MINISTRY OF HEALTH

NATIONAL HIV / AIDS / STIs STRATEGIC PLAN

2006 - 2010

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AMI	Assistência Médica Internacional
ARV	Antiretroviral
ASHM	Australasian Society for HIV Medicine
CBO	Community Based Organisation
CCF	Christian Children's Fund
CCYCF	Comoro Child and Youth Foundation
CRS	Catholic Relief Service
CVTL	Cruz Vermelha Timor-Leste
CWS	Church World Service
DCI	Development Cooperation Ireland
DENORE	Development of Knowledge and Research
FHI	Family Health International
FSW	Female Sex Worker
FTH	Fundasaun Timor Hari'i
HAI	Health Alliance International
HIV	Human Immunodeficiency Virus
IOM	International Organisation for Migration
MARG	Most At Risk Group
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAPWA	National Association of People Living with HIV/AID S
NGO	Non Government Organisation
OI	Opportunistic Infection
PWHA	Person With HIV/AIDS
STI	Sexually Transmitted Infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

TIMOR-LESTE HIV/AIDS NATIONAL STRATEGIC PLAN 2006-2010

Executive Summary

Overview

HIV/AIDS is a health crisis that is wreaking devastation for individuals, families, communities and nations worldwide. Almost 30 million have died and an estimated 40 million are currently living with HIV/AIDS, mostly in developing countries. In the absence of effective treatment most face a debilitating illness ultimately leading to death.

However HIV/AIDS is not only a health crisis but also one that fundamentally threatens the development aspirations of those nations most affected. Economies have been devastated and basic social service sectors such as health and education are collapsing. HIV/AIDS is a disease that disproportionately infects young people, particularly those of childbearing age. The death of parents has left millions of children orphaned, with little hope of a supportive upbringing.

Timor-Leste is a country in the early stages of national development. As such it faces significant challenges common to all new nations as well as specific challenges resulting from its own unique history, culture and environment.

It is believed that HIV prevalence in Timor-Leste is currently low. However HIV/AIDS has had a devastating impact on other countries in comparable circumstances to Timor-Leste. Among Timor-Leste's nearest neighbours Papua New Guinea appears to be in the early stages of a generalised HIV epidemic which threatens to not only halt, but reverse the development achievements that nation has made in its relatively short history. Many of the circumstances that have led to the current HIV situation in Papua New Guinea are also present in Timor-Leste including large-scale social dislocation and high levels of HIV related risk behaviours.

Timor-Leste has adopted a National Development Plan that provides clear strategic directions including processes for implementation, to address development challenges. The government, key organisations within civil society and international development partners, have also recognised the unique challenge HIV/AIDS creates to sustaining strategies required to develop this new nation.

Over the past four years Timor-Leste has adopted and implemented strategies, policies, programmes and projects to address HIV/AIDS. However among key stakeholders it is generally accepted that while many effective activities have been implemented overall coordination is weak and important gaps exist.

During 2005 the Government, through the Ministry of Health, in partnership with civil society organisations and United Nations agencies engaged in a consultative process to develop a new national strategy to provide a more comprehensive and coordinated response to HIV/AIDS and STIs. This document presents the new National Strategic Plan developed through that process.

National Context

The Democratic Republic of Timor-Leste was officially proclaimed as a new nation on 20th May 2002. This followed a period of enormous social and economic turmoil that occurred during a quarter century of occupation and conflict.[1]

Timor-Leste faces enormous development challenges related to historical, demographic and social factors. The turmoil that occurred prior to independence and the challenges of building a new nation since have resulted in significant social dislocation. Much of the infrastructure of the nation, including the health and education system, is being rebuilt. This is occurring in the context of widespread poverty, extensive population movement, high levels of illness and disease and relatively low levels of literacy.

The National Development Plan[2] provides an overall framework for addressing the development goals of Timor-Leste. Those goals are:

a) *To reduce poverty in all sectors and regions of the nation, and*
b) *To promote economic growth that is equitable and sustainable, improving the health, education, and well being of everyone in East Timor.*

Within the National Development Plan, health priorities are described as being among the most crucial. HIV/AIDS is acknowledged in the National Development Plan as having the "potential to have devastating effects on the people of East Timor as they become exposed to the rest of the world."[3]

[1] World Health Organisation. *WHO Country Cooperation Strategy 2004-2008 Democratic Republic of Timor-Leste*. World Health Organisation Regional Office for South East Asia. April 2004.
[2] Planning Commission, East Timor *National Development Plan*, Dili May 2002.
[3] Planning Commission, East Timor. Ibid p151

The Ministry of Health has defined its strategic priorities and directions to achieve these goals in the "East Timor Health Policy Framework". The strategic approach underlying the framework is the provision of comprehensive primary health care.[4]

HIV Risk and Vulnerability

HIV risk in Timor-Leste is framed by both the development challenges the nation faces and behavioural, social, and cultural factors. A multi-sectoral approach is required to strategically address both the broader social determinants of health and the more immediate risk factors leading to HIV infection.

HIV/AIDS has disproportionately affected less developed nations. Vulnerability is linked to poverty, low literacy and social upheaval. Poverty limits employment options (*e.g.* leaving some women little choice but to engage in sex work, placing them at higher risk of HIV infection), and limits access to the means of protection (*e.g.* ability to pay for condoms), among other consequences. Low literacy makes it more difficult to promote knowledge regarding HIV prevention and challenge misconceptions. Social upheaval, often leading to significant population dislocation, undermines established community, family and peer support structures as well as social/cultural norms and values. All of these vulnerability factors and others are present in Timor-Leste.

More immediate determinants of HIV risk are also present in Timor-Leste. There is a significant level of sexual partner change, particularly among some population groups. Young people who are entering the ages of sexual initiation are a disproportionate segment of the population. There are high rates of Sexually Transmitted Infections (STIs) among most at risk groups (particularly sex workers and Men who have Sex with Men (MSM)). Condom use is low across the population. Knowledge regarding HIV and how to prevent it is not widespread. [5]

Principles

HIV is a disease that raises sensitive issues, disproportionately affects marginalized populations and often requires potentially controversial responses. The complexity of HIV medicine, the sensitivity of the personal and social issues involved and the rapidly changing medical and social dimensions of the disease create the potential for HIV programmes to be riven by conflict, chaos and organisational gridlock. The principles underlying the programme are intended to provide a framework through which conflict can be mediated by focusing on common goals, a shared commitment to evidence-based programming and role delineation based on strategic planning. They also facilitate increased programme reach and enable changes in environments and policies across sectors and organisations.

The principles underlying the HIV/AIDS National Strategic Plan 2006 – 2010 are:

[4] East Timor Ministry of Health, *East Timor Health Policy Framework* ,Ministry of Health June 2002
[5] Family Health International, *HIV, STIs and risk behaviour in East Timor: an historic opportunity for effective action*, Family Health International, Dili 2004.

- A strategy based on respect for human rights
- A strategy that is participatory and multi-sectoral
- A strategy built on partnership that draws upon the strengths of government, non government, private sector and faith based organisations and includes the involvement of HIV positive people
- A strategy that is evidence-driven but encourages creativity
- A strategy consistent with the principles underlying the development of Timor-Leste
- A strategy that is multifaceted drawing on the underlying tenants of health promotion (*i.e.* development of personal skills, supportive environments, healthy public policy, strengthening community action and reorientation of health services)

Strategy Components

"To maintain Timor-Leste as a low prevalence HIV nation and minimise the adverse consequences for those infected with HIV" is the overall goal of the HIV/AIDS National Strategic Plan 2006 – 2010. To achieve this, action is required in the areas of Prevention and Education, Voluntary Counselling and Testing (VCT), Clinical Services and working across sectors. The principles of health promotion are imbedded across each of these components.

Prevention and education

Sexual and reproductive health promotion is a fundamental requirement for people to protect themselves from HIV infection. This includes having the capacity to adopt specific prevention behaviours including:

Abstinence from sexual activity that can transmit infection
Being faithful to one partner who is also faithful and uninfected
Consistent Condom Use

All members of the population have the right to be fully informed regarding how to protect themselves from HIV infection. However messages should be prioritised based on the likelihood of behaviour being adopted. While overlapping, different interventions need to be implemented targeting the general population, young people and those populations in Timor-Leste identified as most at risk groups (sex workers, men who have sex with men, clients of sex workers, mobile populations including uniformed services).

Voluntary Counselling and Testing (VCT)

Diagnosis of HIV infection has both an individual and public health benefit. Advances in medical science mean that HIV, while a serious chronic illness, is not necessarily fatal. With appropriate treatment and support, people with HIV can lead relatively normal lives. Capacity to ensure that all people diagnosed with HIV in Timor-Leste receive such treatment is now being established. Attention is also being

directed to the development of peer support structures and other measures to assist people with HIV to cope with a positive diagnosis.

From a public health perspective, people with HIV can minimise the risk of transmission to others by adopting safe sex behaviour. Also morbidity and mortality for those infected can be reduced. Furthermore maximising the diagnosis of HIV infection means that patterns of infection can be better monitored and interventions better targeted.

This strategy prioritises comprehensive VCT service provision to most at risk groups (MARGs), developing capacity to provide VCT at all levels of the health system, and the development of quality assurance mechanisms. It also promotes the inclusion of STIs in VCT service provision for most at risk groups.

Multi-sectoral Action

Addressing the causes of vulnerability to HIV infection requires a response that is broader than the health sector. While the underlying determinants (*e.g.* poverty, social dislocation) must be dealt with in the context of Timor-Leste's national development strategy, some of their consequences can be addressed specifically in regard to HIV. Furthermore, action is required in other sectors to effectively target HIV interventions and to build a supportive environment.

The development of specific interventions in those sectors reaching high priority populations has already occurred and will be further enhanced over the life of this strategy. The two most immediate priorities are the education sector and the armed forces sector.

Involvement in inter-sectoral forums at both the national and district levels is necessary to advocate for public policy that supports the goals of this strategy.

Multi-sectoral action also requires partnership between government, non-government, and private sectors as well as the involvement of faith-based and international agencies at national and district levels. This strategy proposes the establishment of infrastructure that provides capacity to work across sectors at the national and district levels.

Creating an environment that facilitates the greater involvement of positive people in all aspects of strategy will also require multi-sectoral action.

Clinical Services

This strategy addresses a range of issues regarding clinical services. While ensuring access to antiretroviral treatment is the highest priority, a number of other clinical issues are also related to HIV. They include provision of STI services, infrastructure support in areas such as laboratory and pharmaceutical services, and policies and procedures on issues such as infection control in health care settings and the safety of the blood supply.

There are significant gaps in policies and protocols across a range of issues. In addition, quality assurance procedures to monitor compliance with policies and protocols and to rectify deficiencies need to be developed.

Building linkages with service provision in other clinical streams is also an objective of this strategy. These include not only other infectious diseases such as STIs and TB but also population-based streams such as maternal and child health.

Organisational Arrangements

Ensuring effective strategy implementation will require a range of initiatives in regard to infrastructure. Priorities are outlined in this strategy in regard to coordination, capacity development and strategic information.

A new national HIV/AIDS Commission is proposed in this strategy to provide advice on all relevant issues, build partnerships between sectors, and advocate for supportive public policy. Members should be selected on the basis of their capacity to contribute to these functions.

Ensuring a multi-sectoral and national approach requires infrastructure. This strategy proposes the employment of HIV officers in district-based organisations to assist in the implementation of multi-sectoral district plans. District plans will be developed in the framework provided by this strategy and its implementation plan.

Capacity development, particularly in regard to human resources, but also policies and systems, is required for effective strategy implementation. Training is required for staff employed to work on HIV and STIs, volunteers, and key intermediaries (*e.g.* religious leaders, media).

There are significant gaps in strategic information on which to base programme decisions. These gaps exist across traditional public health domains such as surveillance and epidemiology but extend to behavioural monitoring, social research and evaluation studies.

This strategy recognises the Ministry of Health as having the leadership role in strategy coordination. However this leadership occurs in the context of the principles articulated including participatory decision-making and partnership in implementation.

Conclusion

HIV is a disease that respects no timetable but its own. However, like other infectious diseases, the risk of it occurring and its impact can be mediated by decisive action. The government of Timor-Leste, the Ministry of Health, Non Government Organisations and United Nations agencies are committed to implementing a new comprehensive response to HIV/AIDS. There is a clear understanding that Timor-Leste has the opportunity to avoid a HIV epidemic as is unfolding in neighbouring countries but that time is of the essence.

1 Context

Timor-Leste is a country in the early stages of national development. As such it faces significant challenges common to all new nations, as well as specific challenges resulting from its own unique history, culture and environment.

HIV/AIDS has had a devastating impact on other countries in comparable circumstances to Timor-Leste. Among Timor-Leste's nearest neighbours, Papua New Guinea appears to be in the early stages of a generalised HIV epidemic which threatens to not only halt but reverse the development achievements that nation has made in its relatively short history. Many of the circumstances that have led to the current HIV situation in Papua New Guinea are also present in Timor-Leste including large-scale social dislocation and high levels of HIV related risk.

Timor-Leste has adopted a National Development Plan that provides clear strategic directions including processes for implementation to address these development challenges. The government, key organisations within civil society and international development partners have recognised the unique challenge HIV/AIDS creates to sustaining strategies required to develop this new nation.

In 2002 a National HIV/AIDS/STI Strategic Plan was adopted. In the period since, Timor-Leste has adopted and implemented strategies, policies, programmes and projects to address HIV/AIDS. However, among key stakeholders it is generally accepted that while many effective activities have been implemented, overall coordination is weak and important gaps exist. Knowledge about HIV across the general population remains low, the level of unsafe sex practices is high and STI rates are also high.

From mid-2005 until early 2006, the Ministry of Health led a participatory multi-sectoral process to develop a new national strategic plan to cover the period 2006 - 2010. This document is the result of that process.

1.1 National Context

The Democratic Republic of Timor-Leste was officially proclaimed as a new nation on 20th May 2002. This followed a period of enormous social and economic turmoil that occurred during a quarter century of occupation and conflict.[6] During the final withdrawal of the Indonesian occupying forces in 1999, much of the basic infrastructure of the country was destroyed, including that of the health system.

The Democratic Republic of Timor-Leste is situated on the eastern part of the island of Timor. The enclave of Oecussi in the western part of Timor Island and the islands of Atauro and Jaco are also part of Timor-Leste.

Timor-Leste has a land area of approximately 14,610 square kilometers with a population of 924,642 as of 2004. The age structure shows a relatively young population with about 43 percent under 15 years of age. Approximately 19.9 percent of the total population is under 5 years old.[7] Average life expectancy is 55 years. Population growth is estimated at 3.2 percent per year, with a sex ratio (males per 100 females) of 104.[8]

The country is divided into 13 districts, 67 postos (sub districts), 498 sucos (villages) and 2336 aldeis (hamlets). The districts have district administrators with a small complement of staff and coordinators at the postos.

Other relevant indicators include:

- Most people live in rural areas, mainly around the northern coastal regions in small, dispersed villages[8]
- About 83 percent of those aged 15-24 have a basic level of literacy[6]
- Per capita income in 2002 was US$494[9]
- More than 40 percent of the population live below the national poverty line[10]
- Maternal mortality rate is estimated to be around 800 per 100,000 live births[11]
- Infant mortality rate is 90 per 1000 live births (June 2002) [7]
- Under 5 mortality rate is 46 per 1000 live births (June 2002) [7]
- Communicable diseases (e.g. malaria, acute respiratory infections and diarrhoeal diseases) account for approximately 60 percent of deaths[10]
- Malaria is highly endemic in most districts[10]
- There are an estimated 8,000 active tuberculosis cases nationally[10]
- Only about 56 percent of the population have access to safe drinking water[6]
- About 19 percent of the population has access to sanitation[6]

[6] World Health Organisation. *WHO Country Cooperation Strategy 2004-2008 Democratic Republic of Timor-Leste*. World Health Organisation Regional Office for South East Asia. April 2004.
[7] UNICEF, *Multiple Indicator Cluster Survey (MICS) Timor-Leste 2002*, Dili, May 2003
[8] National Statistics Directorate, Census 2004
[9] Asian Development Bank, *Key Indicators 2003*, 2003
[10] UNDP, *Millennium Development Goals Report*, 2004
[11] WHO op cit p5/6

Many of the development challenges create specific vulnerability in the context of HIV. Increasing numbers of people are moving into the age group that is sexually active. This is occurring at a point in Timor-Leste's history where population movement into and out of the country is increasing (*e.g.* an emerging tourism sector, Timorese seeking employment overseas), while social dislocation is weakening traditional social support structures and affecting established behavioural and social norms. Many young people are not well-equipped with the knowledge and life skills to manage HIV risk in an increasingly challenging environment.

The National Development Plan[12] provides an overall framework for addressing the development goals of Timor-Leste. Those goals are:

c) *To reduce poverty in all sectors and regions of the nation, and*
d) *To promote economic growth that is equitable and sustainable, improving the health, education, and well being of everyone in East Timor.*

Within the National Development Plan, health priorities are described as being among the most crucial. The plan states:

> Development strategies have been devised to emphasise the importance of providing adequate access to primary health care, focusing on prevention and clinical support in underserved areas. Health planners will develop a system of primary health care, universally accessible to individuals and families in the community through household participation, and at a cost that the community and country can afford to maintain at each stage of its development.
>
> Longer term health sector priorities are to ensure that health providers and clinical specialists can sufficiently meet the needs of the country's health system within the framework of overall social and economic development. In order to accomplish this, short term activities include recruitment and staff training activities, a national plan for regional and rural health services, and an epidemiological approach to preventive medicine, inoculations, public health information, and improved hygiene.[13]

The Ministry of Health has defined its strategic priorities and directions to achieve these goals in the "East Timor Health Policy Framework". The strategic approach underlying the framework is the provision of comprehensive primary health care. Key areas of policy are human resource development, health financing, organisation and management and drug policy.[14] In the short period since independence there has already been a significant improvement in the availability of primary health care services.

A more detailed operational description of services to be provided at different levels of service delivery is outlined in the Basic Package of Services Policy.[15] This document is particularly relevant to HIV/AIDS and STI strategy because it provides a

[12] Planning Commission, East Timor *National Development Plan,* Dili May 2002.
[13] Planning Commission, East Timor, Ibid pp9,10
[14] East Timor Ministry of Health, *East Timor Health Policy Framework* ,Ministry of Health June 2002
[15] East Timor Ministry of Health, *Basic Package of Services Policy,* Ministry of Health March 2004.

context for planning capacity development actions to address service delivery needs and identifying linkages in service delivery across different policy areas.

In Timor-Leste there are factors that contribute to additional vulnerability among women to the risks and impact of HIV/AIDS. They include domestic violence, lower literacy and education levels, and cultural constraints in discussing issues of sex. In Timor-Leste only 16 percent of women aged 15-49 have heard about HIV/AIDS.

The Regional Women's Congress has raised concerns about HIV/AIDS in relation to sexual violence against women. Rape and gender based violence represent 50 percent of the criminal cases reported to the police. The vast majority of the East Timorese female sex workers entered sex work after experiencing trauma, and many adult women entered sex work to sustain their families after their husbands abandoned them. [16]

In Timor-Leste many women and men labour in the informal sector, but women tend to be concentrated in the lower income-generating areas of the informal workforce. There are also gender gaps in earnings, with male earnings estimated to be eight times that of females'. This creates economic dependence on men, and seriously compromises the ability of women to negotiate protection and leave risky relationships. [17]

1.2 HIV/AIDS in Timor-Leste

Information with which to assess the current situation regarding HIV/AIDS and more generally STIs in Timor-Leste is relatively sparse. Routine surveillance systems are not fully developed, there is no sentinel surveillance system, and prevalence studies have only been conducted in some subpopulations and are not current. Behavioural studies have been conducted in some population groups believed to be at higher risk but are not current. Studies of knowledge and attitudes have been ad hoc. An understanding of specific cultural factors and practices in Timor-Leste that might impact on HIV risk is lacking.

There have been 30 cases of HIV notified to the Ministry of Health. However it is unlikely that this represents a true picture of the level of HIV infection in this country. A prevalence study coordinated by WHO at three hospitals among 1373 patients showed prevalence among those sampled of 0.5 percent. [18] If this were a random sample of the population over the age of 15 this would indicate over 2000 people in Timor-Leste living with HIV. However the sample was not representative of the adult population.

A sample of sex workers and men who have sex with men included in a survey conducted in 2003 by Family Health International (FHI) in Dili showed HIV

[16] Trafficking in East Timor. A look into the Newest Nation's Sex Industry 2004. ALOLA Foundation. 2004

[17] Gender and Nation Building in the Democratic Republic of Timor-Leste. Country Gender Assessment. ADB 2005.

[18] Ministry of Health. *Expanded comprehensive response to HIV and AIDS in Timor-Leste.* Submission to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Ministry of Health, Dili June 2005

prevalence in those populations of 3 percent and 1 percent respectively.[19] All further references in this section to data related to behaviour, knowledge and attitudes is derived from the study referenced here. The methodology was relatively robust and it is likely that this provided a reasonable estimate of HIV prevalence among those populations in Dili at that time. However no comparable data has been collected since and consequently the current situation is unknown.

Within populations where there is a high level of mixing, HIV transmission rates can increase quickly. This has been especially noted among injecting drug users; in various cities throughout the world HIV prevalence among injecting drug users has moved from virtually non existent to higher then 25 percent within one or two years. Rapid increases in HIV infection rates among MSM have also been identified. In the past year, HIV prevalence among MSM in Bangkok was over 25 percent, compared to approximately 17 percent one year prior.

Among a sample of 210 taxi drivers and 250 soldiers in Dili in the 2003 FHI study there were no HIV infections detected. Given there is significant evidence that these populations are more likely to engage in sexual behaviour at higher risk then other members of the heterosexual population (excluding sex workers) this would indicate that HIV infection was relatively rare at that time.

Routine surveillance of STIs is underdeveloped and unlikely to provide a meaningful indication of infection rates. However between January and October 2005, 1259 STI infections were reported to the Ministry of Health.[20] The transitory nature of STI symptoms, low population awareness, documented practices of self-treatment, stigma and minimal diagnosis of asymptomatic infection suggest the number of infections reported is likely to be a small percentage of actual infection levels. High levels of STIs are an indicator of HIV risk because of common routes of transmission while also increasing the biological risk of HIV transmission.

Among female sex workers in the 2003 FHI study, 14 percent tested positive for gonorrhoea, 15 percent for chlamydia, 16 percent for trichomonas and 60 percent for HSV-2. At the same time among a sample of MSM, 14 percent tested positive for gonorrhoea, 13 percent positive for chlamydia, and 29 percent for HSV-2.

Rates of gonorrhoea and chlamydia among taxi drivers and soldiers in the 2003 FHI study were relatively low. Among taxi drivers 1 percent tested positive for gonorrhoea and 2 percent for chlamydia. Among soldiers 0.5 percent tested positive for gonorrhoea and 2 percent for chlamydia. However, given that sex workers are the main extramarital sexual partners of these populations and that more than 50 percent have extramarital partners, these rates could have increased significantly since then.

STI infections are important both because of associated morbidity and the increased biological risk they create for HIV infection.

[19] Family Health International, *HIV, STIs and risk behaviour in East Timor: an historic opportunity for effective action*, Family Health International, Dili 2004.
[20] Ministério da Saúde, República Democrática de Timor-Leste. *Bulletin Epidemiologia.* Department of CDC. MOH Dili October 2005

Most sex workers and MSM in the 2003 FHI study did not use condoms on a regular basis. No female sex workers always used condoms in commercial sex and only 29 percent used condoms during their most recent commercial sex.

Condom use by taxi drivers and soldiers during commercial sex was also rare. Seventeen percent of taxi drivers and 33 percent of soldiers used a condom on the last occasion they had commercial sex.

Awareness of HIV was relatively high among all groups sampled in 2003 (except sex workers) but many did not know that HIV can be prevented by condom use. This highlights the need for a greater focus on education around causes of transmission and how to reduce risk.

	Taxi drivers	Soldiers	MSM	Sex Workers
Percent who have heard of HIV	84	91	86	42
Percent who know condoms prevent HIV	42	60	63	21

The lower level of knowledge among female sex workers than among male population groups in the above table is a reflection of more general gender inequality in Timor-Leste.

Some information is available that contributes to a broader understanding of the social context of sex work and male-to-male sex in Timor-Leste. Much of this information has been gathered in mapping exercises conducted by Fundasaun Timor Hari'i (FTH), discussions undertaken at a district level and in Dili as part of the process in developing a new national strategic plan, and discussion with staff of FTH and Cruz Vermelha Timor-Leste (CVTL), who in recent years have conducted outreach prevention programmes with these groups..

An estimated 500 MSM in Dili are relatively open regarding their male-to-male sexual behaviour. Outreach activities implemented by FTH have reached most of these men over the past year (2005). Reliable information is not available regarding the presence of visible MSM communities elsewhere in Timor-Leste.

It is difficult to estimate the number of men who have sex with men who are unlikely to be part of a visible MSM community. In Thailand, for example, studies show between 15 percent and 25 percent of male army conscripts reporting sex with men. [21] Most of these men do not identify as MSM. In the 2003 FHI study, 5 percent of male university students reported sex with men.

Discussions with MSM during a workshop conducted as part of the strategic planning process did not indicate a high level of stigma associated with male-to-male sex. Participants in district workshops who in the main were not MSM did not display

[21] Jackson, *Lady Boys, Tom Boys, Rent Boys, Male and female Homosexualities in Contemporary Thailand,* p44

obvious discomfort discussing related issues. However there is an absence of any more detailed social research regarding this phenomenon in Timor-Leste.

Mapping undertaken in developing outreach projects indicates that currently there may be around 500 female sex workers in Dili and perhaps about 70 in Suai. More generally it is reported anecdotally that there may be a higher concentration of sex workers in border districts but that there are sex workers throughout the country. It is reported that in Dili most sex workers solicit clients in the street or in entertainment establishments and that brothel based sex work is largely nonexistent.

It is also reported that most sex workers are Timorese nationals. The presence of sex workers from other countries appears to have declined in recent years.

In the 2003 FHI study a survey was also undertaken among university students. However, methodological problems indicate the results should be viewed with caution. Only 3 percent of female students and 27 percent of male students reported any sexual activity. Among the male students who reported having sex, over half had sex with a sex worker. Anecdotally others suggest that rates of sex among young people, if not specifically university students, are probably significantly higher.

Rates of injecting drug use in Timor-Leste are unknown. Anecdotally, key informants suggest there is no apparent injecting drug use scene. However, significant levels of injecting drug use in neighbouring Indonesia, which has fuelled HIV transmission in that country, may in the future contribute to the emergence of a similar phenomenon in Timor-Leste.

The 2003 FHI study showed 3 percent of male university students and 4 percent of MSM reporting having injected drugs. However some informants believe this may have reflected a misunderstanding of the question asked, e.g. medical injection for vaccination.

In many countries, prisons are sites of rapid HIV transmission. This is usually related to injecting drug use, but sometimes to male-to-male sex. There has been no study of HIV risk in prisons in Timor-Leste. Research should be undertaken to investigate prisons as a risk context for HIV transmission in Timor-Leste.

1.3 Development of Strategic Plan 2006-2010

In mid-2005, the Ministry of Health, with support from UN agencies and key civil society organisations, initiated a process to review the National HIV/AIDS/STI Strategic Plan 2002-2005 and develop a new strategic plan. The process was participatory, multi-sectoral, and occurred at the national and district level. The process was overseen by a steering committee chaired by the Minister of Health. A team of facilitators from Non Government Organisations, the Ministry of Health, and UN agencies implemented the process.

The process occurred in two phases. The first phase reviewed the existing plan and developed a framework for a new plan. A national conference was held in December

to consider the review and agree to the framework. The second phase developed the content of the new strategy as well as district implementation plans.

During phase one, workshops were conducted with key sectors and organisations at the national level. District workshops were conducted in six locations (Ainaro, Dili, Baucau, Maliana, Oecussi, and Manatuto). People from more than one district attended each workshop. It is estimated that over 150 people attended workshops.

The review process included input from workshops, interviews with stakeholders and documentation review. In summary, the review noted that while a significant amount of worthwhile activity has taken place during the past three years, there has been a lack of coordination and key gaps remain. The strategy itself was poorly structured and failed to provide clear prioritisation.

Over 250 people attended the December national conference. Participants came from all districts and sectors. Participants were highly engaged with most attending all sessions.

During phase two, workshops were held in all 13 districts to develop draft district plans. They identified local priorities, key actions and key partners. Feedback was also provided on priority issues and actions, identified in the draft national strategic plan.

An expert advisory group was established to provide technical input to the development of the strategy and national implementation plan.

The second National Congress was held on February 23 and 24. The new National Strategic Plan was presented and workshops conducted on the implementation plan and district plans.

1.4 Principles

The complexity of HIV medicine, the sensitivity of the personal and social issues involved and the rapidly changing medical and social dimensions of the disease create the potential for HIV programmes to be riven by conflict, chaos and organisational gridlock. The principles underlying the programme are intended to provide a framework through which conflict can be mediated by focusing on common goals, a shared commitment to evidence-based programming, and role delineation based on strategic planning. They also facilitate increased programme reach and enable changes in environments and policies across sectors and organisations. The principles are:

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- A strategy based on respect for human rights
- A strategy that is participatory and multi-sectoral
- A strategy built on partnership that draws upon the strengths of government, non government, private sector and faith based organisations and includes the greater involvement of HIV positive people
- A strategy that is evidence-driven but encourages creativity

- A strategy consistent with the principles underlying the development of Timor-Leste
- A strategy that is multifaceted, drawing on the underlying tenants of health promotion (i.e. development of personal skills, supportive environments, healthy public policy, strengthening community action, and reorientation of health services)

This Plan takes into consideration the human rights conventions that RDTL ratified in 2003. This includes the General Recommendation N 15 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) on the "Avoidance of Discrimination of Women in National Strategies for the Prevention and Control of AIDS" (1990) as well as General Comment N 3 of the Convention on the Rights of the Child on HIV/AIDS and the Rights of the Child (2003).

1.5 Goals and Objectives

1.5.1 Goal

"To maintain Timor-Leste as a low prevalence HIV nation and minimise the adverse consequences for those infected with HIV"

1.5.2 Objectives

- To implement a National Strategic Plan consistent with the principles outlined in the National Development Plan of Timor-Leste and those underlying best practice in HIV/AIDS programming
- To address those factors which are most likely to contribute to HIV transmission and/or cause adverse consequences for those infected
- To adopt programme priorities in the areas of health education, treatment and care, VCT, and multi-sectoral action
- To meet organisational requirements in the areas of coordination, capacity development, strategic information, and monitoring & evaluation

1.6 Target Populations

This plan outlines strategies to reach the entire population of Timor-Leste with more intensive interventions to reach specific subpopulations. More specific discussion of target populations occurs in each component.

The general population is a target because all people have a right to know how to protect themselves from HIV infection and to create an environment that is supportive of more specifically targeted actions. Effective HIV programming requires discussion of what are sensitive issues and actions that might challenge conventional social norms. A broader understanding of the personal risks associated with HIV infection and the potential impact on the nation as a whole can create an environment in which those actions can be implemented.

Within the broader population a more comprehensive approach is required to target young people. Youth is a period of transition from dependence on adults to independence. It is also when people reach sexual maturity. Young people require specific knowledge of HIV risk as well as broader life skills to be able to minimise their risk of HIV infection.

Timor-Leste has the highest birth rate of any nation in the world. In countries with high prevalence of HIV, children have suffered enormously. However, effective strategies exist to prevent mother to child submission. Women of reproductive age are specifically targeted in the VCT component of this strategy.

There is also a need for intensive intervention for most at risk groups. They include sex workers, men who have sex with men, clients of sex workers and mobile populations.

2 Strategy / Programme Components

"To maintain Timor-Leste as a low prevalence HIV nation and minimise the adverse consequences for those infected with HIV" is the overall goal of the HIV/AIDS National Strategic Plan 2006-2010. To achieve this, action is required in the areas of prevention and education, Voluntary Counselling and Testing (VCT), Clinical Services, and working across sectors. The principles of health promotion are imbedded across each of these components.

Programme logic / assumptions

This strategy has been structured around operational components, *e.g.* clinical services, to provide clarity for programme implementation. The connection between operational components and changing risk factors is apparent, *e.g.* under education and prevention increasing individual knowledge and skills to enable people to adopt safe sex practices, and it is easier to identify and respond to organisational requirements. For instance, respective disciplines required for capacity development are generally grouped and aligned with operational functions such as clinical services or VCT. The alternative of structuring the strategy around broader principles/themes, *viz.* supportive environments and sustainable communities, does not readily lead to a logical action framework that can be easily operationalised.

While the strategy has been structured in an operational framework, actions in different components will support action in others. The adoption of a programmatic approach is based on the proposition that the factors contributing to achieving the goals of the programme are complex, interrelated and function at a number of levels. It assumes that several related interventions operating in concert are more likely to be

effective then the sum of those interventions delivered independently. This assumption is consistent with an extensive body of research. [22]

This strategy can be broadly defined as sitting within a social model of health. It recognises that while individual factors such as knowledge, attitudes, and skills underlie behaviour, they are mediated by broader social factors ranging from socio-economic status to cultural/community values and norms. This approach is outlined in the Ottawa Charter, which was adopted by the World Health Organisation in 1986. [23] The Ottawa Charter identifies five key action areas by which individuals, communities and governments act to improve health. They are:

- Healthy public policy
- Supportive environments
- Strengthening community action
- Developing personal skills
- Reorientation of health services

Healthy public policy refers to legislation, regulatory frameworks, policies, and protocols. Policy across a range of sectors impacts on the achievement of HIV strategic goals and objectives. For example, the level of sales tax on condoms, which is the responsibility of departments administering finance, influences people's ability to purchase condoms. The multi-sectoral component of this strategy outlines directions for developing health public policy. Organisational arrangements outlined under planning and coordination will also facilitate the development of health public policy.

Supportive environments are those in which institutional and individual practices, values and social/cultural norms facilitate healthy behaviour. An environment in which stigma and discrimination is not practiced in relation to HIV is one in which people are more likely to come forward for testing. The successful implementation of VCT programmes will be facilitated by education and prevention programmes that improve understanding of HIV and reduce unnecessary fears and multi-sectoral action.

The breadth of action required for effective HIV strategy implementation requires an informed and involved community. A range of community-based organisations have made an important contribution to achieving the goal and objectives of this strategy. For example, faith-based organisations have an important role in addressing stigma and discrimination, providing care and support, and supporting prevention programmes. Organisations that have credibility with marginalized populations can be effective in prevention and education and promoting access to testing/treatment services. The private sector can help provide a supportive environment by ensuring discriminatory practices do not occur against HIV-positive employees. The multi-sectoral component of this strategy provides a framework to promote widespread involvement in the strategy.

[22] National Health Service. *HIV Prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission. Evidence Briefing.* London: National Health Service, 2003.

[23] World Health Organisation. *Ottawa Charter.* Geneva: World Health Organisation, 1986.

Personal skills are necessary to adopt safe behaviours. This requires practical knowledge and skills to adopt safe sex behaviour in sexual encounters but also includes broader life skills. Abstinence from sexual activity that can transmit infection, being faithful to one partner who is also faithful and uninfected, and consistent condom use requires self-esteem and negotiation skills. While the education and prevention component provides the main actions to achieve these outcomes, health education in clinical settings including VCT will also contribute.

Health services are generally oriented to the provision of curative services. However they are important sites for health education. In the context of HIV and STIs, they are often accessed when people have engaged in risk behaviours. The provision of counselling in this context can be a very effective intervention. Ensuring services are provided in a non-judgemental manner also increases the likelihood that people (particularly MARGs) will continue to access such services as required.

2.1 Prevention / Education

Sexual and reproductive health promotion is a fundamental requirement for people to protect themselves from HIV infection. This includes the capacity to adopt specific prevention behaviours, including:

- Abstinence from sexual activity that can transmit infection
- Being faithful to one partner who is also faithful and uninfected
- Consistent Condom Use

All members of the population have the right to be fully informed regarding how to protect themselves from HIV infection. However, messages should be prioritised based on the likelihood of behaviour being adopted. While overlapping, different interventions need to be implemented targeting the general population, young people, and those populations in Timor-Leste currently identified as most at risk.

Injecting drug use is a significant cause of HIV transmission in most other countries. More information is required regarding the extent of injecting drug use in this country. Should injecting drug use be, or become, significant, a rapid response will need to be implemented.

2.1.1 Situation Analysis

- Current infection level low
- High level of vulnerability linked to social and demographic factors (*e.g.*, low literacy is barrier to HIV and STI health promotion)
- High levels of risk associated with
    - Knowledge (*e.g.*, many people don't know about condoms)
    - Attitudes (*e.g.*, you only get HIV from foreigners)
    - Behaviours (low level of condom use)
    - STIs (high level of STIs)
- Some populations have higher levels of risk behaviour (*e.g.*, MSM, soldiers, sex workers)

- Young people at increasing risk (*e.g.*, earlier puberty, later marriage, experimentation)

POLICY STATEMENT

To enable all people in Timor-Leste to have the knowledge and skills to minimise their personal risk of HIV infection.

2.1.2 Prevention and Education Objectives

- Improve knowledge across the general population of how to prevent HIV and STIs
- Enhance ability of young people to prevent risk of HIV and STI infection through life skills (*e.g.*, how to say no) and knowledge regarding safe sex practices (*e.g.*, condom use)
- Ensure specific programmes are targeted at most at risk groups to promote knowledge, create norms regarding condom use, and enhance access to testing
- Increase availability of condoms through targeted outreach and at public health services
- To initiate a rapid response if evidence emerges in Timor-Leste of significant risk of HIV transmission through injecting drug use

2.1.3 Programmes

Separate programmes will be developed for each target population according to their specific needs. However, the programme targeting the general population will impact on those targeting young people and Most at Risk Groups. Young people and members of MARGs will be exposed to the programme targeting the general population, thereby reinforcing more specifically targeted messages.

A range of agencies bring particular strengths to the implementation of prevention and education programmes. This is recognised by the Ministry of Health, which has as one of its goals for health promotion "Expansion of partnership for health promotion".[24] The Ministry of Health has a leadership role in facilitating partnership between agencies.

The strategic framework of the Ministry's Health Promotion Policy will also guide HIV/AIDS prevention and educations programmes, as well as inform multi-sectoral programmes and organisational arrangements in this strategy. That framework is:[25]

[24] Ministry of Health Democratic Republic of Timor-Leste. *National Strategy for Health Promotion 2004-2010.* Dili August 2004 p15
[25] Ibid p16

1. Strengthening community action to develop a shared responsibility for health and to take action to improve health
2. Targeted health promotion programmes that address priority needs of the general population
3. Increasing knowledge and skills of individuals, communities, civil society, and all bodies to promote health as a shared responsibility
4. Effective, targeted communication to ensure provision of quality health information and improved access to quality health information
5. Effective health promotion practice to ensure optimal outcomes

2.1.3.1 General Population

The purpose of the General Population Programme is threefold:

- To promote an environment that is supportive of HIV strategy initiatives
- To ensure all members of the population have access to information to reduce their risk of HIV infection
- To reach people at higher risk that may not be accessed through more specifically targeted programmes

A supportive environment is one in which unnecessary fear is minimised and there is broad understanding of the range of measures adopted to address HIV. Basic knowledge of HIV, including transmission risks, is the key priority. Increasing awareness of the overall threat of HIV to the national development of Timor-Leste is also important.

All people have a right to know how to protect themselves from HIV infection. This includes abstaining from sexual activity that can transmit HIV infection, being faithful to one partner who is also faithful, and uninfected or consistent condom use. Abstaining from sexual activity that can transmit infection or being faithful to one partner (provided the partner is also faithful and not infected) are the most reliable practices. However many people do have sex with more then one partner. By using a condom they can minimise their risk of infection and protect their regular partner who may be adopting the strategy of being faithful.

Some members of most at risk groups may not be reached through more specifically targeted programmes. This includes some MSM who only have contact with that population in the context of sex and don't self-identify as such, and some women whose involvement in sex work may be very infrequent. They can be reached through a programme targeting the general population.

The general population programme needs to be multifaceted. Advocacy is needed through various forums. All available media needs to be utilised. HIV awareness needs to be promoted at all levels of health service delivery.

Advocacy is required from key opinion leaders across a range of organisations, particularly in the faith-based and health sectors as well as more broadly at the political level. Faith-based leaders have a significant impact on the values people hold and therefore have a particularly important role addressing stigma and discrimination. Health workers are key sources of information on health issues and have high

credibility in providing health information. The measures required to address HIV are often controversial and political leadership is required to ensure they are understood in the context of their implications for the development of the nation and not politicised for political advantage.

HIV awareness needs to be promoted through reproductive health services. This is included in the National Reproductive Health Strategy.[26] That strategy outlines initiatives to provide HIV and STI knowledge and skills on an intensive basis through community education classes and counselling.

Special attention will be paid to the specific needs of women, addressing higher biological vulnerability, and socio-cultural and economic inequities. In line with the Second National Women's Congress Plan of Action 2004-2008, education programmes in the communities about family planning and reproductive health and rights[27] will be increased.

2.1.3.2 Young People

Young people are at particular risk of HIV infection. They are at the start of their sexual lives and consequently lack the experience of older people. As their reliance on family decreases, they are more subject to peer pressure. Youth is often a period of confusion influenced by biological changes, increasing life responsibilities, and exposure to a wider sphere of influences. Many young people lack the life skills required to deal with these changes and knowledge regarding the biological context of sex.

HIV programming for young people is complex. Social norms place value on abstinence from sex. To reinforce these norms, programming needs to include a strong emphasis on the development of life skills. Most young people will be subject to pressure to engage in sexual activity. They need skills in assertiveness and negotiation if they are to take actions based on informed decision-making. However it also needs to be acknowledged that some young people will engage in sexual experimentation and that those who do need knowledge regarding condoms to prevent risk of HIV transmission.

The population group of young people covers a wide range of years. Sub-programmes need to be developed for primary school, junior secondary, senior secondary, university/post secondary and out-of-school young people.

Education settings and youth centres will be primary sites for the delivery of life skills based education. Popular culture should be utilised to promote broader HIV prevention messages.

2.1.3.3 Most at Risk Groups (MARGs)

Groups identified in Timor-Leste as most at risk include: sex workers, men who have sex with men, clients of sex workers, the national police and the armed forces. Within

[26] Ministry of Health Democratic Republic of Timor-Leste. *National Reproductive Health Strategy.* Dili September 2004 p25

[27] Second National Women's Congress Plan of Action 2004-2008 of Timor-Leste.

Timor-Leste, research indicates significant levels of sexual activity with multiple partners by members of each of these groups as well as low levels of HIV knowledge and condom use. Research also shows high STI rates among sex workers and men who have sex with men. This research was undertaken two years ago and projects implemented since may have resulted in improvements in risk practices.

In various countries each of the above groups has had higher rates of HIV infection then in the broader population. They have sometimes been a catalyst for more widespread HIV transmission in the broader population.

In many countries injecting drug user populations have also experienced high levels of HIV transmission. It is assumed that injecting drug use is extremely rare in Timor-Leste; however, there is minimal evidence to substantiate this claim.

The implementation of programmes described under strategic information in this strategy may reveal other risk contexts and population groups that require more intensive interventions. Anecdotal information has been provided in developing this strategy of particular risk contexts in prisons and border areas. Other specific district-based risk contexts have been described, such as people staying in major district centres when markets are conducted, and young people living in shared households away from their home for education purposes.

Intensive prevention and education interventions need to be targeted at MARGs. They need to be clearly focused on the promotion of condom use and regular testing for both HIV and STIs. STI testing needs to be conducted as enhanced syndromic management. See section 2.4, *Clinical Services*, for further discussion.

Action will also be required in other components that address discriminatory attitudes towards some most at risk groups. Facilitating access to services requires a non-judgmental approach.

Interventions targeting the military and police need to use existing infrastructure. This ensures high reach among those groups. Peer-based projects are required to reinforce knowledge and skills-based education by promoting safe sex behavioural norms.

A range of strategies are required for other MARGs. They include peer-based education, social marketing, condom distribution, and direct provision of clinical services. Many of these interventions need to be delivered through outreach services.

2.2 Voluntary Counselling Testing (VCT)

Diagnosis of HIV infection has both an individual and public health benefit. Advances in medical science mean that HIV, while a serious chronic illness, is not necessarily fatal. With appropriate treatment people with HIV can lead relatively normal lives. Capacity to ensure that all people diagnosed with HIV in Timor-Leste receive such treatment is now being established.

From a public health perspective, people with HIV can minimise the risk of transmission to others by adopting safe sex behaviour. Also morbidity and mortality

associated with HIV can be reduced. Furthermore, maximising the diagnosis of HIV infection means that patterns of infection can be better monitored and interventions better targeted.

This strategy prioritises comprehensive VCT service provision to most at risk groups, developing capacity to provide VCT at all levels of the health system, and the development of quality assurance mechanisms. It also promotes the inclusion of STIs in VCT service provision for most at risk groups.

The principle of confidentiality needs to be clearly integrated into VCT provision. Fear of discrimination and stigma is a major barrier to VCT access. Standard protocols need to be developed for implementation across both the public and private sectors.

2.2.1 Situation Analysis

- HIV and STI VCT need high among MARGs, particularly in Dili and border districts
- Significant STI counselling need across sexually at-risk populations in all districts
- Capacity to provide VCT to MARGs in Dili reasonable but only at small number of sites; sub optimal in border districts
- Low capacity to provide STI counselling across broader sexually at-risk populations in Dili and all other districts
- Quality of VCT service provision not monitored
- Utilisation of VCT services sub-optimal among sex workers; current utilisation among other MARGs unknown
- Prevention of mother-to-child transmission of HIV requires VCT capacity across all health services

POLICY STATEMENT

To implement VCT services that optimise the diagnosis of HIV and STIs and build the capacity of individuals to manage risk and the consequences of infection.

2.2.2 VCT Objectives

- Increased provision of HIV and STI VCT for MARGs
- Implementation of specific projects to promote access to VCT among MARGs
- Increase provision of STI counselling for the broader sexually at risk population
- Incorporate information on STIs into VCT training programmes for clinical staff
- Monitor the quality of VCT service provision

2.2.3 Programmes

2.2.3.1 Most at Risk Groups (MARGs)

Given current low levels of condom use and high levels of STIs among sex workers and men who have sex with men, both the frequency and reach of VCT services for these groups needs to be increased. The counselling and testing components of STI enhanced syndromic management should be included with HIV VCT for these groups.

Availability of VCT for sex workers and MSM needs to be expanded to major population centres outside of Dili. More intensive training for a small number of staff trained as part of the programme to prevent mother-to-child transmission should occur to develop necessary capacity.

Expert advice needs to be sought to develop protocols regarding the frequency of VCT service provision for individual sex workers and men who have sex with men.

Utilisation of VCT services needs to be integrated into prevention and education programmes targeting all MARGs.

The provision of HIV VCT for other most at risk groups should be integrated into more focused promotion of syndromic STI management. However, counselling should be given higher priority in syndromic management with these groups, given higher levels of risk-taking behaviour than in the broader population. Sentinel STI surveillance should occur among these groups, and should infection levels warrant, consideration should be given to adopting enhanced syndromic management.

Standard protocols should be developed for VCT provision in each programme area and systems developed for monitoring compliance.

2.2.3.2 Prevention of Mother to Child Transmission

HIV VCT needs to be available at all health services. This is necessary to offer testing to all pregnant women in the context of preventing mother-to-child transmission. Development of human resource capacity to achieve this needs to be integrated with the implementation of the National Reproductive Health Strategy. Standard protocols need to be developed and compliance monitored on a regular basis.

2.3 Multi-Sectoral Action

Addressing the causes of vulnerability to HIV infection requires a response that is broader then the health sector. While the underlying determinants (*e.g.* poverty, social dislocation) must be dealt with in the context of Timor-Leste's national development strategy, some of their consequences can be addressed specifically in regard to HIV. Furthermore, action is required in other sectors to effectively target HIV interventions and to build a supportive environment where institutional and individual practices, values and socio-cultural norms facilitate healthy behaviour.

This multi-sectoral response will require working broadly across sectors in order to bring together all parts of government for policy dialogue, including the ministries of health, finance and planning, education and defence. It will also require partnership between government, non-government, and private sectors as well as the involvement of faith-based and international agencies at national and district levels. In this regard, political commitment and appropriate government involvement will be key to an effective response. Communications are necessary for building this political understanding. This strategy proposes a programme to support work across sectors at the national and district levels.

In addition, special attention must be paid to gender issues, addressing the specific needs of the Timor-Leste reality. It includes recognizing the influence of biological, socio-cultural, economic and political factors that increase the vulnerability of women to infection.

The development of specific interventions in those sectors reaching high priority populations has already occurred and will be further enhanced over the life of this strategy. The two most immediate priorities are the education sector and the armed forces sector.

The Government of Timor-Leste has recognised the need for multi-sectoral action to address health issues in the "Intersectorial Action Framework for Well Being and Health".[28] That policy describes the need for involvement in inter-sectoral forums at both the national and district levels as necessary to advocate for public policy. Such advocacy is also required to support the goal of this strategy.

Multi-sectoral action also requires partnership between government, non government, and private sectors as well as the involvement of faith-based and international agencies at national and district levels. This strategy proposes a programme to support work across sectors at the national and district levels.

2.3.1 Situation Analysis

- Low levels of awareness and knowledge on HIV/AIDS among the general population
- Social Dislocation – people separated from families/regular partners more likely to engage in sexual risk practices
    - Armed forces
    - Transport workers
    - Mobile populations
- Large vulnerable youth population reaching age of sexual experimentation, characterized by
    - Less-developed life skills
    - Low knowledge of HIV/STI risk
    - Low utilisation of health services
- Gender inequities

[28] República Democrática De Timor-Leste. *Intersectorial Action Framework for Well Being and Health (Draft).* May 2005. Dili

  - *Biological vulnerability*. Women are doubly vulnerable to HIV/AIDS and four times more prone to STIs than men.
  - *Socio-cultural.* Due to culturally rooted ideas of gender identities and behaviours, women are more vulnerable to coercion, and less likely to be able to negotiate methods of protection.
  - *Economic*. Women's dependence on men limits their control over their lives, including overexposure to HIV.
- Poverty – 40 percent of the population lives below poverty line
  - Financial costs associated with prevention, *e.g.* condoms
  - Economic deprivation and lack of employment options encourages involvement in the sex trade. Those most financially deprived have the least power to negotiate safe sex.
- High level of stigma/discrimination about HIV and STIs
  - A barrier to voluntary testing
  - Human rights violation

POLICY STATEMENT

To engage all sectors of society in the development
and implementation of strategies to minimise HIV transmission
and the adverse consequences of infection.

2.3.2 Multi-sectoral Action Objectives

- Promote policies and programmes that create and encourage supportive environments regarding HIV and STIs, increasing the level of awareness and knowledge of HIV/AIDS among the general population
- Identify sectors employing higher rates of transient workers and establish public/private sector partnerships to implement prevention initiatives
- Develop life skills and knowledge and awareness among youth, and enhance their use of the health services
- Promote changes in gender relations which decrease women's vulnerability to HIV
- Draw up policies and legal frameworks to ensure that the rights of PLWHA are protected and they are able to take recourse to legal remedies if necessary, and reduce barriers to HIV prevention
- Establish infrastructure that supports a national (centre and districts) and multi-sectoral response
- Develop initiatives that provide support for HIV positive people and promote involvement in all aspects of the strategy

2.3.3 Programmes

2.3.3.1 Advocacy Programme

The Government of Timor-Leste has adopted the "Intersectorial Action Framework for Well Being and Health", which has as its goal "to enhance the wellbeing and

health of the peoples and communities of Timor-Leste through a shared understanding of public health problems and a combined approach of all of government along with the community itself to address key determinates of health."[29]

In adopting that goal it is recognised that "the health and wellbeing of the peoples and communities of Timor-Leste can only be improved through a collaborative approach to recognition of priority health problems and their causes and subsequent public and individual action."[30]

The Intersectorial Action Framework identifies HIV/AIDS as an issue requiring an inter-sectoral approach. Apart from health it recognises social services, education, gender, law, and human rights as being particularly relevant.[31] In identifying gender and human rights the policy elsewhere discusses the need to address gender inequality and discrimination against marginalized groups. Other issues highlighted in the policy which more broadly impact on health outcomes are:[32]

- Low levels of education plus lack of public debate on key health issues has left many public health issues known to policy developers and planners completely off the public agenda
- Public expectations are far below a level to maintain positive health outcomes, healthy lifestyles and a general sense of well-being
- People cope with high levels of infirmity and disease without seeking medical intervention
- Knowledge of what has caused a health problem is often scant
- Personal actions (driving habits, drinking, violence) are not conducive to healthy lifestyles
- Low levels of disposable wealth guide behaviours; the choice between spending on an essential item for the home or something important for the children as opposed to making time and paying for transport to seek medical attention is often a difficult one

The Intersectorial Action Framework identifies the need for advocacy through forums at national, district and community level. To enable this to happen with HIV/AIDS, mechanisms to enhance multi-sectoral collaboration at the national level need to be established; ongoing communication between the national, district and community level needs to occur; and a programme to promote public awareness of HIV/AIDS must be implemented. Interventions to achieve this are discussed in this strategy under coordination mechanisms (National AIDS Commission), National/District linkage programme, and General Population Programme.

2.3.3.2 National/District Linkage Programme

This strategy explicitly aims to develop a Timor-Leste-wide response to HIV/AIDS that includes implementation at national, district and community levels. While the Ministry of Health has a leadership role through the coordination of inter-sectoral

[29] Republica Democratica De Timor-Leste. Op.cit p11
[30] Ibid. p12
[31] Ibid p8
[32] Ibid p8

forums and broad policy setting, other sectors/organisations at the district level lack capacity to be fully involved. This includes access to knowledge necessary to be involved in devolved planning, which is a guiding principle of the inter-sectoral participatory approach of the Intersectorial Action Framework,[33] and assistance from national organisations in implementing projects. This includes implementation of district plans.

The employment of HIV/AIDS project officers in district-based organisations is proposed to address these needs. They would be supported by a project officer based in a national organisation through provision of information, access to national resources (training, projects, resource materials) and regular networking.

2.3.3.3 HIV Positive Programme

The HIV Positive Programme's main goal is to empower PLWHA to involve themselves in the battle against HIV/AIDS. An appropriate legal rights framework that fosters the creation of a supportive environment free of stigma and discrimination is necessary for this to occur in a coordinated and open fashion. Such an environment will alleviate fears of alienation and encourage positive people to organise and build supportive networks.

Internationally the involvement of HIV positive people in all aspects of HIV strategy has been widely accepted as a core principle. The Greater Involvement of People with HIV/AIDS (GIPA) principle was adopted at a meeting in Paris in 1994 of 42 heads of government and subsequently endorsed at various international forums. GIPA acknowledged the central role of PLWHA in AIDS education and care and in the design and implementation of national and international policies and programmes, in order to successfully tackle HIV/AIDS. It also acknowledged that, for positive people to take on a greater role in the response, they need increased support.

Article 1 of the Declaration resolved to facilitate this greater involvement of positive people:

> The success of our national, regional and global programmes to confront HIV/AIDS effectively requires the greater involvement of people living with HIV/AIDS... through an initiative to strengthen the capacity and coordination of networks of people living with HIV/AIDS... By ensuring their full involvement in our common response to HIV/AIDS at all - national, regional and global - levels, this initiative will, in particular, stimulate the creation of supportive political, legal and social environments.

The Declaration committed governments to develop and support structures, policies and programmes to facilitate the greater involvement of positive people.[34]

The GIPA principle is included in the core principles of this strategy. It is included in the multi-sectoral component because its achievement will require commitment and action across sectors.

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[33] Ibid. p12

[34] Asia Pacific Network of People Living with HIV/AIDS. *APN+ Position Paper 2 GIPA.* www.hivasiapacific.apdip.net January 2004 p3

Self-empowerment of positive people is fundamental to the GIPA principle. During the period of this strategy, positive people must be supported in developing organisational structures through which they can determine their own priorities and develop initiatives to promote them. In the immediate future, support structures need to be established to facilitate peer support and commence work on achieving the GIPA principle.

In addition to specifically protecting the rights of PLWHA and those most vulnerable to HIV/AIDS, it is also necessary to ensure that appropriate and accessible legal remedies are available to them. This can be done by inserting relevant provisions in the respective constitutional and the civil and criminal laws where such safeguards and remedies do not already exist.

To ensure that the rights of PLWHA are protected and they are able to take recourse to legal remedies, is necessary to build a supportive environment so that fear, discrimination and stigma do not hinder access to the judicial system, and to support public education to reduce fear and loathing, which is at the heart of stigma and discrimination.

In this regard the current resources available in Timor-Leste to provide legal and human rights remedies for positive people will be reinforced. Those resources are:

Office of the Provedor. Article 27 of the Constitution of Timor-Leste provides for the creation of the Office of the Ombudsman for Human Rights, which examines and finds solutions to citizens' complaints of abuse of public powers, prevents injustice and initiates the process to remedy injustice.

Civil remedies. People may possess certain rights that may not be fundamental rights, but are legal or civil rights. Such rights are enforceable through the civil courts in the country. Therefore, if a private employer discriminates against a PLWHA, then subject to the existing laws, the employer can be taken to court for the violation of employee rights.

Criminal law remedies. The penal code and other penal statutes lay down acts or omissions that constitute an offence. Victims of violence, persons who have been thrown out of their house, or have been otherwise exploited due to their HIV-positive status can file a complaint in the police station. If the complaints are not registered they can refer themselves to senior officials and also make a complaint to the magistrate.

National resources on human rights protection. Every Ministry have a human rights focal point. The Ministry of Health focal point will be aware and will receive special training on HIV/AIDS issues.

2.4 Clinical Services

This strategy addresses a range of issues regarding clinical services. While ensuring access to antiretroviral treatment is the highest priority, a number of other clinical issues are also related to HIV. They include provision of STI services, infrastructure

support in areas such as laboratory and pharmaceutical services, and policies and procedures on issues such as infection control in health care settings and the safety of the blood supply.

There are significant gaps in policies and protocols across a range of issues. In addition, quality assurance procedures to monitor compliance with policies and protocols and to rectify deficiencies need to be developed.

Building linkages with service provision in other clinical streams is also an objective of this strategy. These include not only other infectious diseases such as STIs and TB but also population-based streams such as maternal and child health.

2.4.1 Situation Analysis

- Number of sites at which HIV and STIs can be adequately diagnosed is low
- Few doctors trained in HIV management
- Significant number of health care workers trained in syndromic management of STIs, but compliance with standard protocols poor
- Enhanced syndromic management of STIs among MARGs not widely conducted
- Supply of HIV drugs (ARVs and OI drugs) likely to be adequate in future due to Brazil donations
- Laboratory services and pharmaceutical management inadequate
- Policies, guidelines, protocols in most areas of clinical service delivery inadequate or nonexistent, undermining quality monitoring
- Linkages with related health issues inadequate (*e.g.* TB, maternal/child health)
- Compliance with infection control/universal precautions inadequate
- Safety of blood supply not optimal

POLICY STATEMENT

To ensure quality HIV and STI clinical services are available to all people in Timor-Leste that need them.

2.4.2 Clinical Services Objectives

- To enhance capacity to diagnose HIV and STIs across all levels of the health care system
- To ensure high-level quality HIV treatment is available to all PLWHA
- To improve the quality of syndromic management of STIs across all levels of the health care system
- To increase the availability of enhanced syndromic management to MARGs
- To develop and maximise compliance with standard policies, guidelines and protocols in all priority areas of HIV and STI clinical service delivery
- To enhance capacity and quality of laboratory and pharmaceutical management services

- To develop policy on and promote compliance with universal precautions for infection control
- To optimise the safety of the blood supply system
- To integrate prevention of Mother-to-Child Transmission in reproductive health services
- To ensure access to Post-Exposure Prophylaxis for service deliverers

2.4.3 Programmes

This section describes programme priorities in clinical services. Areas described are delivery of HIV and STI diagnostic and treatment services, management of pharmaceuticals, laboratory services, blood supply and infection control. Underlying the delivery of services is:

- Development and adoption of policies, protocols and guidelines
- Human resource capacity
- Management/operational systems
- Quality assurance mechanisms

Ensuring equitable and high quality diagnostic and treatment services requires comprehensive policies, protocols and guidelines. The complexity of HIV medicine and the rapid development of new scientific findings and their implications for treatment require procedures for regular review.

Human resource needs and related capacity development to deliver HIV and STI services vary according to complexity of disease, point of service access, service provider type (*e.g.* medical, nursing, allied health) and disease management approach (*e.g.* STI syndromic management, management of drug resistant STIs). Likely changes in treatment protocols also require systems for upgrading skills.

The provision of HIV treatment in Timor-Leste presents unique challenges to the health system. It requires the provision of highly specialised services in a resource-poor setting where the priority in health service provision is to ensure access to basic primary health care services. However, it also involves the provision of testing services through those basic primary health care services with appropriate referral mechanisms where infection is diagnosed. Efficient linkages are also required between different functional areas (treatment, laboratory services, and pharmaceutical provision).

The availability of funds through the Global Fund presents both opportunities and risks for the health system. The provision of HIV services requires the development of capacity across the broader discipline of infectious diseases both in regard to human resources and infrastructure. Given the existing impact of infectious diseases on morbidity and mortality in Timor-Leste, this is potentially of significant benefit. However it also carries the risk of developing infrastructure that is not sustainable should funds be reduced or withdrawn later.

Quality assurance mechanisms need to be implemented across clinical service provision. Where service provision is limited to a small number of sites (*e.g.*

antiretroviral treatment, laboratory services), opportunities for partnering arrangements and/or benchmarking against services in other countries should be considered. Where provision will occur across a large number of sites (*e.g.* syndromic management of STIs), quality indicators should be developed for benchmarking within Timor-Leste.

2.4.3.1 HIV Treatment Services

It is feasible in Timor-Leste to ensure the availability of HIV antiretroviral treatment to all those diagnosed with infection. Numbers believed to be infected are relatively low. Antiretroviral drugs are available from donor nations. Technical support for the development of system and human resource capacity is available from international agencies. Additional funding is available through the Global Fund for other infrastructure needs. The basic infrastructure for the delivery of services exists in Timor-Leste.

Given the relatively low number of people believed to be currently infected with HIV and the complexity of treatment, delivery of antiretroviral treatment should be focused at a small number of sites. Where patients are located outside of Dili, partnership arrangements should be made with local health services for drug storage and ongoing patient monitoring on the basis of non-laboratory diagnostic procedures (*e.g.* weight loss, symptoms of opportunistic infections), with regular periodic referral to specialist facilities for full assessment.

The National Hospital in Dili, in addition to being a site for antiretroviral delivery, should also provide HIV inpatient facilities as well as acting as the HIV prescribing site for patients outside of Dili. If over the next five years the number of patients increases significantly outside of Dili, the provision of antiretroviral prescribing should be expanded while more specialised inpatient facilities remain centralised in Dili.

Policies, protocols and procedures need to be developed across all aspects of patient management. An immediate priority is the development of guidelines regarding when to commence and alter antiretroviral treatment based on clinical assessment and international best practice, while also taking account of factors specific to Timor-Leste (*e.g.* drug storage capacity outside Dili, transport of specimens for laboratory diagnostic testing) and the drugs available through donation from Brazil. While allowing for flexibility in the implementation of patient management guidelines based on clinical assessment by individual clinicians, protocols regarding patient review should be developed for quality assurance purposes.

Procedures covering patient confidentiality need to be developed. The issues to be covered range from exchange of information between clinicians and health care workers to the availability of patient records.

Human resource development needs range from those required by highly specialised clinical staff to auxiliary staff (*e.g.* among cleaners addressing fear of infection, respect for confidentiality). For more highly specialised clinical training, Timor-Leste is currently dependent on external providers. For financial reasons (*i.e.*, the cost of such training is expensive but generally provided free by external organisations) and

capacity reasons, this is likely to continue over the life of this strategy. Harmonisation between training provided by external organisations should be promoted to ensure consistency in treatment service provision through compliance with patient management frameworks developed in Timor-Leste.

Relationships with other areas of clinical service provision need to be developed. Priorities are other infectious diseases – particularly TB, as it may be an indicator of HIV infection and clinical management of co-infection – and reproductive health (to ensure integration of prevention of mother-to-child transmission). Shared care protocols need to be developed and ongoing relationships maintained.

Clinical service providers also have a role in educating the general public regarding the availability of treatment.

Developing an appropriate policy framework for HIV clinical service delivery, getting commitment to its implementation and building clinical policy capacity in Timor-Leste requires participation from clinicians. The establishment of a standing committee on clinical services under the National AIDS Commission would provide a mechanism for achieving this.

2.4.3.2 STI Treatment Services

STI treatment in Timor-Leste occurs within the framework of either syndromic management or enhanced syndromic management.

Syndromic management is diagnosis of infection on the basis of symptoms, provision of counselling, and provision of treatment, according to standard protocols. Timor-Leste has adopted a policy framework (Basic Package of Services)[35] for the delivery of services. The basic package of services states that STI counselling and treatment should be provided at all levels of health service delivery in Timor-Leste.[36]

National guidelines on STI syndromic management were developed, and training was subsequently provided in 2001 and 2002. More then 270 health personnel (including170 midwives, 57 nurses and 23 doctors) were trained. However, a survey in 2004 showed that only 23 percent of facilities complied with standard protocols, and that there was a shortage of STI drugs in most facilities.[37]

A review of syndromic management to identify the reasons for poor compliance needs to occur. The review also needs to assess current capacity to provide syndromic management at all health services. On the basis of that review, protocols may need to be revised and additional training provided.

Enhanced syndromic management is diagnosis on the basis of laboratory testing, pre- and post-test counselling (including sexual history-taking), and treatment. There are no existing Ministry policy frameworks covering enhanced syndromic management. A small number of sites in Dili provide laboratory-based diagnosis of STIs within

[35] Ministry of Health, Timor-Leste. *Basic Package of Services Policy (Draft).* Dili, March 2004.
[36] Ibid. p30
[37] Ministry of Health. *Expanded comprehensive response to HIV and AIDS in Timor-Leste.* Submission to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Ministry of Health, Dili June 2005

variable frameworks of enhanced syndromic management. Protocols may be site-based, research project-based, or non-existent.

Enhanced syndromic management should be the standard of STI management for most at risk groups. STIs are often asymptomatic; due to the higher rates of sexual partner change characteristic of MARGs, members of these are more likely to be at risk of, and transmit, STIs. Integration of counselling in STI management can also contribute to the adoption of safer sex practices.

Protocols need to be developed for enhanced syndromic management of STIs for MARGs. In addition, capacity needs to be established to provide enhanced syndromic management at a limited number of sites outside Dili where there are significant populations of MARGs. Access to these services needs to be promoted to MARGs.

As established in the Second National Women's Congress Plan of Action 2004-2008, gender-sensitive initiatives will be undertaken to address sexually transmitted diseases and HIV/AIDS.

2.4.3.3 Laboratory Services

Laboratory services are a key component of HIV service delivery. The Timor-Leste Health Policy Framework identifies the National Laboratory attached to the National Hospital in Dili as being the central referral point for all laboratory services.[38] Laboratories mainly supporting diagnosis of malaria and TB are located in each of the districts. A number of unregulated private laboratories also exist.

Overall infrastructure capacity at the national laboratory is inadequate in regard to space, equipment and human resource skills. However many of these gaps are being addressed through assistance from a major international donor.

Laboratory capacity for the diagnosis of bacterial STIs and antimicrobial susceptibility is currently highly inadequate. Because of the higher susceptibility to HIV infection caused by bacterial STIs (recognised above in the higher priority proposed for enhanced syndromic STI management among MARGs), it is essential that this be redressed.

Surveillance of HIV and STIs requires laboratory-based reporting systems. A regulatory framework is required that proscribes such reporting from private laboratories through licensing arrangements. Such a framework is also required to ensure quality in both the private and public sectors. Further quality mechanisms need to be established to ensure basic management functions are adequately implemented, such as inventory control and procurement of requirements.

2.4.3.4 Procurement and Supply of Drugs and Other Commodities

Clinical management of HIV and a number of other strategic functions are dependent on an infrastructure that ensures reliable procurement, storage, and distribution of essential drugs and other commodities (*e.g.* condoms, reagents for HIV testing). It is a

[38] East Timor Ministry of Health, *East Timor Health Policy Framework* ,Ministry of Health June 2002 p45

priority that management in this area be improved. Comprehensive protocols and procedures need to be developed, management systems improved and human resource capacity enhanced.

Unregulated involvement by the private sector creates significant risk regarding the provision of substandard products and unethical (*i.e.* dishonest or misleading) marketing. A regulatory framework needs to be established to govern private sector involvement in this area.

2.4.3.5 Blood Safety

Minimising HIV transmission through blood transfusions requires adequate screening of the blood supply. Currently in Timor-Leste infrastructure is inadequate to facilitate a level of blood donations required to meet needs. Consequently the system is heavily dependent on blood donations from families of patients. This involves risk of accidental residual transmission of HIV due to the window period of donation. Increasing voluntary blood donations can reduce this risk.

Accidental needle-stick injury in health care settings is a risk for HIV transmission as well as other infectious diseases. The adoption of universal infection control procedures will minimise this risk. Protocols and quality assurance mechanisms need to be developed and implemented, and training provided to all staff working in health care settings.

The provision of Post-Exposure Prophylaxis (PEP) where needle-stick injuries occur can reduce the likelihood of HIV infection. The availability of PEP can also increase the comfort of health care workers who are in contact with HIV positive patients, thereby enhancing quality of care. Resource constraints limit the capacity to provide PEP to sites where HIV positive patients receive treatment. Protocols and training need to be developed for the provision of PEP.

3 Organisational Arrangements

Organisational arrangements are outlined for coordination, capacity development and strategic information. These arrangements need to be put in place for the strategy to be effectively implemented

3.1 Planning and Coordination

Coordination arrangements are framed by:

- Ministry of Health leadership in strategy coordination
- Participatory decision making
- Partnership in implementation

Timor-Leste is a sovereign nation and the Ministry of Health is part of the public administration architecture through which that sovereignty is exercised. The National Development Plan of Timor-Leste specifically identifies HIV/AIDS prevention and promoting reproductive health as health priorities to be achieved through:[39]

- Providing Information, Education and Communication (IEC) targeting vulnerable groups and individuals
- Establishing voluntary counselling and testing
- Encouraging community participation and working with social, religious and women's organizations
- Developing the capacity of health workers and community groups
- Developing the legal and policy framework
- Developing support services
- Advocacy work with key stakeholders, such as churches and women's organisations
- The creation of awareness on STI and other reproductive health problems

[39] Planning Commission East Timor. *Op. cit* pp158-159

- Sex education in schools, media and health facilities, and youth centres
- Promoting the benefits of family planning
- Early detection, diagnosis and treatment of breast cancer, cervical cancer, STI/HIV

The Ministry of Health is the principle recipient and allocator of funds for HIV/AIDS/STIs, as well as being a key service provider.

The principles outlined in this strategy, based on those of the National Development Plan, provide a framework in which that leadership is exercised.

While the Ministry of Health has the leadership role in strategy coordination, participatory decision-making is a guiding principle of the National Development Plan and a necessity to achieve the objectives of this strategy. Responding effectively to HIV/AIDS/STIs requires a multi-sectoral response. It also requires decision-making that draws upon expertise that exists both within and outside government. The involvement of people with HIV in all aspects of strategy, including decision-making, is also a principle of this strategy.

Partnership between different sectors and agencies is also a requirement of coordination. An effective HIV strategy requires people with different expertise and experiences to work together. Government agencies, non-government organisations, faith-based organisations, and international agencies all have different strengths that can be combined to create a more effective strategy. Implementation decisions should be based on evidence of most likely effective outcomes but be balanced by the objective of building capacity/expertise in Timor-Leste. To ensure transparency and accountability, activities to be funded outside the core functions of government departments should be subject to open tender processes.

3.1.1 Situation Analysis

- Cross sector leadership is not strong
- Advisory structures weak
- Limited collaboration between and within sectors
- Involvement of HIV positive people lacking
- Planning, review, monitoring and evaluation not systematic
- Involvement of districts outside Dili in national programme lacking

3.1.2 Planning and Coordination Objectives

- To implement decision-making processes that facilitate involvement across sectors
- To ensure the best available expertise and experience is utilised in decision-making
- To enhance collaboration between and within sectors
- To ensure planning, implementation, review, monitoring and evaluation occur on a systematic and transparent basis
- To facilitate the involvement of HIV-positive people in planning and coordination

- To facilitate involvement of districts in planning and coordination nationally and at the district level

3.1.3 Organisational Arrangements

Discussed below are specific arrangements regarding the establishment of a National AIDS Commission and overall systems for planning and coordination. However other components of this strategy also address the objectives described above. They include multi-sectoral action (2.3) and the advocacy programme, a national/district linkage programme, and a HIV positive programme, as well as monitoring and evaluation (4.0).

3.1.3.1 National HIV/AIDS Commission

This strategy proposes the establishment of a National HIV/AIDS Commission (NAC) as the key advisory structure at the national level. Its membership would be both multi-sectoral and expert-based. Subcommittees and expert working groups drawing upon a broader membership base would be sponsored by the NAC to develop advice on specific policies, guidelines and protocols required for programme implementation.

National HIV/AIDS Commission Terms of Reference

- To advise the Government of Timor-Leste through the Ministry of Health on all matters related to HIV/AIDS
- To monitor and report on the implementation of the National Strategic Plan
- To advise on factors impacting on the implementation of the National Strategic Plan
- To identify and advise on demographic, social, behavioural, cultural or other changes that occur over the life of the strategy that may impact on achieving the goals and objectives
- To establish subcommittees and working groups to provide expert advice on specific areas of policy, procedures and guidelines
- To facilitate partnership between sectors in the implementation of the strategic plan
- To promote the national strategic plan through public forums, media and other structures

Representation Required

- Expertise in programme and organisational component areas (prevention, clinical, VCT, cross-sector training, social research, public health, monitoring/evaluation)
- Most at risk groups
- HIV-positive people
- Cross-sector (government, non government, private sector)
- Cross-sector (health, education, armed forces, other)

Chair: Minister of Health

Frequency of Meetings: Quarterly

The role of the NAC is advisory, as opposed to programme coordination and implementation. Inputs to that advice need to be drawn from the range of agencies involved in the response to HIV/AIDS/STIs in Timor-Leste. It is neither practical nor desirable, given limited resources, to replicate that expertise within the organisational infrastructure of the NAC. However, a small secretarial function is required to meet administrative requirements, *viz.* office space/equipment, project management, secretarial support.

3.1.3.2 Planning and Administration

It is the responsibility of the Ministry of Health to ensure the overall establishment of the administration required for implementation of the National Strategic Plan. This includes the disbursement of funds, financial and performance monitoring, and system integration. This should occur according to the following planning requirements:

- Five-year National Strategic Plan
- Five-year national implementation plan
- Annual business plan
- Midterm strategic review
- Three-year district plans (amendment and continuation subject to outcomes of midterm review)

As discussed above, this planning should occur on the basis of participatory decision-making.

Decisions made regarding funding allocations for programme/project implementation should be in accordance with the principles of accountability and transparency.

3.2 Capacity Development

Capacity development, particularly in regard to human resources, but also policies and systems, is required for effective strategy implementation. Training is required for staff employed to work on HIV and STIs, volunteers and key intermediaries (*e.g.* religious leaders, media).

Over the next five years the strategic response to HIV will be significantly expanded. Funding levels will increase. The number and range of organisations involved will increase. So too will the number of people employed, as well as those participating on a voluntary basis.

Section 3.1 outlines broad directions in planning and coordination to support an enhanced response. This section focuses on the human resource implications.

3.2.1 Situation Analysis

- Significant number of staff in Ministry of Health and some NGOs with core competencies in prevention and education and VCT
- Gaps at district level in human resource capacity in prevention and education and VCT capacity
- Clinical capacity variable
- Core competencies in programme/project planning and management not well defined
- Training sometimes provided on a strategic basis (*i.e.*, core competencies clearly defined in relation to functional roles, need quantified, training provided to maximise coverage), but often provided on an ad hoc basis
- Training often generic and consequently often not well matched to context in which skills will be applied

3.2.2 Programmes

A systematic approach needs to be developed for the implementation of training. This will involve:

- Identifying the human resource needs in each of the component and organisational programme areas of the strategy
- Defining the competencies required
- Identifying gaps in capacity
- Assessing current training provided against competencies defined and ability to address gaps in capacity
- Identifying other opportunities to address gaps
- Prioritising needs identified and contracting training provision to address those needs

Based on the above analysis specific training plans should be developed on:

- Prevention and education
- VCT
- Clinical Services
- Sector-specific
- Surveillance
- Strategic Information
- Programme Management

Opportunities for collaboration with other policy areas should be actively sought so as to avoid duplication and make optimal use of available resources. By example, the Ministry of Health has adopted a National Strategy for Health Promotion, which prioritises capacity development both within services provided by the Ministry and in community based organisations. This provides a framework for partnership between the Ministry and non government sectors in health promotion training.

There are immediate priorities in this strategy to be implemented where capacity is currently limited in Timor-Leste (*e.g.* sentinel surveillance, behavioural monitoring).

Initiatives to address these priorities should include processes to develop capacity for future implementation from within Timor-Leste.

3.3 Strategic Information

There are significant gaps in strategic information on which to base programme decisions. These gaps exist across traditional public health domains such as surveillance and epidemiology, but extend to behavioural monitoring, social research, and evaluation studies.

3.3.1 Situation Analysis

- Existing routine surveillance provides inadequate information of HIV/STI incidence, prevalence and patterns of disease
    - High levels of self-diagnosis and treatment not reflected
    - Occurs in context of syndromic management and therefore does not reflect asymptomatic infection
    - Limited provision of demographic and risk factor information
- Use of routine surveillance provides some capacity to observe indicators of some changes in disease patterns (*e.g.* geographic, gender, age)
- Ad hoc surveillance among MARGs limits ability to promptly identify significant changes in disease patterns and evaluate programme interventions
- Sexual behaviour studies lacking in broader population, making it difficult to identify patterns of risk and target interventions appropriately
- Behavioural monitoring as well as well as predisposing risk factors (*e.g.* knowledge, attitudes, testing levels) not systematic among MARGs, thereby reducing capacity to observe changes in risk patterns, evaluate interventions and modify programmes if required
- Studies exploring risk behaviour in general population largely nonexistent
- Lack of information regarding risk contexts of those being newly diagnosed with HIV
- Lack of qualitative research describing cultural factors specifically relevant to Timor-Leste (*e.g.* use of traditional healers, gender roles, etc.) that might impact on strategy
- Differences within population that might contribute to risk (*e.g.* employment status, family/ethnic background) not known

3.3.2 Strategic Information Objectives

- To increase capacity of routine surveillance to provide additional information relevant to monitoring HIV and STI disease patterns
- To establish a sentinel surveillance system at a limited number of sites to monitor incidence and surveillance across the population and among MARGs
- To monitor changes in risk factors and behaviours among MARGs
- To establish baseline indicators of knowledge, attitudes and behaviour across the general population
- To identify cultural and social/demographic factors specific to Timor-Leste associated with risk behaviour

3.3.3 Programmes

Strategic information will be collected through:

- Routine surveillance
- Sentinel surveillance
- Behavioural studies
- Social research

Strategic information will also be collected through monitoring and evaluation processes.

The quality and extent of strategic information available will improve over the five-year period of this strategy. Immediate priorities areas are sentinel surveillance and behavioural studies.

3.3.3.1 Routine Surveillance

Timor-Leste is in the process of establishing a routine surveillance system across all areas of disease. Routine surveillance is a core function of the health system for overall strategic planning of the delivery of health services, as well as responding to specific disease outbreaks. There is clear evidence that current endeavours to build this capacity is resulting in the development of a well-functioning disease surveillance system. Unrealistic expectations of what routine surveillance can contribute to information relevant to HIV and STI strategy must not undermine the systematic development of routine surveillance.

Ongoing development of the routine surveillance system will, over time, improve the quality of information available relevant to HIV and STIs. Reporting of diagnoses will become more complete, thereby providing a more reliable source of information for monitoring trends in disease patterns. As capacity increases to identify disease outbreaks, consideration can be given to the feasibility and cost-effectiveness of integrating contact tracing into HIV and STI surveillance.

The involvement of health services in the private sector needs further investigation. Given the stigma often associated with STIs, many people may be seeking treatment in the private sector because of perceptions regarding confidentiality in the public sector.

3.3.3.2 Sentinel Surveillance

Section 2.4.3 of this strategy proposes that enhanced syndromic management becomes the standard of care for MARGs. This is likely to occur at only a limited number of sites. The inclusion of sexual history-taking and consequent testing for asymptomatic infection, counselling, and laboratory-based diagnosis in enhanced syndromic management and standardised reporting provides the framework for sentinel surveillance that can be used to monitor incidence and prevalence.

This strategy also proposes the provision of HIV VCT for pregnant women. A limited number of sites could be selected to also include STI enhanced surveillance. This could be used as a framework for sentinel surveillance among pregnant women. This would provide a proxy indicator to monitor incidence and surveillance among the broader population.

3.3.3.3 Behavioural Studies

A baseline behaviour study should be conducted across the broader population. This would also include knowledge and attitude measures. Such a study is needed to establish a clear picture of existing patterns of risk in Timor-Leste. It is unlikely that a cost-benefit analysis would justify repeating such a study on a frequent basis—while the levels of risk could change significantly as a result of intensive prevention interventions, the relative distribution of risk across the population is unlikely to change quickly. However, it may be feasible to repeat such a study after five years in evaluating the implementation of the strategy.

Behavioural monitoring studies should be conducted on a regular basis among MARGs. Such studies will also include knowledge and attitude measures. Levels of risk are higher, changes in risk patterns often occur more quickly, and these populations are bridges of transmission to the broader population. Proposed prevention and education interventions are more intensive and should be rigorously evaluated.

3.3.3.4 Social Research

In addition to behavioural studies, other social research is required to inform strategic planning as well as project planning and evaluation. This includes mapping and various forms of qualitative research as well as evaluation studies.

Mapping research is necessary for both overall strategic planning and project planning. Mapping of risk (*e.g.*, higher numbers of sex workers in border districts related to cross border mobility) and vulnerability (*e.g.*, population mobility related to seasonal labour patterns) should occur at the national level to inform intervention planning and resource allocation. More specific mapping of risk (*e.g.* locations of soliciting for sex work) should occur in the context of project planning.

Social research, generally of a more qualitative nature, is required to develop a better understanding of cultural and social factors related to risk and vulnerability. Qualitative research undertaken in project development (*e.g.* focus testing of campaign materials) can also contribute to broader understandings of factors associated with risk.

4 Monitoring and Evaluation

Monitoring and evaluation processes are necessary for the purpose of accountability and transparency as well as programme modification.

4.1 Monitoring

As discussed in section 3.1, core funding and performance reporting requirements should be standardised across funding agencies. These will include performance indicators that can be both compared across funded organisations and aggregated for the purpose of evaluation. It is expected that these requirements will be consistent with frameworks already implemented by most agencies (*e.g.*, detailed budgets, milestones, timelines) and that specific indicators can be integrated (*e.g.*, Performance Indicator/Milestone—number of target group reached within particular time period). A set of draft indicators are outlined in Appendices 1-3.

Clinical service delivery data also provides strategic information that can be used for programme planning as well as monitoring and evaluation. Standardised measures need to be established to assess activity such as service utilisation data and efficiency. These measures should be integrated into a quality improvement framework that allows services to benchmark their performance against other services and modify delivery arrangements when desirable.

An annual report should be produced that collates reports produced and aggregates data against standard indicators. This will provide transparency and public accountability as well as facilitate quality improvement.

4.2 Evaluation

Evaluation will be conducted in a framework that measures:

- Process—were activity/project outputs achieved, *e.g.* number of target group reached?
- Impact—were programme objectives achieved, *e.g.* changes in risk behaviour, treatment compliance?
- Outcome—was the strategy goal achieved, *e.g.* minimisation of HIV transmission, reduction in morbidity/mortality?

Process measures will be collected as part of the standard funding and performance requirements of the programme. In addition, district-based HIV project officers will be asked to provide an annual report on specific process indicators, *e.g.*, number of agencies where print resources are available.

Impact will be measured through activity implemented to collect strategic information.

Outcome measures will be available through routine surveillance.

An overall evaluation of the programme should occur after two years and at the completion of the five-year strategy.

Appendix 1:
Draft Indicators, Prevention and Education

A. Impact

Indicator	Information Sources
% of programme target population group (general population, youth, MARGs) that practice safe sex	Population survey; Anonymous health clinic surveys; Condom sales; STI surveillance
% of programme target population group with STI symptoms that seek treatment from health clinics	Population survey; Anonymous health clinic surveys;
% of programme target population group that know how to prevent HIV	Population survey; Anonymous health clinic surveys;
% of programme target population group that know how to use a condom	Population survey; Anonymous health clinic surveys
% of programme target population group that consider HIV a serious personal risk if they don't practice safe sex	Population survey; Anonymous health clinic surveys
% of programme target population group that consider HIV a significant threat to the development of Timor-Leste	Population survey; Anonymous health clinic survey
% of programme target population group that would not engage in discriminatory practices against people with HIV	Population survey; Anonymous health clinic survey; Documentation of discriminatory practices
% of young people who are confident in their capacity to resist pressure to have sex when they choose not to	
Frequency of STI testing among MARGs	Sentinel surveillance
Awareness of asymptomatic STI/HIV infection among MARGs	MARG population surveys

B. Process

Indicator	Information Sources
The number of agencies/sites where print resources are available for clients	District reports
The number of agencies implementing education programmes	District reports
The availability of information resources at suco/sub-district level	District reports
The implementation of a multi-sector public education programme in each district	District reports
The level of accurate media coverage of HIVSTIs in Timor-Leste	

% of schools implementing life skills education for young people	Implementing agency reports
Number of youth centres where life skills education is implemented	Implementing agency reports
Number of sites frequented by sex workers where outreach education is implemented	District reports
Implementation of specific projects for Military, police, clients of sex workers, itinerant workers	NAC Information collection, District reports

Appendix 2:
Draft Indicators, VCCT

A. Impact

Indicator	Information Sources
Frequency of STI testing among MARGs	MARG behaviour surveys; Sentinel surveillance
% of MARGs ever tested for HIV	MARG behaviour surveys; sentinel surveillance
% of MARGs tested for HIV after HIV risk exposure	MARG behaviour surveys; sentinel surveillance
% of pregnant women tested for HIV	Health Management Information System
% of VCT clients with improved knowledge and skills to reduce risk of HIV/STI transmission Reduction in risk behaviour among VCT clients	MARG behavioural surveys; Measurement of changes against benchmarks in quality improvement programme MARG behavioural surveys; Sentinel surveillance
% of people diagnosed with HIV without an opportunistic illness	HIV surveillance system

B. Process

Indicator	Information Sources
VCT services available at all public health services VCT offered to all pregnant women	Health Management Information System Health Management Information System
Standard protocol developed for provision of VCT to pregnant women	Protocol distributed by MOH
Standard protocols developed for provision of VCT to MARGs	Protocols distributed by MOH
Standard protocols for providing VCT to general population	Protocols distributed by MOH
Compliance with standard protocols	Quality Improvement System
MARG-targeted VCT services available in all districts	Health Management Information System

Appendix 3:
Draft Indicators, Clinical Services

A. Impact

Indicator	Information Sources
% of people with HIV surviving *x* years after diagnosis	Health Management Information System (HIV observational data base)
% of people with HIV experiencing opportunistic illness	Health Management Information System (HIV observational data base)
% of people diagnosed with HIV on antiretroviral therapy	Health Management Information System (HIV observational data base)
% of people diagnosed with curable STI cured	Health Management Information System
Accuracy of laboratory diagnosis of HIV and STIs	External Audit
Frequency of shortages in availability of essential drugs and commodities (number and % of sites reporting no stock out of drugs and supplies)	Annual report
Number of HIV infections occurring through use of blood products in medical procedures	Surveillance system
Number of needlestick injuries	Health Management Information System
Number of health care workers infected with HIV through occupational exposure	Surveillance system

B. Process

Provision of comprehensive quality HIV clinical service in Dili	Participation in quality assurance system (e.g. Treat Asia Project)
Protocols/systems established for provision of ARV treatment and monitoring of patients outside Dili	Health Management Information System (HIV observational database)
Capacity available for treatment of opportunistic illnesses	Health Management Information System
Protocols developed for commencement of ARV therapy, including drug regimens	Protocols distributed by MOH
Patient confidentiality protocols developed	Protocols distributed by MOH
Shared care protocols developed for patients co-infected with TB	Protocols distributed by MOH
Protocols developed for management of pregnant women with HIV	Protocols distributed by MOH
HIV clinical services standing committee established under NAC	NAC report
STI syndromic management available at	Health Management Information System

all public health services	
% of public health services complying with standard operating protocols for STI syndromic management	Quality Improvement System
STI syndromic management protocols revised and modified if necessary	Protocols distributed by MOH
% of MARGs receiving STI enhanced syndromic management as standard of care	Behavioural surveys; sentinel surveillance
Enhanced syndromic management protocols developed for MARGs	Protocols distributed by MOH
Regulatory framework established for private sector provision of laboratory services	NAC clinical standing committee report
Systems developed to enhance diagnosis of bacterial STIs and microbial susceptibility	NAC clinical standing committee report
Protocols and systems for the procurement and supply of drugs and other commodities reviewed and modified if necessary	Review Report
Regulatory framework established for private sector involvement in supply of drugs and other commodities	Review Report
Number of blood donation and storage facilities increased	Health Management Information System
Universal infection control protocols developed	Protocols distributed by MOH
Post-Exposure Prophylaxis for health care workers available through the national hospital	HIV observational database