.2. Re-organization of the role of the HR Directorate:**

The MoH, through the HR Directorate, will re-direct its role to proactive management function in accordance with its role in harmonisation, standards, and oversight of projected needs as a central level entity.

This will involve the HR Directorate management having the highest level of authority to reduce or increase its own daily and clerical administrative roles.

This will enable the achievement, at least in part, through the clear separation of administrative and clerical functions from strategic and management functions, and have staff dedicated with more focussed relevant competencies; better organised procedures (such as above); delegation of authority and proper decision making (so as to limit unproductive roles); review and sharing of tasks with others.

The consequence is a senior manager being available to dedicate more time and energy (and in the end saving time) for strategic activities, such as inter-sectoral coordination, health labour market analysis, health workforce planning and policy, projection of future needs, instead of (as at present) being tied to urgencies of an administrative nature.

Mandatory tasks that continue to be unaddressed that fall back on the HR Directorate are the drafting of annual departmental progress reports, compiling, analysis and interpretation of data from the municipalities, and the preparation of the situational analysis every five years. All future strategic and operational plans will be produced in house by the MoH.

The consequence of inaction will be ongoing disconnect from the proper strategic role and lack of ability to anticipate problems.

### **3.3. Management and leadership capacity:**

The MoH will facilitate the development and aquisition of management and leadership capacity for health professionals at all levels of the system. Adequate administration for health institutions and proper leadership is needed at all levels of the health system, making allowance for the varying needs and teams/sizes of the facilities in different locations.

Many health professionals are requested to perform roles that involve management tasks and leadership of teams of varying sizes, without, in the majority of cases, receiving any training or practice in these skill áreas. The development of skills in this área must include formal standardised courses for

diferente levels, including diploma and M.Sc. (at identified quality institutions) for individuals selected for positions that they will hold for a sufficiently lengthy period of time; as well as short workshops, ideally organised by the INS as in-service training (see Strategy 3.1.2), which must be considered for health professionals being deployed, with modules defined on the basis of postings and needs.

Training needs to be oriented to health management specificities but should include basic management and leadership practices ordinarily used for some administrative positions. This is an area where new modalities for skills development have multiplied and gained acceptance globally; these include traditional methods such as training, individual mentoring, peer relationships; however there are also on-line platforms with modules provided via apps and smart-phones—which enable greater audience reach, while playing a significant role in increasing knowledge, skills and attitudes.

High quality modules must be developed that are adapted on the basis of results and evidence but readiness to experiment with new methodologies and techniques, and to pioneer their implementation within the limitations of the context.

Increased understanding of proven practices and methodologies will increase the confidence of health professionals, while minimizing the learning and adaptation periods for new postings and will facilitate communication with senior level professionals. Inaction in this area will maintain the status quo of poor management practices which in turn affect the performance and efficacy of the entire system.

### **3.4. Coordination of health workforce development and performance**

#### **Health Workforce Working Group:**

The MoH will facilitate the establishment an intersectoral health workforce Technical Working Group (TWG). While the MoH HR Directorate has the main responsibility for health workforce distribution and management, contribution from the Ministry and Finance and the Ministry of Education allows their education and recruitment in the first stage; very similarly to the key roles undertaken by the Civil Service Commission, the Ministry of State Administration and other who help with continuity.

Because of this it is essential to have a formal mechanism for regular interactions to enable the sharing of information and the alignment of policies and investors in the different Government sectors and the range of constituencies within society. Matters requiring high level decisions must be noted by working group members from their respective hierarchies for discussion and follow-up action at the appropriate levels.

The result will be coordination and policy coherence for the health workforce in different Government sectors. The consequence of inaction may be counterproductive divergence of interest and activities within line ministries and at different levels of government.

### **2.4.3. Simplify workforce management practices.**

#### **Standard Operating Procedures:**

The MoH, through the HR Directorate, will coordinate and monitor the implementation of written Standard Operational Procedures (SOPs) regarding recruitments (filling of vacancies), placement (selection for a work station or posting), deployment (being dispatched to the posting) and transfers (replacements).

Extra time for sequential components for individual procedures will be reviewed that shorten, lengthen, simplify or remain to be measured again, so as to be properly organized. This will inform the meritocratic nature of recruitment and decisions for career advancement. It will eliminate components that are open to interpretation (and subsequent abuse).

The consequences of this action will be a series of transparent procedures that protect decision makers from inadequate influence. The consequence of inaction, will be the perpetuation of risks from a non-transparent system for abuses that are caused by irrational allocation of resources – or 'inconsistent mission deployment' leading to unfair, inequitable practices and resulting in reduced readiness to accept isolated or less favourable postings.

### **2.4.4 Regulations and implementation of legislative package regarding health workforce management:**

Implementation of regulations/legislation for supplementary remuneration awards, career legislation for other health technicians, and legislation of rights and awards. Improvements to working conditions will be particularly implemented through administration laws.

Establishment of a joint commission with the civil service will enable socialization of the application of mechanisms for the career regime for professional technicians and the general health workforce regime in the municipalities, regions and at the national level. This will also require dissemination for implementation of professional technician rights and awards and also for the general regime (all civil servants have the right to a range of benefits, such as overtime in lieu of pay, transfer subsidies, shiftwork, per diems, relocation allowances, scholarships, attendance at training, leave, professional remuneration for remote areas, foreseen in Decree Law No. 20/2010/1 Dec. 2015. It also includes better staff administration management services (management of personnel data, management of holidays, absences, leave, remuneration, performance evaluations).

### **Statutory regulations**

The MoH will promote legislation to establish a Professional Council to supervise curricula, health staff competencies and licensing, including for doctors, nurses, midwives and the allied health professionals workforce.

Through the legal obligation to issue licenses only for those professionals demonstrating satisfactory completion of pre-service education with the required competencies, knowledge and behaviours the Professional Council will guarantee competency levels that will protect the public from poor quality health care. The Council must have access to other skills to enable professional judgement.

The consequences of employment despite some individuals lacking certification, and not having the competencies for the hierarchy is the risk of devaluing the profession, the reputation of other authentic professionals, the irremediable damage to public trust, the destruction of the governments efforts to deliver quality health services for its citizens and also barriers for future training and employment overseas (once the domestic market is saturated).

### **Interim licensing and registration:**

The MoH will continue the registration process for health professionals as an interim-licensing mechanism prior to the establishment of a professional council.

The MoH will require and issue registrations for health professionals (doctors, nurses, midwives and other allied health professionals) in the MoH registration system, at the Office and health Quality Assurance, under the MoH, as the pre-requisite for practice in the government health service. Progressively, registration will become obligatory for work in the private sector. This will be facilitated with coordination with health professional associations and through direct visits to health facilities.

Practice based registration will also be required for foreign doctors. This measure will be temporary, until there is a Health Professional Council with the competencies to assume responsibility for licensing, undertaking those processes need to guarantee certifications and equivalence.

The consequences of this measure will be to set minimum standards for qualified health professionals leading to improved quality and preventing patients from being exposed to unqualified professionals. The consequence of inaction will be the proliferation of uncontrolled and unregulated health professionals.

### **Dual practice:**

The MoH legal officers will review existing legislation the governs the administration of private sector health care delivery, including dual private/public practice by public service employees.

At the same time the MoH will investigate and document its prevalence. Subject to the outcomes of the review, the MoH will consider proposing legislation through the Parliament to establish binding regulations for dual practice by individual health staff. The intention is to ensure the application of uniform quality standards in all public and private institutions, and to prevent unregulated double practice, which may result in uncontrolled expansion of private sector delivery by public servants in the health sector which may have a negative impact on public sector health service delivery.

The regulation of dual practice may include the possibility for some cadres (e.g. doctors and specialists) to combine designated appointment with private sector practice (whether in self-employment or by an institution), which provides that in this context there is obligatory sharing of information with public and private sector employers regarding this work situation, and part-time preparations that ensure that publicly financed services are conducted at agreed times and standards of quality. However, post graduate training opportunities that are publicly financed and other opportunities for career advancement must be preferentially available to staff working full time in the public sector. The consequence of not having or neglecting to have legislation, or of unclear legislation that is left open to interpretation will result in conflicts of interest and suspect practices.

## **2.5 Strategic Objective 5:**

**Health Workforce Information System** “Availability of timely, reliable and relevant information for health workforce management

### **2.5.1. Strengthening the Health Workforce Information System**

#### **Health Workforce Registration:**

The MoH will continue establish a dynamic health workforce information system. This electronic platform will be strengthened to consolidate it as the sole repository of all data and evidence from a range of data sources, involving all health staff within the country, and with the capacity to generate timely reports regarding the quantity, composition, distribution, employment status, health workforce demographic characteristics, including gender and age.

All health education institutions, professional councils (once established), private health sector employers, public sector employers at all levels will have a duty (enshrined in relevant regulations/legislation) to contribute on a regular basis to updated information for the national health workforce register.

On the basis of improvements to health workforce evidence, the MoH will be in a position to maintain and publish a national health workforce annual report of relevant health workforce statistics and for policy areas to strengthen national and sub-national level planning and monitoring, including international reporting.

The consequence of not developing a dynamic health workforce register will be persistent uncertainty about critical information about the health workforce, leading to mis-alignment of policies with the current health system and the needs of the population.

### **3. Anticipated Outcomes/ Key Indicators:**

- National health workforce strategic plan developed and approved by the National Directive Council;
- Revision of staffing standards developed and adopted;
- Proportion of vacancies filled each five years monitored;
- Staff to population ratio clearly identified;
- National curriculum defined for medicine and health sciences and leadership management to 2024;
- National institution for training and accreditation regionally recognised;
- A training mechanism for managers at all levels, with action plans, tools for evaluation and sanctions developed and implemented;

- By 2024 the availability of qualified staff increased significantly;
- Integration of health workforce data into the Health Management Information System;
- Computerised System established and maintained at a central location at the MoH for staff placement, with regular updating of health service delivery at the municipal, autonomous region and central levels;
- Comprehensive directives for human resource management developed and adopted;
- General improvements to the application of staff rights and obligations

## **SECTION V. FINANCING OF THE HEALTH WORKFORCE**

### **1. Costing of needs scenarios with a view to projected demands to 2030**

With a rapidly increased supply of health staff, matching the population and health system needs for health staff in Timor-Leste is a major challenge, or in other words, the economic capacity of the nation to purchase health service, (whether in the public or private sector), paid for by individual employers or through individual private practice.

Also in relation to demand, it is useful to maintain a distinction between the public and private sectors as at present, private sector demand for health staff is more limited and is estimated to remain at about 10% of public sector demand for these estimates. Table 20 a, b and c present the costs for public health sector staffing based on the three identified needs scenarios.

Costings according to more conservative approaches, assume the ongoing use of the current salary scale, rural incentives etc. Costs for pre-service education are a very strong factor for part of this cost analysis, as is the essential focus for analysis on sustainability of salary accounts.

**Table 20.a. Costs for payroll to meet the health Workforce Requirements of the NHSSP 2011-2030.**

Cadre	Monthly salary (USD)	Annual cost	NHSSP Requirements 2030	Total (USD)
Specialist doctors	1,025	14,760	293	4,324,680
General practitioners	610	8,784	1,065	9,354,960
Nurses	450	6,480	3,944	25,557,120
Midwives	450	6,480	2,115	13,705,200
Nurses aides	360	5,184	10	51,840
Allied Health Professionals	450	5,670	1,703	9,931,896
Ancillary staff	150	2,160	1,391	3,004,560
General/admin staff	450	6,480	1,391	9,013,680
Total				<b>74,943,936</b>

**Table 20.b. Cost of payroll to achieve the Health Workforce Requirements for PHC Policy 2014.**

Cadre	Monthly salary (USD)	Annual cost	PHC Requirements 2014	Total (USD)
Specialist doctors	1,025	14,760	293	4,324,680
General practitioners	610	8,784	1,044	9,170,496
Nurses	450	6,480	3,579	23,191,920
Midwives	450	6,480	1,896	12,286,080
Nurses aides	360	5,184	10	51,840
Allied Health Professionals	450	6,480	1,879	12,175,920
Ancillary staff	150	2,160	2,309	4,987,062
General/admin staff	450	6,480	2,309	14,961,186
Total				81,149,184

**Table 20.c. Costs for payroll to achieve health workforce requirements for staffing levels reviewed for 2021 (ESP 2019).**

Cadre	Monthly salary (USD)	Annual cost	2021 staffing norms requirements	Total (USD)
Specialist doctors	1,025	14,760	148	2,184,480
General practitioners	610	8,784	807	7,088,688
Nurses	450	6,480	1,874	12,143,520
Midwives	450	6,480	801	5,190,480
Nurses aides	360	5,184	10	51,840
Allied Health Professionals	450	6,480	529	3,427,920
Ancillary staff	150	2,160	944	2,038,284
General/admin staff	450	6,480	944	6,114,852
Total				38,240,064

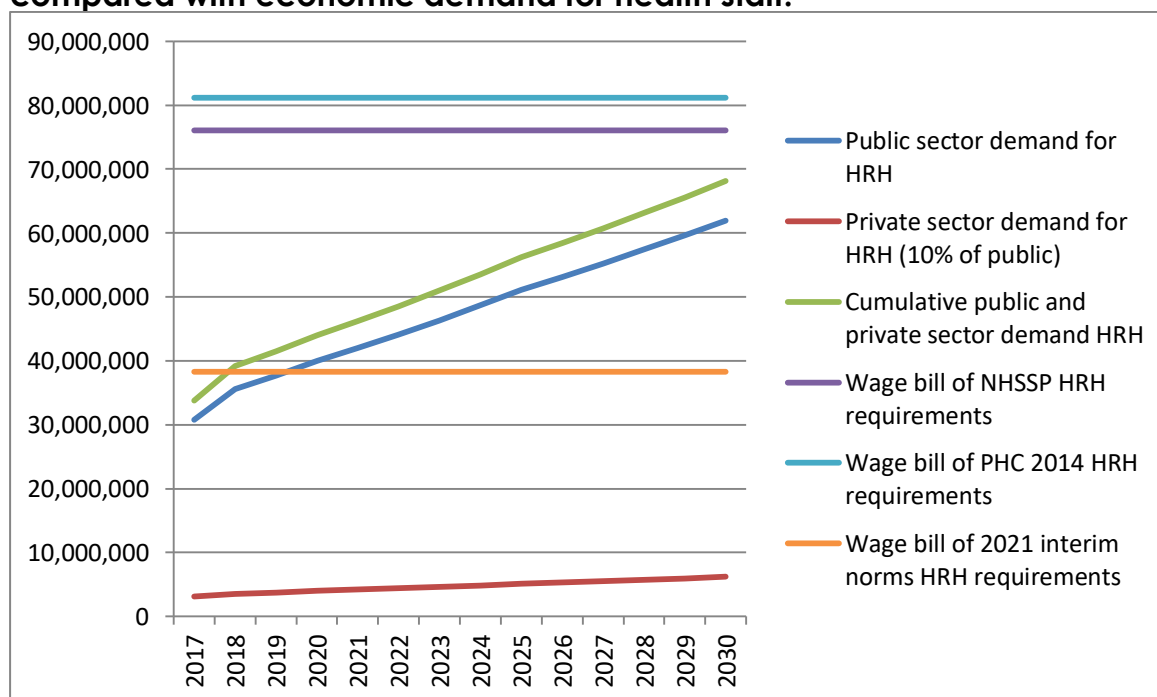
Cost estimates for the plan to increase the health workforce need to be compared with forecasting of economic growth and the resulting fiscal space to evaluate the financial feasibility to achieve the requirements of the health system for health staff.

In order to estimate public sector demand for health staff, the estimate assume a rate of GDP growth of 4% to 2020, 3% from 2021 to 2025, 2% from 2026 to 2030 (reflecting essential uncertainties regarding the petroleum industry in the country), a constant proportion for general government health expenditure (DSGG) as a percentage of non-petroleum GDP (5% based on available data), and a constant percentage for health workforce expenditure as a proportion of public health sector expenditure (42% based on available data).

Based on simulations of this economic demand, the planned increased forecast by the NHSSP and PHC 2014 policies remain far above the forecasted available resource envelope and thus will not be available over the long-term (figure 4).

A modest proportion of private sector expenditure means that its increase will not significantly alter the picture despite private-public partnership efficiencies that are assumed. Only the adoption of interim staffing standards for 2021 suggested in the ESP 2019 enable the sustainability of the resources needed within the available resource envelope.

**Figure 4: Costs for health workforce requirements for the 3 needs scenarios compared with economic demand for health staff.**

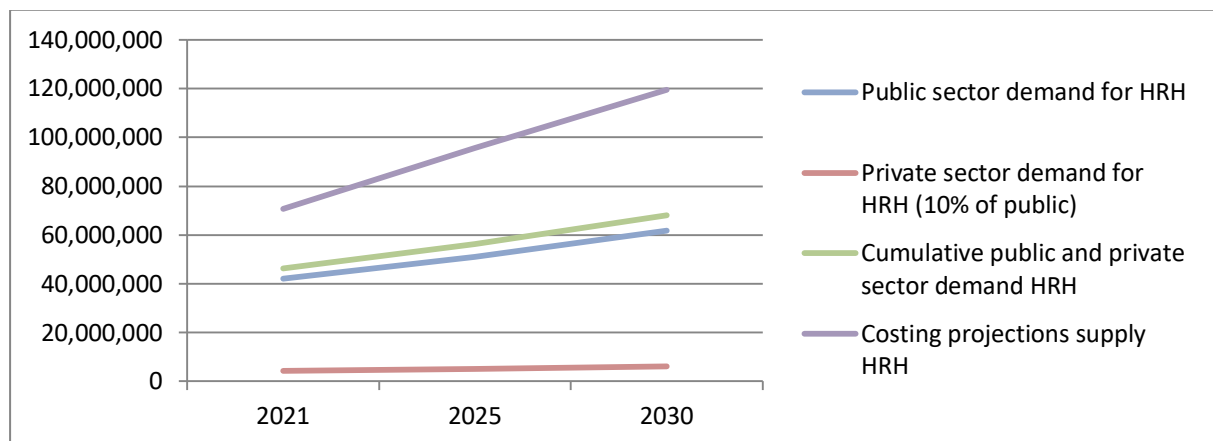


NB: All figures are in dollars 2015.

Furthermore cost of supply of projections of health workforce based on current production levels (see first section) significantly overshoot the likely available resource envelope (figure 6). This analysis is supported by the World Bank’s “Mid-Term health Expenditure Pressure”.

Each of the three scenarios above underlines the importance of maximizing the impact of the current workforce in order to maintain a financially sustainable health workforce payroll. The study advises a strategy to maximise the value of the current health workforce instead of continuing the expansionary path. Changes to the strategic focus will be particularly critical considering the unsustainability of increases to payroll

**Figure 5: Cost of health workforce requirements for health workforce supply projections compared with economic demand for health staff**



World Bank - IBRD, 2015. Mid-Term Expenditure Pressure Democratic Republic of Timor-Leste. Xiaohui Hou, Augustine Asante

## SECTION VI. PREPARATIONS FOR IMPLEMENTATION OF THE NSPHRH

### 1. Implementation Mechanism

The National Strategic Plan for Human Resources for Health (NSPHRH) 2020-2024 will be executed under the responsibility and coordination of the Ministry of Health, at the level of the Office for Cooperative Service General, National Directorate for Human Resources and synchronized with various Ministry of Health services.

The National Directorate for Human Resources will organize the execution of the planning, delivery, annual budget execution and staff data base operations.

At the sectoral level, the Planning, Monitoring, Evaluation and Cooperation Service will be in charge of the department for delivery and resource mobilisations, based on ESP 2019 needs, annual plan development, the information system and also for the monitoring and evaluation of the plan.

## **2. Monitoring of the NSPHRH 2020-2024**

Monitoring and evaluation of the health workforce will require strong collaboration between the Ministry of Health and other relevant sectors as secure sources of information, mainly the Civil Service Commission, the Ministry of Finance, the FDCH, Ministry of Education, Ministry of State Administration, National Institute for the Public Administration and the Health Professionals' Association.

The Ministry of Health will continue to mobilise development partners to provide support for the execution, monitoring and evaluation of the plan.

Effective monitoring and evaluation of the health workforce also requires the existence of basic shared indicators, as a means to inform national authorities and other stake-holders about the execution of the plan.

## **3. Evaluation**

Based on the baseline data at the MoH NDHR, an evaluation committee should be established with the aim of undertaking periodic analysis and to review progress over time, verifying activities that have been implemented by the NDHR, in accordance with the action plan and strategic objectives of the NSPHRH. Evaluation of the NSPHRH will be as follows:

- Annual evaluation
- joint evaluation;
- Final evaluation, in the second semester of 2023.

### **3.1. Annual evaluation**

The annual evaluation is an internal evaluation for execution of the annual action plan for the Ministry of Health's NDHR because on the following reports:

- NDHR Activity Reports;
- MoH EIS Reports;
- Partners' reports for health professional training;
- Health Workforce Database;
- Indicator map.

### **3.2. Joint Evaluation**

The joint evaluation (internal and external) will be undertaken jointly with development partners, other departments of the Ministry of Health, at the end of the year 2020/2021.

This evaluation will use the following tools:

- Results indicators, in relation to program interventions: rates of completion of *inputs and outputs*;
- Coverage indicators, relating to priority activities (Strategic objectives);
- NHSSP evaluation report 2011-2030.

### **3.3. Final evaluation.**

The final evaluation will be conducted with participation of implementation partners using quantitative and qualitative methods. Quantitative analysis will include results of impact coverage from program actions.

The qualitative analysis will use health workforce satisfaction measures and final evaluation indicators of outcomes and coverage.

## **4. Mobilisation of adequate financial resources for plan implementation**

The MoH, through the Office of Policy, Planning and Cooperation and the National Directorate for Budgeting and Finance Management will request and negotiate annual allocations for financial resources with requirements identified in this plan.

This process will be coordinated in order to be able to synchronise with the annual budget cycle and resource appropriations for the health sector. If the plan is not linked to the budget process, the consequence will be lack of adequate financial resources for its implementation.

External development partners will align their assistance for the health workforce based on national priorities, including the NHSSP, PHC Policy for 2014, the 2019 ESP and this Health Workforce plan.

Going forward they will avoid competition with the government for the same groups of qualified health personnel by paying higher salaries in the special programs they manage. This anticipates that, as the relative external funding for the health sector continues to reduce gradually over the next few years, the support from external partners to the health workforce must progressively concentrate on relevant catalytic technical cooperation and initiatives for capacity building, instead of the provision of or direct support for training and salaries.

Development partners will make efforts to collaborate with the MoH to facilitate the progressive absorption into the public sector of Timorese public health experts with experience to be able to contribute to strengthening the capacity of the public sector, in a way which is compatible with financial limitations and consistent with transparent and competitive recruitment and deployment criteria being implemented by the Government.

Increased harmonization and alignment of development partners support for the health workforce will increase the relevance, sustainability and ownership of this assistance. If external support is not aligned with national priorities it is likely to diminish impact and fragment initiatives.

## **SECTION VII. SWOT analysis for implementation context for the NSPHRH 2020-2024**

### **1. SWOT Analysis Objectives**

The aim of the SWOT analysis is to analyse the internal and external environments for the Ministry of Health, particularly for human resource matters, based on four variable,

- 1) Strengths,
- 2) Weaknesses,
- 3) Threats, and
- 4) Opportunities,

and to create an approach for the development of strategies to improve the performance of human resource services.

In this way, the SWOT Matrix (table 21) will enable managers to properly understand the opportunities, threats, strengths and weaknesses relating to human resource management issues to that managers can efficiently outline plans and make decisions.

## 2. Table 21. SWOT Analys of the NSPHRH 2020-2024 Implementation Context

Strengths	Weaknesses	Opportunities	Threats
<b>Availability of the National Health System</b>	Increasing weightage to tertiary delivery level	Existing National Strategic Development Plan and National Health Sector Strategic Plan 2011-2030;	Changes in Government lead to potential changes in direction for vision and policies
<b>Political Will</b>	Weak capacity of Municipal Health Services in the areas of planning, monitoring and evaluation;	The existing PHC 2014 Package; The Revised ESP 2019	Risk of increasing expenditure on health if there is no improvement in social coverage for vulnerable diseases
<b>The existence of helath indicators</b>	Lack of training institution for medical specialisations and other areas;	The existence of career paths for doctors and nursing;	High level of dependency on international technical assistance in areas of specialisation
<b>Youthful productive age of the population, the demographic dividend</b>	Insufficient supply of specialized professionals for areas identified as priorities	Municipal Health Service decentralization and participation of the private sector in health;	Reduction of development partner funding
<b>There is a program for investment returns for continuing education and specialized training</b>	Inadequate funds for continuing education and training in priority areas.	Relatively young health workforce;	Environment of international crisis.
<b>The existence of tools for Planning, Monitoring and Evaluation of Health Workforce performance</b>	Inadequate funding for the health sector, presenting difficulties for continuing education and courses	Existing cooperation with development partners, availability of global funds and bilateral donors;	
<b>Existence of Technical/Higher Education training institutions with courses in Medicine and health Sciences;</b>		Active participation from Timor-Leste in the South East Asian Region	
<b>Availability of budget for health workforce recruitment at different health service delivery levels.</b>			



### 3. Challenges for the NSPHRH 2020-24

Human Resource management is an important component for development of the sector where the NSPHRH will be implemented.

Increases to staffing, based on objective needs with balanced and equitable distribution between the different levels of delivery has the following ends:

- 1) Improved quality of delivery;
- 2) Equity of access to delivery;
- 3) Decongestion at the referral levels;
- 4) Service at useful times for the patient and adequate health delivery structure;
- 5) Reduction in inter-municipal and overseas evacuations;
- 6) Availability of health professionals for health promotion actions, disease prevention and rehabilitation.

Health workforce management continues to face challenges in the health sector, because of the duty to deal with the following proposals:

- 1) Decentralisation of health workforce management, particularly at the national, regional and referral hospitals, Municipal Health Services, Community Health Centres, need support and strengthening of skills/competencies in these areas;
- 2) Planning relevant to the health workforce implies the need for calculations of projections for staffing of team types and current needs and the objectives to be achieved;
- 3) Promotion of financial and non-financial incentives. Career plans, particularly the creation of a public health career and for other allied health technicians;
- 4) Implementation of an information system in coordination with the Civil Service Commission and integrated into the EIS, for management, monitoring, execution and evaluation of the NHSWSP;
- 5) Planning and progressive implementation of specialized training overseas and in-country, and courses for specialized health professionals in a range of categories, including specifically: Public Health, Pediatrics, Gynecology and Obstetrics, Pathological Anatomy, Family Medicine, Instrumentists, Hospital Administration, Psychology, Health Service Management, Health Economy and Project Management and Planning;

- 6) Implication of a range of actors in health workforce programs, including the Ministry of Education Higher Education, Universities, public and private training institutions, bilateral and multilateral development partners – as the foundations for for changes to the quality and availability of health professionals.
- 7) Although health workforce tools exist and there are specific legislation measures for health staff, with deployment to other locations, medical and nursing careers, gaps remain in management level mechanisms, including incentives to support recruitment and setting of roles and responsibilities at the central level, the Municipal Health Service and Health Programs levels - and also for the National, Regional and Referral Hospitals.

4. Table 22: Logical Framework for Implementation of the NSPHRH 2020-2024

STRATEGY	PLANNED ACTIVITY	INDICATORS	TIMELINE					RESPONSIBLE/ OBSERVATIONS
			2020	2021	2022	2023	2024	
<p><b>I. Availability &amp; Distribution of Health Workforce:</b>  <b>“Ensure the availability and equative distribution of health Workforce for proper functioning of the health system”</b></p>								
<p><b>Appropriate planning for a rational mix of skills for local needs</b></p>	Review the minimum staffing standards; Establish a working team for review of each service package with Terms of Reference and obtain support from a national/international expert	% of HP, CHC staff positions filled based on the ESP 2019 Standard.	X					Guidance from DGs, DNRU, SMS, WHO
	Literature Review & strengthen through field assessment for service package at the Primary level;		X					KSP 2015 Document
	Literature Review & strengthen through field assessment for service package at the Secondary and Tertiary levels;	% of Regional Hospital, Referral Hospital and National Hospital staff positions filled based on the standard	X					DGPS, DNSH, HN, HR. (There is not yet a Secondary-Tertiary Service Package)
	Dissemination and implementation of ESP 2019	Staffing levels and numbers of people who have received the disseminated ESP 2019	X					DGSC, DNRU Review of ESP 2019

	Review of the job descriptions/ToR/s for health staff		X	x				DGSC, DNRU
<b>Redistribute Health Workforce, by professional categories, and areas of specialization for all health facilities</b>	Advocacy to Municipal leaders to develop a Health Workforce Office at the Municipal level	% of functioning of municipal management teams in accordance with the roles and responsibilities in 2023	X	x				DGSC, DNRU, SSM
	Create job descriptions for all health staff based on workstation and level of education		X					DGSC, DNRU, SSM
	Create performance evaluation indicators for all health staff based on their responsibilities	% of staff performance at: -Very Good -Good -Satisfactory	X					DGSC, DNRU, Coordination with CSC
	Training on Human Resource Management for all managers	% of staff trained in Health Workforce management	X	x	X	x	X	DNRU, Coordination with CSC, INAP, Partners
	In country comparative study (between municipalities/between agencies)			x				Plan will come from SMS
	Develop regulations and criteria for re-distribution based on civil status		X					DGSC, DNRU, Coordination with CSC
<b>Promote equitable deployment and retention</b>	Formalise a connection scheme for work in rural areas for new graduates from medicine, nursing and midwifery	% of required new graduate positions filled for HPs in rural areas	X	x				DGSC, DNRU, Coordination with CSC
	Develop regulations and criteria regarding the Bonding scheme		X	x				DGSC, DNRU, GAJC, GGQS, Coordination with CSC

	(introduce maximum time for graduates based on the deployment location)							
			X	x				
	Advocacy to the CSC and support for adequate system, career and financial scale incentives in accordance with Decree-Law No. 20/2010/1 Dec. 2015)	% of implementation of Decree-Law for remuneration and incentives for posting in isolated areas		x				DGSC, DNRU, GAJC, GGQS, Coordination with CSC
<b>II. Health Workforce Training/Education: “Develop capacity/training and education for the production of qualified workforce” .</b>								
<b>Align the Health Workforce production in by education sector for health sector needs</b>	Consultation: ME, ANAAA, Associations, UNTL, Private Higher Education Institutions	% of Health Professionals Governance Organs established;  % Professional categories having approved competency standards;  % of competency exams introduced	X	x				DGSC, DNRU, GGQS & GAJC, INS, Professional Associations (in coordination with the MoE, ANAAA )
<b>Recommend and reposition the Health Ministry in relation to education with the MoE and existing Higher Education.</b>	Organise stakeholder meeting to discuss draft legislation regarding professional training in the health sector		X	x				DGSC, DNRU, GGQS & GAJC, INS, Partners

<b>Re-unite Health Higher Education under the Ministry of Health</b>	Approval of new legislation regarding health professional training		X	x				DGSC,DNRU, INS GGQS & GAJC (in coordination with the MoE, ANAAA )
<b>Implement competency exams as a condition for receiving professional certificates</b>	Establish a mixed committee to develop and finalize Competency Standards, comprised of MoH HR , GGQS, GAJC MS with representatives from each Nurse and Midwife Association (review) and AMTL, Dentists Association and TDTSP Association (new)		X	x				DGSC,DNRU, INS GGQS & GAJC, Professional Associations (in coordination with the MoE, ANAAA)
	Organise meeting for final approval (Association's General Assemblies)		X	x				DGSC, DNRU,
	Final draft submission for approval			x				
	Establish a regulatory body for health professionals with authority to organize Competency Exams (Establish Health Professionals Board)		X	x				DGSC, DNRU, INS GGQS & GAJC, Professional Associations (in coordination with the MoE, ANAAA)
	Establish Steering Committe for Health Professionals Board		X					DGSC,DNRU, GGQS,GAJC, INS,

	Appointment of Health Professionals Board		X					WHO, with Association representatives
	Implement competency exams		X	x				
	Establish National Competencies Examinations Board made up of members for nominated by the Health Professionals Board (appointment request to CHC Prezident)		X					
	Capacity Building of National Competency Examinations Board potential members (training in Indonesia, Philippines, Vietnam, Fiji, Bangladesh, Sri Langka) – INS, RU, GGKS, Associations		X					
<b>Strengthen education institutions</b>	Joint agreement between MS, ME, MF and CSC for accreditation	% of health training institutions obtaining accreditation each year						DGSC, DNRU, GGQS,GAJC, INS, WHO, with Association representatives
<b>Unified Examination</b>	Recommend to MoE to consider National Exam for higher education for health in all universities							
<b>Ongoing training and education</b>	Change the INS law as the institutions providing certification to their graduates	% of scholarship plan for ongoing health education, and	X	x				DGSC,DNRU, GGQS,GAJC, INS, ME, FDCH, with

	Propose to the Council of Ministers to alter the UNTL Law to enable other institutions to be able to certify graduates	capacity building established  Proposal submitted to the Council of Minister and approved	X					Association representatives
	Establish categories for teaching facilities	% of health facilities certified as teaching facilities	X	x				
	Certify health facilities as teaching facilities		X	x				
<b>Specialised training for trainers and educators</b>	Create a new category in the special career regime for teaching professionals	% of new categories in the special career regime for teaching professionals established	X	x				DGSC, DNRU, GGQS, GAJC, INS, ME, FDCH,
	Conduct refresher training of teachers regarding practical skills	% standards for courses for improvement established	X	x				DGSC, DNRU, GGQS, GAJC, INS, ME, FDCH,
	Create a joint regulation between MoH and MoE to oblige teachers to conduct practical skills at teaching facilities		X	x				DGSC, DNRU, GGQS, GAJC, INS, ME, FDCH,
<b>Strengthen and update content and modalities for pre-service education</b>	Curriculum revision, MoH follow-up and recommendations as necessary	% of curriculum revision and competency standards established	X	x				
	Supervise curriculum based on competencies defined for health staff		X	x	X	x	X	DGSC, DNRU, GGQS, GAJC, INS, KFS,
	Competency based training	% of competency based training results assessment	X					

	Increase practice sites: recommend to UNTL and Private Universities to increase the quantity of learning labs and simulations	Number of practice sites with quality learning and simulation labs	X	x				
<b>Strengthening cooperation with countries and international and national institutions, for Health Workforce capacity building</b>	Review scholarship scheme	% scholarship plan established on the basis of need	X					DNRU, INS, FDCH, Partners
	Evaluate the existing scholarship procedures			x				
	Identify course failures from those provided with scholarships		X					
	Strengthen institutional management				X			
	Redefine scholarship needs					x		
<b>III. Performance &amp; Motivation: Create a favourable environment to improve work performance and motivation of the existing and newly recruited workforce”.</b>								
<b>Integrated training</b>	All staff benefit from in-service training	Number of health worker; professional regime no general regime to receive training every year	x	x	x	x	x	
<b>Supervision</b>	Supportive supervision (mentoring)	Number of health facilities received supportive supervision every year	x	x	x	X		
<b>Rural incentive</b>	Housing	Number of HW; CHCs and housing		x	x	x	x	
<b>IV. Governance and regulation of Health Workforce management: “Strengthen capacity building Health Workforce management, planning, and administration, develop and implement realistic mechanisms for registration, regulations and quality assurance for all health practitioners”.</b>								

<b>Build health workforce governance function capacity at the national and local levels</b>	Define the National Health Workforce Policy	National Health Workforce Policy disseminated	X					GPPCS & DNRU
	Identify management tools for civil servants and health workforce	Tools for staff management compiled	X					DNRU (in coordination with CSC)
	Develop a Health Workforce Management Manual to drive improvements in efficiency and as a consequence have an impact on productivity at all levels	Health Workforce Management Manual disseminated	x	X				DNRU
	Define staffing levels for each health facility with the respective tasks	% of CHCs and % of hospitals with defined staffing		X	X	X	X	SMS, HR, HNGV (Technical guidance from DNRU & GAJC)
	Develop criteria to determine health managers's performance, as defined in the manual	% of NHS Hospital Executive Directors and % of Health Centre Heads receiving GOOD performance score			X			HNGV, HR, SMS & DNRU
	Build the skills of managers for distribution and use of staff in accordance with specific tasks	% of managers receiving benefits from staff management training actions	X	X				INS
	Define placement standards for staff in	% of health facilities meeting defined	X					GAJC & DNRU

	accordance with equity criteria	minimum standards for Health Workforce						
	Regulate decentralisation of authorities regarding Health Workforce for health facility managers	% of CHC with a human resource management officer				X		GPPCS & GAJC (in coordination with DGs)
<b>Regulation of Professional Practice and Careers</b>	Review the legal Framework for Health Professional's Practice in order to ensure categorisation based on different professional areas	Review of law regarding Health Professional's Practice	X					GPPCS & GAJC (in coordination with DGs)
	Establish a Health Professionals Board	Health Professionals Board established		X				GGQS & GAJC
	Regulate the registration and process of licensing of professional credentials	Process for registration of professional credentials regulated	X					GGQS & GAJC (in coordination with GLRAS)
	Regulation of private practice for civil servants (regime for exclusivity or mixture)	Dual professional practice regulated		X				GAJC GPPCS DGPS DGSC
	Review the current legislation regarding Health professional's careers, with the aim of	Revisew the Health professional Career legislation;						KFP GAJC

	simplifying and making the career system more flexible;	Number of socialisation actions conducted regarding Health Workforce entitlements and awards; Approved statute for MoH staff; Radiology Technicians and trainers in Health Science disciplines.	X	X	X	X	X	GPPCS DGSC INS
	Undertake regular action for clarification of application of entitlements and awards (subsidies, allowances and incentives) that are in force;		X					
	Propose and negotiate a special statute for specific health professions and for health service managers;		X					
	Coordinate with the Ministry of Higher Education and Culture for the creation of a career for health teachers	% of health professionals receiving benefits from the Teaching Career Regime		X	X			DGSC & DGES

	Institute a Performance Evaluation Committee for Health Professionals (KADPS), develop criteria for monitoring and evaluation of the performance of health professionals	% of health professionals obtaining benefits from the new professional performance evaluation system	<b>x</b>	<b>x</b>	<b>x</b>			DGSC
	Develop procedures to harmonize performance and career progression for themselves and with ongoing training for health professionals	% of health professionals with GOOD evaluations in the career progress; % of health professionals with GOOD evaluations receiving benefits from ongoing training actions	x	x				KADPS DNRU INS
<b>Regulation for Remuneration Incentives</b>	Regulate the situation of staff regarding entitlements and awards in accordance with current legislation	% of health professionals obtaining regular salary supplements; Defined credit system for award of incentives and supplements;	x	x	<b>x</b>	<b>x</b>	<b>x</b>	
	Implement compensation principle for high risk work areas, overtime and shift work;	% of health professional obtaining benefits from rights to subsidies, bonuses	x	x	<b>x</b>	<b>x</b>	<b>x</b>	KFP MF GGQS DGSC DNRU

		and to overtime hours.							DNOGF
	Establish a credit system for award of subsidies and incentives for health professionals and teams, based on merit, performance and type of health facility (HNGV, RH, CHC I, II or III, HP or PA)		x	x					

**V. Health Workforce Information System: “Availability of timely, reliable and pertinente/relevant information for Health Workforce Management”.**

Availability of timely, reliable, and pertinent information for Health Workforce Management	Creation of Health Workforce Information System integrated with the Health Information System.	MoH Health Workforce Information System Software established	x						DGSC, DNRU, DNAL
	Define indicators for planning, follow-up and evaluation of health workforce;	Manual & User Guides for the MoH-HWIS established and approved	x						
Adequacy of Health Workforce Information System for Public Administration in accordance with health Workforce management needs.	Monthly updating of health Workforce data	MoH-Health Workforce data updated quarterly	x						
	ICT, Support, Transport and Furniture		x						

	Uniform reporting forms from Central Services		X	x	X	x	X	
	Develop SOP/guidelines for establishment of Health Workforce Information System		X					
	Establish IT infrastructure for Health Workforce		X	x				
	Decision makers / program users for planning and program improvements		X	x	X	x	X	



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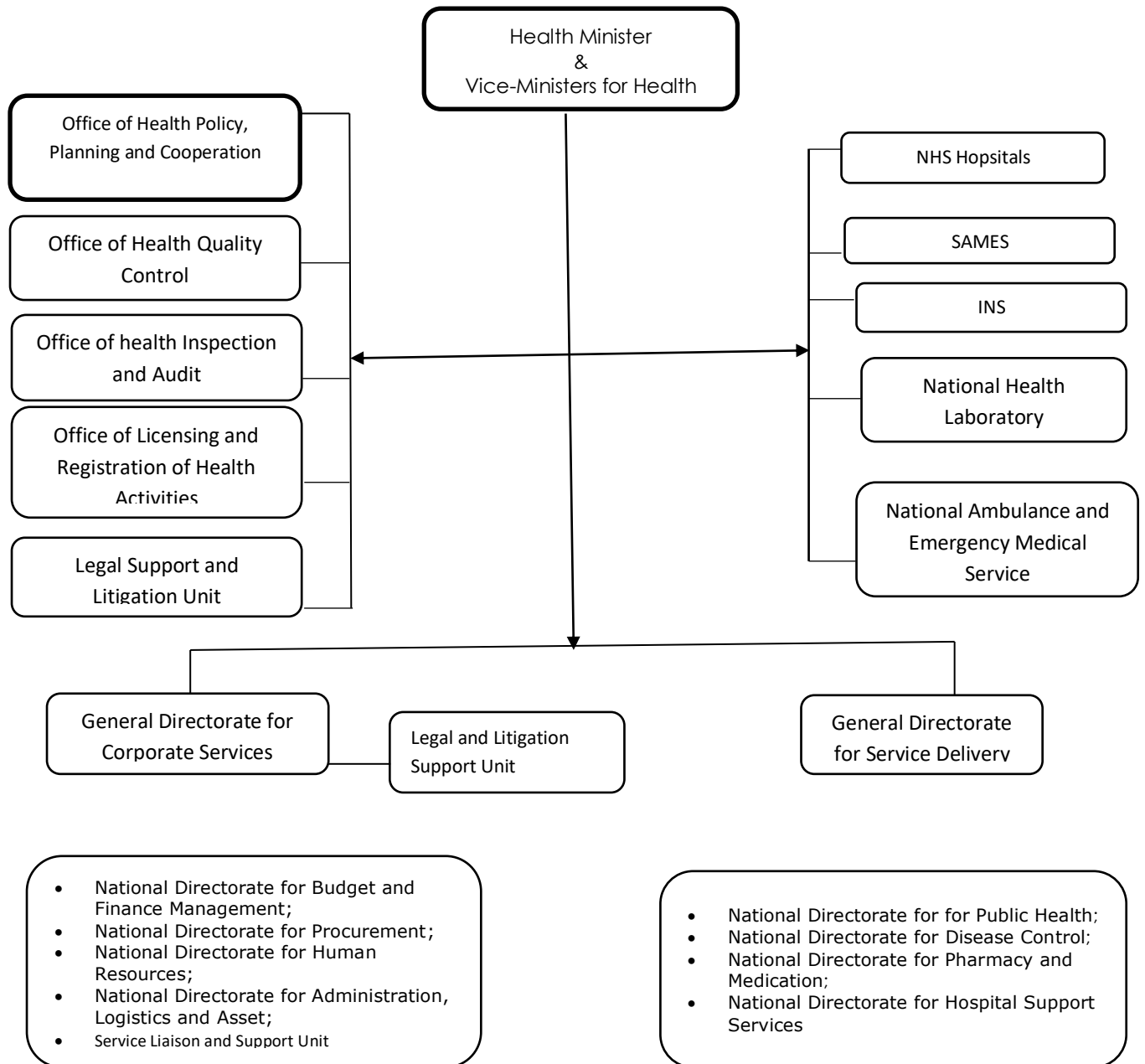
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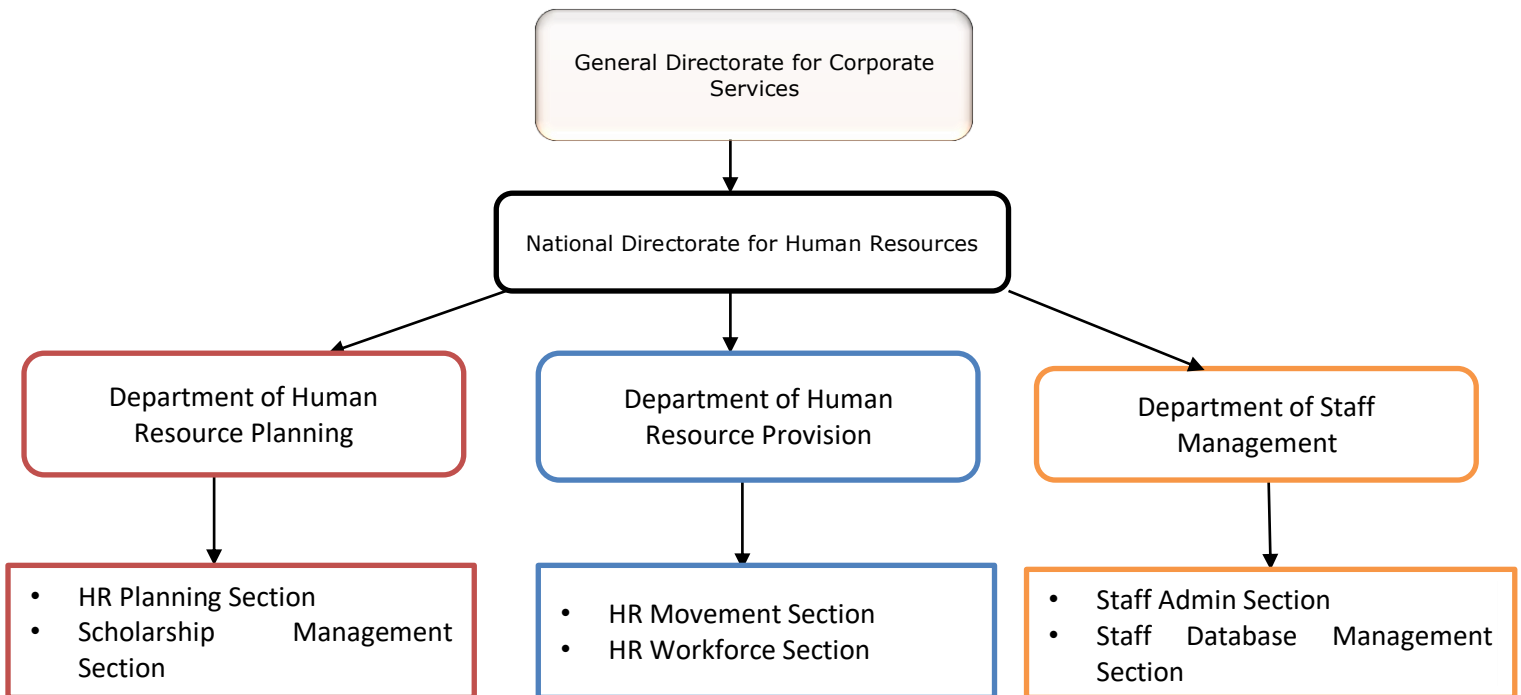
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**ANNEX: A**

**Ministry of Health Organogram**



### MoH ND HR Organogram



## ANNEX: C

### Suggested Health Professional Cadres for Health Facilities in

Timor Leste 2020CADRE	Health post	CHC1	CHC2	CHC3	Referral Hosp.	Baucau Hosp	HNGV
<b>SPECIALIST DOCTORS</b>							
Anesthesiologist					2	4	8
General Surgery					2	3	5
Dermatologist							2
Dental (Specialist Doctor)			1	1	1	2	3
Geriatrics							1
Imaging (Radiology)					1	2	2
Internist			2	2	1	2	3
Cardiologist						1	2
Clinical Pathologist							1
Medico-legal							1
Microbiologist							1
Nephrologist							1
Neonatologist							1
Neumology							1
Neurology							1
Obstetrics & Gynecology				1	1	2	4
Ophthalmology							3
Oncology							2
Otorino (O.R.L)							2
Orthopedics							2
Pediatrics			2	2	2	2	5
Psychiatry							2
Rehabilitation							1
Intensive Therapy							2
Traumatology							2
Urology							1
Total Specialist Doctors	<b>0</b>	<b>0</b>	<b>5</b>	<b>5</b>	<b>10</b>	<b>18</b>	<b>59</b>
<b>GENERALISTS</b>							
General Medicine Doctors (GMD)	1	3	4	4	6	16	50
Total (General Medicine)	<b>1</b>	<b>3</b>	<b>4</b>	<b>4</b>	<b>6</b>	<b>16</b>	<b>50</b>
<b>NURSES</b>							
Anesthesiology Nurse					4	6	8
Intensive care Nurse						8	18
Surgical Nurse (Instruments)					6	10	5
Nephrology Nurse							10
General Nurse	1	3	18	20	18	48	143
Total (Nurses)	<b>1</b>	<b>3</b>	<b>18</b>	<b>20</b>	<b>28</b>	<b>72</b>	<b>184</b>
<b>MIDWIVES</b>							
Total (Midwives)	<b>1</b>	<b>4</b>	<b>8</b>	<b>8</b>	<b>8</b>	<b>16</b>	<b>32</b>

ALLIED HEALTH TECHNICIANS							
<b>Nutritionist</b>		1	1	1	1	2	6
<b>Physiotherapist</b>						4	10
<b>Lab Technician/Analyst</b>		1	2	2	3	5	10
<b>Pharmacist</b>		1	2	2	3	4	10
<b>Medical Documentation Agent</b>			1	1	1	1	5
<b>Clinical Psychology</b>							3
<b>Electromedical</b>			1	1	1	2	5
<b>Ophthalmologist</b>							3
<b>Optical Refraction</b>							3
<b>Radiologist</b>			2	2	2	4	12
<b>Public Health</b>	1	1	3	3	3	4	3
<b>Public Health (Environmental)</b>							2
<b>Bio-Statistician</b>							2
<b>Total (Allied Health Technicians)</b>	<b>1</b>	<b>4</b>	<b>12</b>	<b>12</b>	<b>14</b>	<b>26</b>	<b>74</b>
<b>TOTAL (SPECIAL REGIME)</b>	<b>4</b>	<b>14</b>	<b>47</b>	<b>49</b>	<b>66</b>	<b>148</b>	<b>399</b>





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