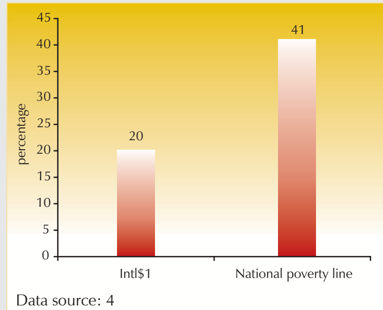
Timor-Leste

Basic information	Latest available value	Year	Source
Total population	1,015,187	2004	{CC}
Area (sq.km.)	14,610		{1}
Density of population (per sq.km.)	69	2004	{1}
Administrative divisions	13 districts and 67 sub-districts		

Development	Latest available value	Year	Source
Gross national income(GNI) per capita (US$)	729	2005	{3}
Highest in the world (GNI) – Norway	59590	2005	{3}
Highest in the Region – Thailand (GNI)	2750	2005	{3}
Population below poverty line – Intl.$1 per day (%)	20	2001	{4}
Lowest in the Region – Maldives	<1	2004	
Population below national poverty line (%)	41	2001	{4}
Lowest in the Region – Maldives	8	2004	
Adult literacy rate >15 years (%)	43	2001	{4}
Highest in the Region – DPR Korea	100	2003	
Net enrolment ratio—primary (%)	75	2004	{CC}
Highest in the Region – DPR Korea	100	2003	
Human Development Index	0.426	2004	{5}
Highest in the Region – Thailand	0.784	2004	
Human Poverty Index (%)	44.6	2004	{5}
Lowest in the Region – Thailand	9.3	2006	
Gender-Related Development Index	0.369	2004	{5}
Highest in the Region – Thailand	0.781	2006	

Percentage of population below poverty line



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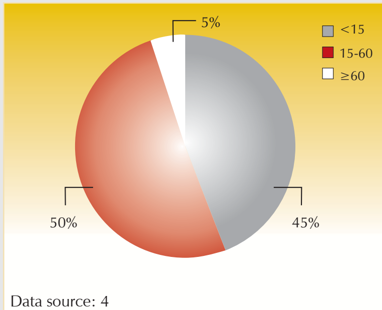
Salient basics

- Timor-Leste is situated on the eastern part of the island of Timor and achieved independence in 2002.
- It is among the poorest 10 countries. Coffee is the main cash crop.
- Literacy also is low, and the human development index is less than 0.5.

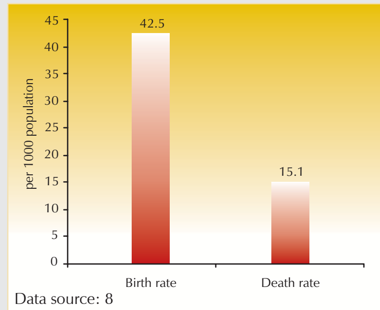
Q1 What are the basic demographic features?

Indicators	Latest available value	Year	Source
Population			
Total population	1,015,187	2004	{CC}
Population growth rate per year (%)	3.2	2004	{CC}
Urban population (%)	15	2002	{1}
Age-sex structure			
Sex ratio (F/1000M)	970	2004	{CC}
Children <15 years (%)	45	2004	{CC}
Elderly ≥60 years (%)	5.0	2005	{CC}
Highest in the world (60+ years) – Italy, Japan	26	2005	{7}
Highest in the Region – DPR Korea	12	2002	
Dependency ratio – (<15 and 65+ years) (%)	94	2004	{CC}
Fertility			
Birth rate (per 1000 population)	42.5	2004	{CC}
Lowest in the world – Germany, Ukraine	8.0	2004	{9}
Lowest in the Region – Thailand	12.7	2002	
Total fertility rate (TFR) (per woman)	7.0	2004	{CC}
Lowest in the world – Ukraine	1.1	2004	{10}
Lowest in the Region – Thailand	1.6	2000	
Contraceptive prevalence (%)	9.7	2004	{CC}
Gross mortality			
Crude death rate (per 1000 population)	15.1	2004	{CC}
Lowest in the world – UAE	1.0	2004	{9}
Lowest in the Region – Maldives	3.0	2005	

Age structure in 2004



Birth rate and death rate in 2004



Salient demographic features

- The total fertility rate is 7.0 per woman and contraceptive prevalence is 9.7%.
- The population is in the early phase of demographic transition as indicated by 45% of the population being less than 15 years old.

Q 2

What is the progress regarding some health-related MDGs?

Indicators	1990	2000	2005	2015 (Target)
Poverty and hunger				
Under-weight children (%)		45 (2001)	N/A	31
Child mortality				
Infant mortality rate (per 1000 live births)		88 (2001)	98 (2002)	53
Under-five mortality rate (per 1000 live births)		125 (2001)	130 (2002)	96
One-year-olds immunized against measles (%)		47 (2001)	42	100
Maternal health				
Maternal mortality ratio (per 100,000 live births)		N/A	420-800* (2002)	252
Deliveries attended by health staff (%)		24-38 (2001)	32 (2005)	60
HIV/malaria/tuberculosis				
HIV prevalence (per 100,000 population)		N/A	10-350	
Malaria prevalence (per 100,000 population at risk)		9000 (2001)	17143	4500
Tuberculosis prevalence (per 100,000 population)		N/A	692 (2004)	
Tuberculosis cases detected and cured under DOTS (%)		80 (2001)	85	90
Water and sanitation				
Population with access to improved water source (%)				
Combined		56 (2001)	N/A	78
Rural		51 (2001)	N/A	
Urban		72 (2001)	N/A	
Population with access to improved sanitation (%)				
Combined		19 (2001)	N/A	46
Rural		10 (2001)	30	
Urban		44 (2001)	65	

* As the estimate is not available, the range is used

MDG progress

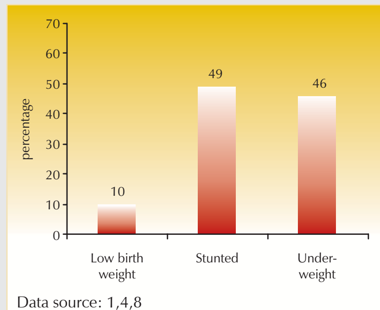
- The 2001 baseline is preliminary and the targets are pro-rata and indicative.
- Data are insufficient to assess the trend of progress.

Q 3

What are the major health problems?

Indicators	Latest available value	Year	Source
In children under-five years			
Low birth weight (%)	10	2002	{CC}
Lowest in the Region – Indonesia	6	2002	
Stunted children (6-60 months age) (%)	49	2003	{CC}
Lowest in the world – Croatia	1	1998-2004	{9}
Lowest in the Region – Sri Lanka	14	2000	
Under-weight children (%)	46	2003	{CC}
Lowest in the world – Chile, Croatia, Ukraine	1	1998-2004	{9}
Lowest in the Region – Thailand	9	2003	
Childhood diseases			
Diarrhoeas prevalence (per 1000 children <5 years)	168	2006	{CC}
Acute respiratory infections – reported cases incidence (per 1000 children <5 years)	140	2003	{CC}
Intestinal parasitic infections (per 1000 children <5 years)	800	2002	{1}
Other diseases			
Tuberculosis incidence (per 100,000 population)	556	2004	{19}
Malaria prevalence (per 100,000 population)	31,370	2006	{CC}
HIV prevalence (per 100,000 population)	10-350		{4}
Comprehensive indices			
Expectation of healthy years lost (years)			
Male	6.9	2002	{12}
Female	8.7	2002	{12}
As % of expected life at birth (ELB) lost			
Male	12.7	2002	{12}
Female	14.4	2002	{12}

Percentage of malnutrition in 2002-03



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Major health problems

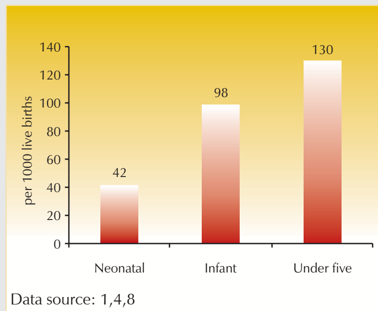
- WHO estimated that nearly 13% of equivalent-life years are lost due to ill-health in the country.
- Under-nutrition in children is very common. Results from the Household Survey show that four in five households do not have enough food for at least two months in a year.
- Malaria and tuberculosis are affecting a large segment ofthe population. Most common childhood illnesses are acute respiratory infections and diarrhoeal diseases. Intestinal parasitic infection is also very common.

Q 4

What is the mortality profile?

Indicators	Latest available value	Year	Source
Mortality rates			
Neonatal mortality rate (NMR) (per 1000 live births)	42	2003	{CC}
Lowest in the world – Singapore	1	2000	{10}
Lowest in the Region – Maldives	8	2005	
Infant mortality rate (IMR) (per 1000 live births)	98	2002	{CC}
Lowest in the Region – Sri Lanka	11	2003	
Under-five mortality rate (U5MR) (per 1000 live births)	130	2002	{CC}
Lowest in the world – Iceland, Singapore	3	2004	{9}
Lowest in the Region – Maldives, Srilanka	16	2005	
Maternal mortality ratio (per 100,000 live births)	420-800	2002	{1}
Lowest in the Region – Thailand	14	2003	
Age at death			
Expectation of life at birth (ELB) (years)	58	2004	{CC}
Highest in the world – Japan	82	2004	{13}
Highest in the Region – Maldives, Sri Lanka	73	1996-2001	
Deaths under-five years (% of of total deaths)	36	2004	{C}
Lowest in the Region – Thailand	4	2002	
Causes of death (percentage of total deaths)			
Three major causes of deaths (%)			
Tuberculosis	10	2002	{14}
Ischaemic heart disease	9	2002	{14}
Lower respiratory infection	9	2002	{14}
Cerebro-vascular disease deaths	5	2002	{14}
Diarrhoeal diseases deaths	2	2002	{14}
Tuberculosis death rate (per 100,00 population)	93	2002	{15}

Child mortality rates of 2002-03



Data source: 1,4,8

Mortality profile

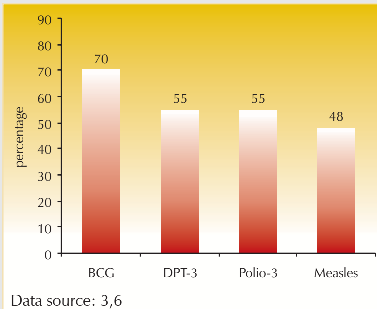
- Both child mortality and maternal mortality are high.
- Expectation of life at birth at 58 years is the lowest in the Region.
- Communicable diseases account for nearly 60% of deaths, particularly in children.

Q 5

What resources are available for the health sector?

Indicators	Latest available value	Year	Source
Expenditure on health			
Percent of GDP	9.6	2003	{13}
Highest in the world – USA	15.2	2003	{13}
Highest in the Region – Timor-Leste	9.6	2003	
Per capita (US$)	39	2003	{13}
Per capita (Intl.$)	125	2003	{13}
Highest in the world – USA (Intl.$)	5711	2003	{13}
Highest in the Region – Maldives (Intl.$)	364	2003	
Food			
Average dietary energy consumption (kcal/day/person)	2790	2000-2002	{16}
Services			
Community health centres (per 100,000 population)	7.6	2002	{1}
Antenatal care coverage (ANC – at least one visit) (%)	61	1997-2005	{8}
Women that have been immunized with TT during pregnancy (%)	50	2005	{CC}
Deliveries by qualified attendant (%)	32	2005	{CC}
Children immunized (%)			
BCG	70	2005	{24}
DPT-3	55	2005	{24}
Polio-3	55	2005	{24}
Measles	48	2005	{24}
Human resources			
Doctors of modern system (per 10,000 population)	2.5	2005	{CC}
Highest in the world – Cuba	59	2002	{13}
Highest in the Region – DPR Korea	32	2003	
Nurses (per 10,000 population)	7.0	2002	{1}
Highest in the Region – DPR Korea	37	2003	
Midwives (per 10,000 population)	4.0	2004	{13}
Dentists (per 10,000 population)	0.5	2004	{13}
Pharmacists (per 10,000 population)	0.2	2004	{13}
Public and environmental health workers (per 10,000 population)	0.3	2004	{13}
Community health workers (per 10,000 population)	20.2	2004	{13}
Lab technicians (per 10,000 population)	0.4	2004	{13}
Other health workers (per 10,000 population)	0.2	2004	{13}

Immunization coverage in 2006



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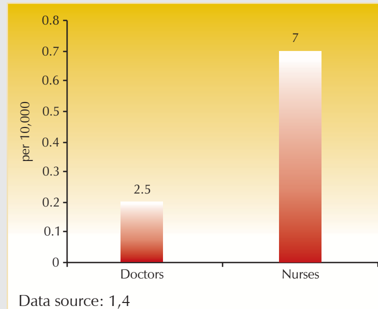
Human resources in 2002



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Health resources

- Expenditure on health is a substantial part of GDP but since the GDP is low, the per capita expenditure is low.
- Health centres per 100,000 population are within the regional average. There is a shortage of health workers.
- Immunization coverage is not adequate.

6 What is the system of health governance?

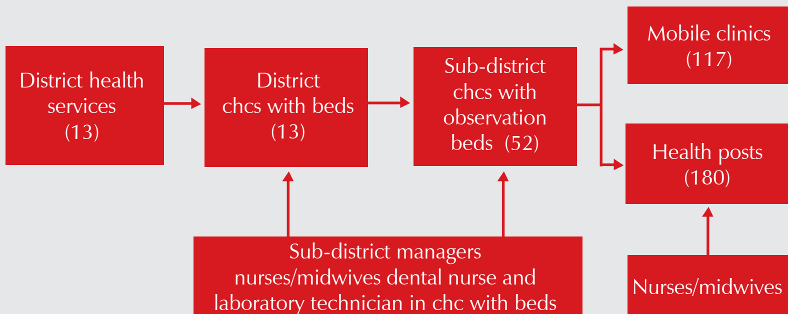
Organization

The Ministry of health has three national directorates reporting to the Permanent Secretary. These are:

- Division of Health Services Delivery
- Division of Health Policy and Planning
- Division of Administration, Financing and Logistic Services

Some central organizations such as the National Laboratory, Institute of Health Sciences, National and Referral Hospitals, and Centre For Drug Supply and Medical Equipment are functioning semi-autonomously but are reporting to the Ministry of Health.

District Health Services are comprised of District Health Centre (CHC), Sub-District Health Centres, Health Posts and Mobile Clinics. Leadership, management and support to health service delivery is provided through District Health Management Teams, with one Head of District Health services and 5-6 other management positions.



As of 2004, there are a total of 13 CHCs with beds in the country. There are six referral hospitals including one national hospital in Dili. Five of these CHCs have only observational beds. General beds are in the hospitals and some CHCs. They provide curative services in accordance with the Basic Services Package at PHC level and the Hospital Services Package at hospital level.

There is a CHC with observation beds at sub-district level. A district-wise count shows that there are a total of 52 such CHCs. Services at the village level are provided by Health Posts (180) and Mobile Clinics. Their areas of operation overlap. There is a sub-district manager at each CHC, supported by nurses and midwives. The services provided by the Health Post and Mobile Clinic include curative consultation, antenatal and postnatal care, immunization, growth monitoring, health education and health promotion activities.

Private sector

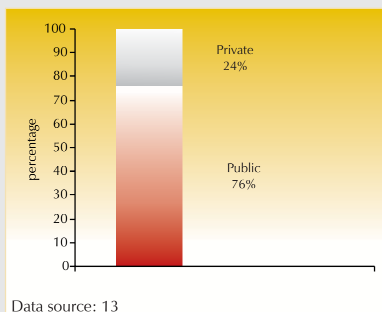
Private practitioners, churches, Coffee Producer Cooperatives and other NGOs also contribute substantially to health services.

Q 7

Who pays for health care?

Indicators	Latest available value	Year	Source
Government expenditure on health			
Out of total health expenditure (%)	76	2003	{13}
Per capita (US$)	30	2003	{13}
Per capita (Intl.$)	95	2003	{13}
Highest in the world – Monaco (Intl.$)	3403	2003	{13}
Highest in the Region – Maldives (Intl.$)	324	2003	
Private expenditure on health			
Out of total health expenditure (%)	24	2003	{13}
Per capita (US$)	9	2003	{C}
Per capita (Intl.$)	30	2003	{C}
Lowest in the Region – DPR Korea	0.4	2004	
Out-of-pocket expenditure (% of private expenditure on health)	26	2003	{13}
Per capita (US$)	1	2005	{CC}
Per capita (Intl.$)	8	2003	{C}
Lowest in the world – Tuvalu	13	2003	{13}
Lowest in the Region – Timor-Leste	26	2003	

Health expenditure



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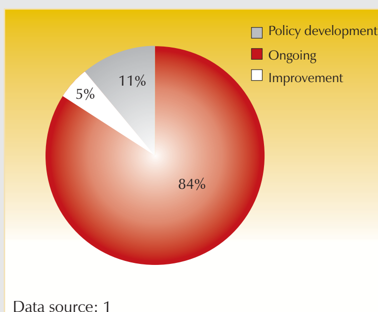
Planned expenditure in health sector 2002-03



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Health expenditure

- The government allocates at least 35% of its budget to education and health. Nearly 60% of health sector expenditure goes to basic health care

Q 8 What are the recent reforms and achievements of the health system?

Health sector reforms

- The progress in policy and process of health development in recent years has been remarkable. The Ministry of Health is widely acknowledged as one of the strongest ministries in the country. The Health Policy Framework was approved in 2002 and Timor-Leste has made tremendous progress in formulating policies and strategies for various activities. Among them are National Child and Adolescent Health Strategy, National Reproductive Health Strategy, National Maternal Nutrition Strategy, National Nutrition Policy, and Guidelines for Food Safety.
- An Integrated Disease Surveillance System (IDSS) has been set up with technical support from WHO. The aim is to collect, collate, analyse, interpret and disseminate the disease data to health managers. The Medical Geographical Information System (GIS) is proposed to be used for mapping the problems and targeting interventions. This system has been used for the planning and implementation of the National Leprosy Elimination, Lymphatic Filariasis Elimination, and Control of Intestinal Parasitic Infections programmes.
- A Health Sector Working Group promoting coordination between the Ministry of Health and development partners is functional, chaired by the Minister of Health. This group will include the donor community, UN agencies and NGOs working in the health sector.

Achievements

- The basic infrastructure and health facilities have been rehabilitated and reconstructed at the district and sub-district levels, which are vital for ensuring access to health care by the people. All hospitals are in the process of being rehabilitated and/or reconstructed and still following the policy that not more than 40% of health expenditure can go to the hospital sector.

- Policies and strategies for various activities are being framed. Staff is being trained. Thus, the whole health system is being set up quickly to take care of the health needs of the people.
- As a young country, Timor-Leste has made considerable progress in compiling information on a number of key indicators. Much of the data are generated through surveys conducted over a few months. Some data are generated through routine administrative channels.
- Achievements in terms of health indicators are not yet visible as efforts are focused on establishing the baseline. Improvements will be assessed in future.
- With the re-establishment and rehabilitation of the entire health infrastructure, there has been a steady improvement of key indicators, but this progress has somewhat slowed down. New initiatives with stronger emphasis on community involvement are now planned to further improve health services delivery.

Legislation

- Timor-Leste has made progress in framing a comprehensive set of health legislations. The Health System Law and the Organic Structure Law have been approved. Among others approved are: Decree for Private Practice, Pharmaceutical Law, Health Professional Law, Disease Surveillance Decree, and Health Sanitation Decree.

Q 9

What are the constraints and challenges of the health system?

Financial constraints

- Timor-Leste is amongst the poorest nations in the world. Considerable progress has been made in a short period after independence. External assistance has been a major input so far, but with a gradual increase in oil and gas revenues, the Government has increased the budget allocation to the health and education sectors.
- Substantial resources have been invested, and more are needed to rebuild the entire health infrastructure, especially in remote areas.
- Substantial resources are also needed for training and human resource development. There is a scarcity of human resources for health including health managers, doctors, nurses and paramedical staff. This includes training, fellowships and strengthening of training institutes in the country.

Expertise and other physical constraints

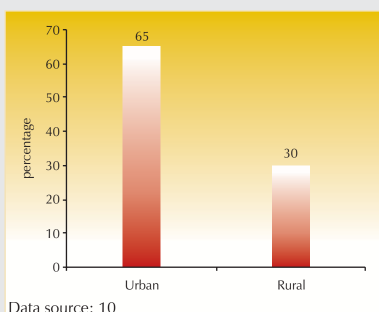
- Lack of human resources in the public health system and their limited technical capability is a major constraint in reducing the incidence of health problems and controlling communicable diseases. The intervention in all areas of public health need to focus on upgrading human resources.
- The country is dependent on expatriate physicians and surgeons to provide medical care, which may not be sustainable. It will be several years before there is an adequate supply of Timorese specialists.
- It is difficult to attract midwives to work in remote locations, with no communication.
- Shortage of basic drugs and adequate equipment is common in health facilities.

Social constraints

- The contraceptive prevalence is very low?less than 10% married women of age 15-49 years are using a modern contraceptive method.
- There is inadequate awareness of health problems, particularly among women, and a general lack of understanding of health benefits. Marriage and pregnancy occur early in life, and distribution of food and health care in the family favour boys. Gender issues are neglected.

Indicators	Latest available value	Year	Source
Inequalities–Gender			
Expectation of life at birth F:M	1.04	2003	{5}
Female share in employment (non-agricultural sector) (%)	35	2001	{4}
Seats held in parliament – F (%)	28.0	2001	{4}
Ratio of girls to boys in primary schools (%)	91	2001	{4}
Inequalities–Spatial			
Population with access to safe water			
Urban	72	2002	{10}
Rural	51	2002	{10}

Sanitation coverage in urban and rural area, 2002



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Health sector constraints

- The complete health infrastructure is being rebuilt. Buildings, equipment, staff and facilities are being rapidly put into place to provide the services.
- Poor and unequal access to health services, the absence of a regulatory framework, and an unequal referral system are some of the problems affecting health system performance.
- There is a need for further technical monitoring in health sector development such as for development and refining health sector strategies and policies, development of long-term budget requirements and capacity building of local staff.
- Drug legislation and policies are lacking and implementation of the existing regulations is poor. Pharmacists need to be trained.
- The capacity of laboratories is limited. Laboratories at district and peripheral levels carry out only malaria and tuberculosis microscopy. The Central Laboratory in Dili conducts only a limited range of tests.
- Vaccination activities at local level are undertaken on a weekly or monthly basis.
- The health service delivery capacity of the government is limited by human resource and technical skill constraints, as well as by more availability of adequate basic equipment and drugs. All these are in short supply.
- Information on some key indicators such as the population below the minimum level of dietary energy consumption and prevalence of tuberculosis is lacking.

Challenges

Health services

- Service delivery to a scattered population is causing extreme difficulties.
- Restoring water facilities is proving to be a big challenge in the absence of expertise.

- A detailed analysis of the factors that can accelerate progress is required. The action plan may require inter-sectoral coordination including help from civil society.
- A majority of the population has had little experience with modern water and sanitation practices, and do not understand the hazards of unsafe conditions. Addressing such problems requires a pervasive change in human behaviour. This will be an enormous challenge.

Control of communicable diseases

- Malaria is highly endemic in all districts, with the highest morbidity and mortality reported in children. Malaria showed a three-fold increase after 1999. Lymphatic filariasis is also highly endemic.

Health information

- There are significant discrepancies in the information on some indicators emerging from the surveys and those generated through the administrative channels. These need to be reconciled.

10

What does the country hope to achieve in the near future in health?

- East Timor–2020: Our Nation, Our Future' summarizes the people's priorities and challenges. This vision encompasses peace, security, freedom, tolerance, equity, improved health and education, access to jobs and food security. For health, it says that people will be healthy, and live a long, productive life. The health vision is 'Healthy Timor-Leste people in a healthy Timor-Leste'.
- The five-year (2002-07) National Development Plan has improving the health as an overriding objective alongwith several other development objectives. For improving health, the plan emphasizes preventive and promotive health care, by adopting primary health care policies that enable increased accessibility and coverage; targets specific groups such as mothers and children for the greatest health impact; and aims to develop health staffing policies appropriate to the needs of the country.
- The National Development Plan also envisages adequate, safe and sustainable water supply and sanitation for villages through community-managed water supply and sanitation facilities. In Dili and other major urban centres, the aim is to recover full cost from the users of water supply.
- The Ministry of Health aims to provide quality health care by establishing and developing a cost-effective and needs-based health system which specifically addresses the health issues and problems of women, children and other vulnerable groups, particularly the poor, in a participatory manner.
- The Ministry of Health has drafted a national policy on immunization that aims to improve health promotion and education regarding the benefits of immunization and to improve the coverage in all districts.

- The national objectives for health include health promotion and education of pregnant women and family members; promotion of exclusive breast-feeding for six months and introduction of safe and nutritionally adequate complementary foods thereafter; improving ante-natal, delivery and newborn care by training medical staff; and establishing adequate facilities and promote appropriate family practices. The country is developing a national Safe Motherhood Strategy that aims to work with other partners to increase the proportion of births attended by trained personnel.
- The aim also is to develop a national child health policy, training for Integrated Management of Childhood Illnesses, implement the integrated child development programme, develop and implement community nutrition activities, and strengthen routine growth monitoring of children upto the age of five years.
- The tentative national targets are to reduce infant mortality by 30% from the baseline by 2010 and by 40% by 2015. For immunization, the target is to achieve and maintain 90% coverage by 2015. For maternal mortality, the target is to reduce it by 40% by 2010 and by more than 50% by 2015. The proportion of attended births are to be increased by 40% by 2015. The country hopes to realize most of the MDG targets.
- The Ministry of Health is preparing a National Health Strategic Plan 2007-2012, including a Medium Term Expenditure Framework. This is an additional step towards SWAP.

Q 11

How is WHO collaborating with the country?

Policy development and planning

- During the emergency period, WHO played a key role in coordinating health services provided by a large number of donors. WHO supported the initial development of the organization and staff of the Ministry of Health and it also implemented priority activities for rebuilding the health sector. This was particularly during the emergency and early rehabilitation phases, using funds allocated for the Ministry of Health from the Trust Fund for East Timor (TFET).
- The Ministry of Health was assisted in the development of annual workplans, mentoring of national staff, development of internal department policies, and a national health promotion strategy as well as regular development and delivery of health campaigns and messages.
- Coordination of work between health and other sectors such as water and sanitation in the development of facilities for personal and community hygiene and sanitation was supported.

  The Ministry of Health was assisted in preparation of the National Strategic Plan

Health system management

- WHO worked with the Ministry to augment the number of health professionals by developing local training programmes for nurses and paramedics, and through fellowships for training in institutions abroad. An advance of nursing practice course to strengthen the essential clinical skills of nurses, especially those working without doctors in the sub-district Community Health Centres has been developed.

- Assistance was provided in quality control of medicines purchased by the government. Kits were also provided for timely detection of water sources.
- The Ministry of health was supported in development and use of a management course for Community Health Centre managers.

Promotion of healthy lifestyles and settings

- The Ministry of Health developed a National Health Promotion Strategy with the assistance of WHO, and the involvement of other partners and stakeholders, through a series of workshops at the sub-district, district and national levels. The strategy outlines the ways to promote all aspects of health.
- WHO is actively working with an increasing number of local NGOs such as Cruz Vermelha De Timor-Leste (CVTL) and the National Red Cross Society for capacity building. Activities of CVTL include training in first-aid and disaster management as well as social mobilization.
- Extensive support was provided in addressing the risk factors and determinants of ill-health. Also the promotive and preventive activities pertaining to priority issues were strenghtened.
- Health communication activities as well as scientific meetings were conducted to address the issue of tobacco abuse. In addition, a mental health strategy was developed. Technical assistance was also provided for development of guidelines for food safety.
- The formulation of the National Child and Adolescent Health Strategy and the National Reproductive Health Strategy was supported. WHO participated in the consultation process for finalisation of national nutrition policy and assisted in the development of the National Maternal Nutrition Strategy.
- Assistance was provided for the development of a policy paper on road accidents injury prevention. The strategies, programmes and draft legislation for road accident injuries have been prepared.

Prevention and control of priority diseases

- Technical assistance was provided for control of communicable diseases and to develop a system of a nationwide weekly

epidemiological bulletin. Several investigations were conducted on outbreaks of various communicable diseases. WHO cooperated with NGOs in a national 'Roll Back Malaria Programme' which included distribution of insecticide-treated nets.

- Assistance was provided in the development of a proposal for combating malaria, and another proposal against tuberculosis. Both were submitted to the Global Fund Against HIV/AIDS, Tuberculosis and Malaria (GFATM). Both proposals were successful.
- WHO provided full financial and technical support for the implementation of the Integrated Management of Childhood Illnesses (IMCI). In addition to training government staff, in-roads have been made into the private sector as well. Training for the treatment of severe cases of malnutrition was provided to general staff.
- Training on the syndromic approach to sexually transmitted infections was developed and conducted for health workers in the government and nongovernmental health sectors. WHO also assisted in development of workplans to implement the national HIV/AIDS strategy adopted by the Ministry.
- A national survey was carried on leprosy in order to re-establish the National Leprosy Elimination Programme. WHO conducted a study to determine the prevalence of Japanese encephalitis and outlined major intervention strategies. During the worldwide outbreak of SARS, WHO was in the forefront for providing appropriate information and preparing infection control measures. It also assisted in the development of a local field manual on the management of all communicable diseases.
- Technical assistance was provided in strengthening Integrated Disease Surveillance System and in building the capacity of the Ministry to detect and respond to epidemics and pandemics, and in preparing an Avian Influenza Epidemic Preparedness Plan.
- Working closely with UNICEF and later the Ministry of Health, WHO supported immunization campaigns and routine immunization programmes.

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