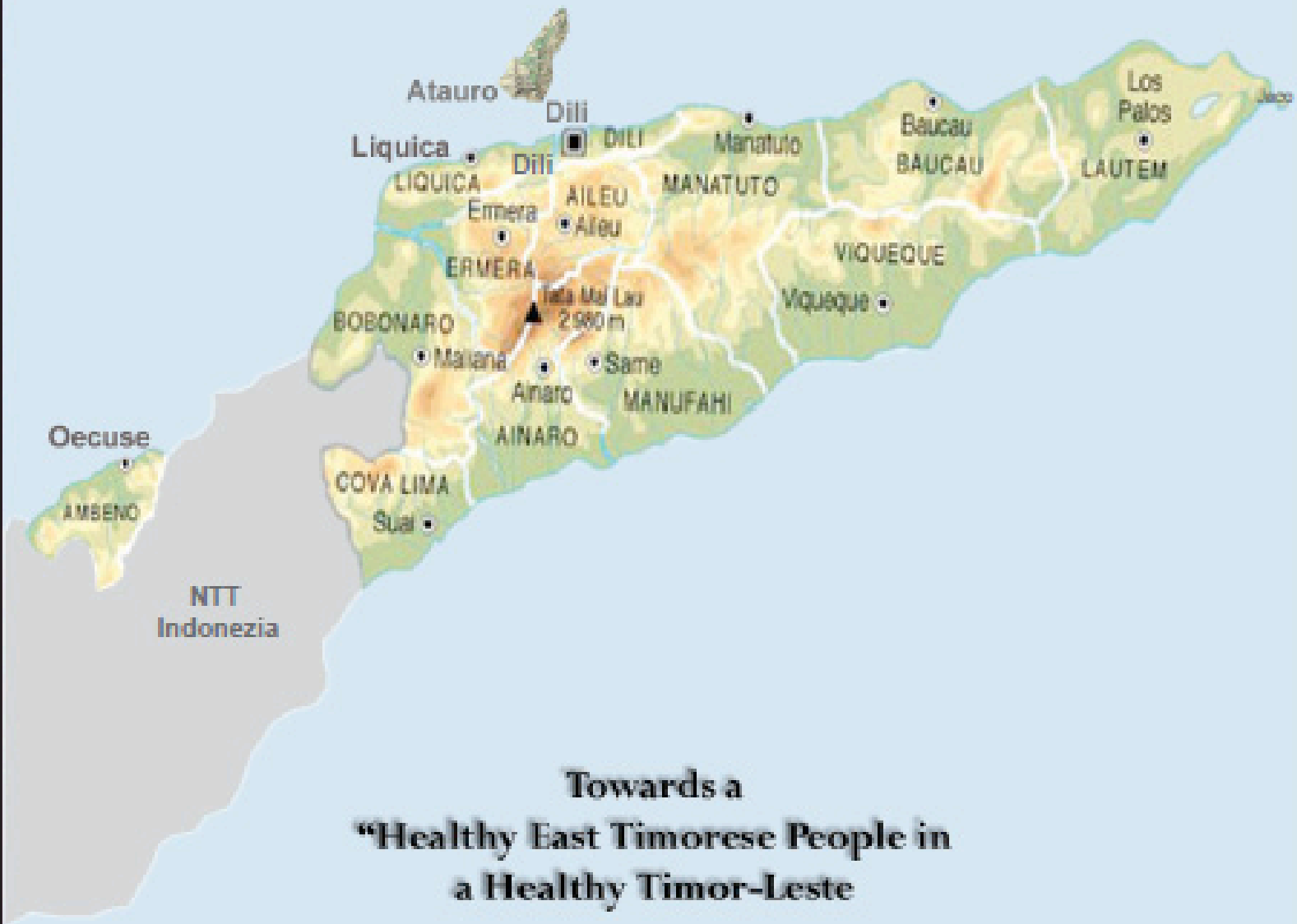
MINISTRY OF HEALTH

Dili, Timor-Leste

NATIONAL HEALTH SECTOR STRATEGIC PLAN 2011-2030



Towards a "Healthy East Timorese People in a Healthy Timor-Leste

NATIONAL HEALTH SECTOR
STRATEGIC PLAN
2011 - 2030

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Published by :
TALITI

Ministry of Health
Dili, Timor Leste 2011

FORWARD

I am pleased to introduce the first Timor-Leste National Health Strategic Plan for the further development of the country's health sector and to accompany Government's vision for a healthier nation.

Despite continuing challenges facing the health care system such as high infant and maternal mortality rates, prevalence of communicable and vector born diseases such as Respiratory Infections, Tuberculosis and Malaria, the health care system in Timor-Leste has witnessed major achievements in the last decade. Also, chronic conditions related to non-communicable diseases, and to injuries, are emerging increasingly as major public health priorities and they will be dealt with appropriately.

With these challenges ahead, the Ministry of Health strives to build on the achievements and improve the services, so that the Timorese people can all to enjoy the high standards of care and the achieved excellent health services in twenty years to come.

The Ministry of Health has embarked on a comprehensive approach to strategic planning, formulated policies related to major challenges, identified strategic directions and, accordingly, set out strategic goals and strategies that will guide the developmental process and the growth of health services.

To bring about all the enhancements in clinical care and public health services, participation and involvement of local communities in health affairs will be encouraged through the revitalization of primary health care services as to empower all people to take decisions based on informed choices with the introduction of 'Servço Integrado de Saúde Comunitária' (SISCa).

New ways of working are being introduced and greater emphasis is being given to quality in all the Ministry does. More efficient and effective practices are essential and many of our systems and procedures need revision, thus, seeking constant improvement in the Ministry's way of working. Further, moving health services forward requires finding alternative ways of funding, ensuring appropriate human resources, supporting improved management practices, developing a proper structure and work process, as well as maintaining the availability of advanced equipment and high technology.

The diverse expertise and experience of health staff is deeply valued, and in order to create a positive difference to health, coordinated actions across different areas with various stakeholders to address a broad range of issues was an integral part of developing this Plan. The most significant consultation meeting took place in July 2009, during a four days retreat organized by the MoH in Ermera District at Suco Coliate and whereby key health personnel occupying leadership and managerial roles, as well as national health professionals and their national and international counterparts were all present to contribute towards this National Health Strategic Plan 2011-2030.

Common ambition is that over time, this framework will influence all health sector processes toward more multi-disciplinary team working, decentralized decision-making, partnership working, and community involvement.

I wish to specifically thank health directors and head of departments for their technical directions and contributions. My gratitude and appreciation also goes to the dedication and energy of national and international health advisers and specialists who assistedsenior health officials in making this Plan a reality.

I have confidence that the implementation of the National Health Sector Strategic Plan will takeour health sector to new heights in serving the Timorese people and towards achieving many national, regional and international development targets.

Prof. Dr. Nelson Martins, MD, MHM, PhD
Minister of Health

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
BCC	Behaviour Change Communication
BCI	Behaviour Change Intervention
BEOC	Basic Emergency Obstetric Care
BSP	Basic Services Package
CCT	Café Timor network (Clinica Café Timor)
CD	Communicable Diseases
CDP&C	Communicable Diseases Prevention and Control
CEOC	Comprehensive Emergency Obstetric Care
CHC	Community Health Centre
CIMCI	Community Based Integrated Management of Childhood Illnesses
CVD	Cardio-vascular Disease
DHC	District Health Council
DHMT	District Health Management Teams
DHS	Demographic and Health Survey
DOTS	Directly Observable Treatment Short Course
EC	European Commission
FHPP	Family Health Promoter Programme
FP	Family Planning
FY	Fiscal Year (Jan-Dec)
GFATM	Global Fund for Aids, Tuberculosis and Malaria
GDP	Gross Domestic Product
GSB	General State Budget (OGE)
HAST	HIV/AIDS/Tuberculosis
HDI	Human Development Index
HRH	Human Resource for Health
HDR	Human Development Report
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HNGV	Guido Valadares National Hospital
HP	Health Post
HRD	Human Resource Development
HSP	Hospital Services Package
HSSP	Health Sector Strategic Plan (2008-2012)
ICS	Institute of Health Sciences (Instituto de Ciências de Saúde)
ICT	Information and Communication Technology
IDS	Integrated Disease Surveillance
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IYCF	Infant and Young Child Feeding
JAPS	Joint Annual Planning Summit
LLITN	Long Lasting Insecticide Treated Net

LSMS	Living Standard Measurement Survey
MC	Mobile Clinics
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoE	Ministry of Education
MoH	Ministry of Health
MoF	Ministry of Finance
MAEOT	Ministry of State Administration
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
NCD	Non Communicable Disease
NDP	National Development Plan
NGO	Non Government Organisation
NHA	National Health Accounts
O&G	Obstetrics and Gynaecology
OH&S	Occupational Health and Safety
PER	Public Expenditure Review
PHC	Primary Health Care
QA	Quality Assurance
RH	Reproductive Health
SAMES	Autonomous Medical Supply System (Serviço Autónomo de Medicamentos e Equipamentos de Saude)
SBA	Skilled Birth Attendant
SIP	Sector Investment Programme
SPWG	Strategic Planning Working Group
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TORs	Terms of Reference
TFET	Trust Fund for East Timor
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing (HIV/AIDS)
WHO	World Health Organisation

BOXES & FIGURE :

EXECUTIVE SUMMARY

The National Health Sector Strategic Plan 2011-2030 (NHSSP)provides the Ministry of Health with a framework for understanding its position and moving forward with a sense of direction, purpose and guidance of activities and decisions required by key actors in the health sector for the next twenty years. It is developed following a review of the Health Sector Strategic Plan (HSSP) for Timor-Leste covering the period of 2008-2012, while taking into account current reforms and policy-makingof the Ministry of Health, its functions and its capacitytocontribute towards the development goals of the Government of Timor-Leste in accelerating economic growth to reduce poverty as stated in the recently updated National Development Plan 2020 (NDP 2020).

Hence, this planning documentis guided by fundamental principles specified in the Timor-Leste Strategic Development Plan 2011-2030, which are already reflected in the National Health Policy Framework.It entails an overall framework for the health sector investment and its major aim is to encourage stakeholders to work together towards common aims and to appreciate how their efforts can contribute towards the improvement of Timor-Leste health profile. Therefore, a set of strategies are established for different functions and structures of the sector with key indicators defined to effectively measure progress against specific targets.

An assessment of a wide range ofhealth sector documents was conducted to provide an in-depth analysis and understanding of the sector and there were also consultations with Directors of District Health Services during National Health Leaders Retreat held in Coliate in 2009 and during the Joint Mid-Term Review Mission (MTR), Districtplanning workshops and Technical Review Meetings. Health Development Partners and Civil Societyand other Ministries have expressly been consulted and involved during the development of the NHSSP.

The Plan is divided into eight essential parts:

Section I begins with a detailed situational analysis of the health issues and provides a portrait of the current demographic indicators and vital statistics which represent the foundation into the future. It also illustrates current service configuration and organizational structure.

Section II provides a rationale for strategic planning, it describes a guiding vision and includes explicit mission and a set of important organizational values.

Section III focuses on management and organizational issues such as the need to have appropriate organizational structures and decentralization, whilst building an integrated model to services development.

Section IV ocuses on the improvement and further development of primary health care services and delineates issues of importance to the development of secondary and tertiary services.

Section V deals with a key asset in the organization - human resources - and focuses on strategies related to human resources management and development.

Section VI aims at a structured approach to capital investment in the major elements of the system which include health facilities, staffing accommodation and office buildings, medical

equipments,water and electricity supplies, as well as transport. It also focuses on Information and communication technology as the cornerstone for the advancement of the NHSSP.

Section VII relates to other support services such as health information system, health assets and transport management, addresses financial planning and partnership involvement to coordinate actions across different programmatic areas.

Section VIII sets the directions for health financing, including the public, private and donor financing of the health sector.

Section IX focuses on implementation mechanisms for the strategic plan.

A set of Annexes complete the Plan. These are:

- MoH organizational structure setting the basis for central services and district health services within a decentralized setting
- An integrated Logframe of NHSSP 2011-2030
- A Roadmap for NHSSP focusing specifically on human resources deployment and infrastructure development.

Strategic Direction & Key Priorities:

1. Provision of Health Services – Delivery of health care services ought to be described within an integrated manner, while taking into consideration the roles of central, district health services and the private health sector. Directions for the implementation of a comprehensive package of health services at primary, secondary and tertiary levels are presented in this plan as cross cutting the human and material support services as well as financial resources, in order to improve access and quality of care to all Timorese people.

2. Investment in Human Capital - A comprehensive workforce plan detailing current staffing gaps, training opportunities and recruitments as per health facility and service levels will be developed, given priorities to the district health services. Strategies for Human Resources Management to ensure patient satisfaction and protection of the rights of both patient and health providers, will include performance based incentive schemes linking reward and promotion to workload, performance and results.

3. Infrastructure Investment - Infrastructure development for the national health services will focus on policy decision to improve access to health services in an equitable manner, thus, introducing family health provision at Suco level, expansion of current community health centres able to accommodate population growth and the challenges of economic development in the next twenty years, as well as provision of secondary health care service at disctrict level.

   There is a direct link between national health configuration and the human resources development required for the provision of primary, secondary and tertiary health care. In this regard, strategies for infrastructure development will cater service delivery needs, including staff accommodation, equipping medical and non-medical investment which supports delivery of services.

4. Health Management & Administration- Institutional strengthening of the Ministry of Health

will require major organizational reforms in order to improve its management capacity. In this regard, priority focus will be on ensuring the Ministry plays its stewardship role accordingly through clear policies and regulations, by establishing intersectorial consultative bodies able to oversea system developmend, and by establishing administrative and management tools required to translate health policies into practice.

Critical Factors for Health Sector Development:

The following analysis is imperative for a successful development of Timor-Leste's health sector.

Assumptions:

- Political stability and commitment to national development
- Small country
- Small number of population
- Availability of Financial Resources

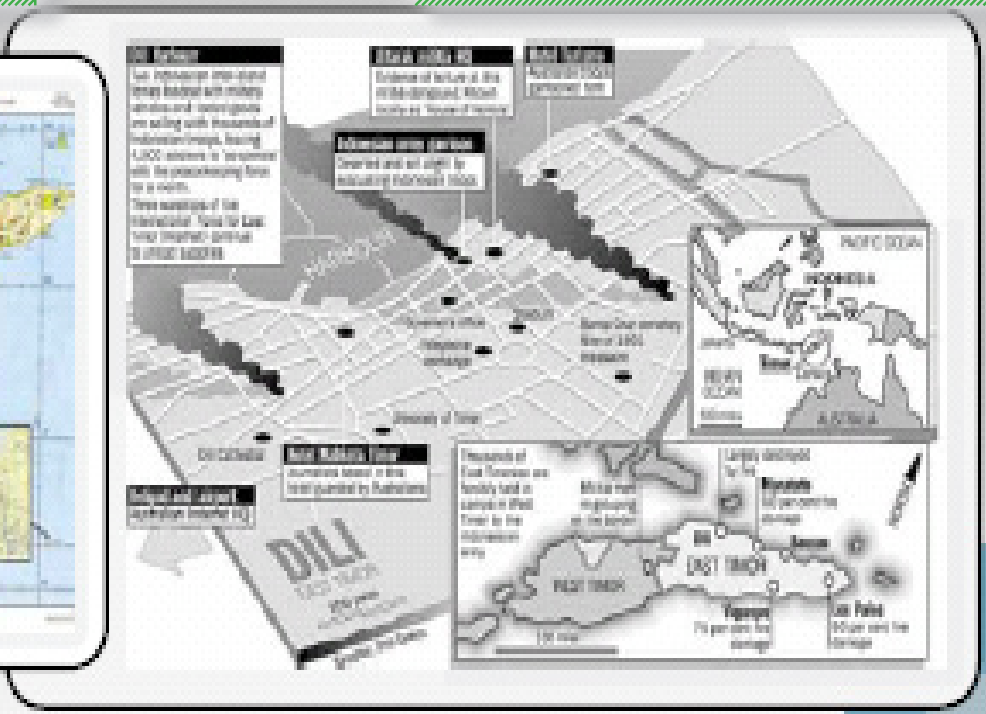
Risks:

- Changes in Government commitment to take the planned strategies forward
- Limited funds allocated to the health sector through General State Budget
- Slow progress in Human Resources Development
- Weak regulatory measures and law enforcement in the national health system

As a twenty year operational document on the sector, the NHSP is a living dynamic document that will be revised regularly and amended based on the outcome of its implementation and on constructive comments and feedback from stakeholders. It provides the basis for formulating short-term operational plans that guide the implementation of sector activities on the basis of consensus developed with related sector constituent partners.

In presenting this National Health Sector Strategic Plan, the Ministry of Health hopes to capture the interest and commitment of stakeholder to the plans therein, while invoking the support of allconcerned to succeed in achieving a better and healthier tomorrow.

SECTION I:
SITUATION ANALYSIS



SECTION I: SITUATION ANALYSIS

I.1 COUNTRY FILE

Timor-Leste is a small country covering half the island of Timor. It has a land mass of approximately 14,610 square kilometers with estimated population in 2009 of 1,114,534. From the 16th century until 1975, Timor-Leste was a Portuguese colony. In December 1975, after a brief period of independence, Indonesia invaded and occupied the country.

Nearly one quarter of the population is believed to have died during the occupation as a consequence of conflict, forced migration, malnutrition and unattended public health needs. In August 1999, after a referendum that endorsed progress to independence, widespread violence led by militias resulted in a mass destruction of infrastructure and displacement of a large portion of the population. On 20th May 2002, Timor-Leste became an independent nation.

The country is comprised of 13 districts, each with three to seven sub-districts, 65 Sub-districts, 442 Sucos (villages) and 2,225 aldeias (hamlets) . The Oecusse District is an enclave located inside West Timor in Indonesia and accessible primarily by sea or air. The two largest urban centres, Dili and Baucau, are home to 29% of the population. Seventy percent of the population is rural with most people living in small, scattered villages often isolated by mountainous terrain and poor roads.

There are several distinct language groups and dialects in Timor-Leste reflecting the diversity of cultural traditions. Major local languages includeTetun and Bahasa Indonesia (around 80%), Portuguese, Mambae and Macassae, each spoken by more than 10% of the population.

The level of prosperity of a nation is measured by the Human Development Index (HDI) which includes health [life expectancy (LE)], education (literacy rate and the average length of the school), and economy (income per capita). The 2010 Human Development Report shows that Timor-Leste's Human Development Index is ranked 120 out of 177 countries with available data and reporting LE of 60.2 years in the year 2009. The LE of Timor-Leste (TL) occupies the lowest welfare level compared to its neighboring countries of the South East Asia Region.

Timor-Leste faces enormous development challenges relating to historic, cultural, demographic, economic and social factors. The age-structure shows a relatively young population with about 45% below 15 years. Approximately 17, 6% of the total population is under-5 years old. Population

[1]MoHFamily Registration, SIS 2010
[2]DHS2009-2010, TL

growth is estimated at 3.12% per year with a sex ratio (males per 100 females) of 107. Population density is about 55 per square kilometer. The country has a hot and humid climate throughout the year with an average temperature of 31 degrees and a humidity of about 80%.

Available data shows that more than 40.8% of the population lives below the poverty line with less than US$ 0.55 per day, though there are significant variations between districts.

Prospects are good for substantially larger financial resources from oil and gas revenues. Petroleum Fund Savings were over U$ 7 billion by 2010, thus, providing a positive ground for medium-term development initiatives to help alleviate poverty.

Economic challenges are compounded by poor infrastructure, notably in the areas of road, telecommunications, transportations and electricity. The rural population still practices shifting cultivation, one-third of households relying heavily on subsistence farming with low productivity contributing to inadequate food security.

Annual population growth in Timor-Leste is around 2.4%, with 46% of the population below the age of 15 years of age. This places great pressure on basic education, and compounds unmet employment demand and the ability of young people to enter the labor market.

I.2 HEALTH FILE[4]

Changes in health indicators over the past eight years after independence shows that Timor-Leste is progressing fast in its efforts to tackle major health challenges characterized by significantly high maternal and child mortality rates, coupled by high incidence of communicable diseases.

Box 1: Selected 2010 health indicators

• Life expectancyatbirth	60.2 (females) 58.6 (males)
• Total fertility rate	5.7
• Maternalmortality ratio	557deaths per 100,000 live births
• Infant mortality rate	44deaths per 1,000 live births
• Under-five mortality rate	64deaths per 1,000 live births
• Percentage of children ≤ five yearswithstunting	53%
• Percentage of childrenwho are underweight	52%
• Tuberculosis incidence rate	133 per 100,000 population
• Malaria incidence rate	104.2 per 1,000 population
• HIV sero-prevalence rate	Low (only indicative figures available) but with high level risk behaviour

[3] UNDP 2010 Human Development Report
[4] Current health data derived from 2009 and 2010 Annual Health Reportand Demographic Health Survey.

i. MATERNAL HEALTH

The recent Demographc Health Survey indicatesa stable decrease on maternal mortality rate from 660/100.000 reported in 2003 to 557/100.000 in 2010. In terms of neonatal deaths, out of 160 neonatal deaths reported, more than 90.9% neonatal deaths are at age of 0-6 days. Dili reported the highest neonatal deaths (20 neonatal deaths) in the year 2010. The major complications of pregnancy reported are hemorrhage, eclampsia, obstructed labor and sepsis. A complication of pregnancy on hemorrhage is reported by 50.2%.

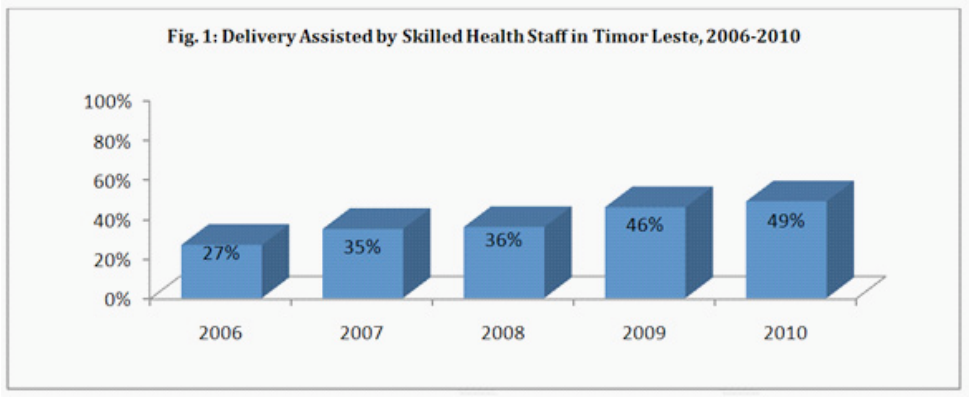


Figure above shows progressive increase in assisted deliveries from 27/ in 2006 to an average of 49.3% reported in 2010[5], with some districts reporting a staggering progress to 68.8% in Baucau, 62.4% in Dili and Bobanaro 59.2% of deliveries assisted by a skilled health professional, while some districts present lower performance.

ii. CHILD HEALTH & IMMUNIZATION

There has been a steady progress in child health care, with the current indicators showing a reduction of unde five mortality rates from 115/1000 in 2003 to 64/1000 in 2010 and an improvement in infant mortality rate from 83/1000 to 45/1000 during the same years.

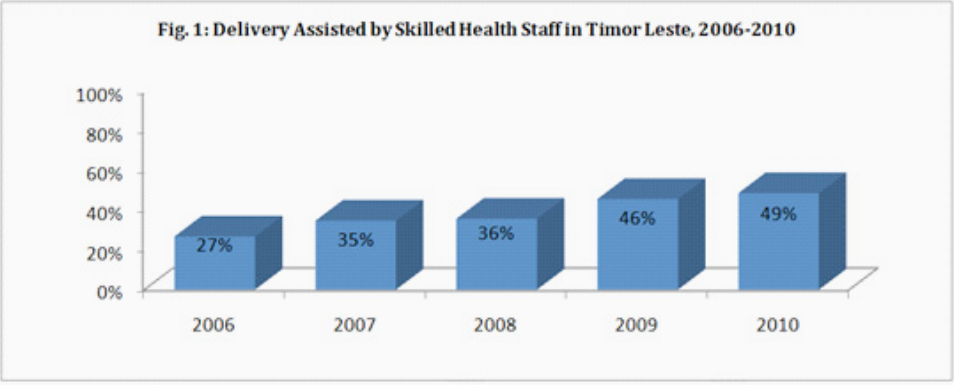
The indicators for the Integrated Management of Childhood Illness (IMCI)program show that Timorese children are confronted with three main deseases: Pneumonia, Diarrhea, Malaria and total Cases Treated. More than 10% of children <5 in Aileu, Baucau, Bobonaro, Covalima, Manatuto, Oecussi and Viqueque are treated for Diarrhoea. It ranges from 4.1% in Lautem to 19.7% in Oecussi. The average number of children <5 treated for Malaria is 9.0%. It ranges from 1.3% in Ainaro to 26.4% in Viqueque. Aileu, Covalima, Dili, Lautem, Manatuto and Viqueque have more than 10% of <5 children treated for Malaria. Again, 10.1% of <5 children are treated for Pneomonia including Acute Pneomonia. It ranges from 3.0 in Ainaro to 22.5% in Baucau. Baucau, Bobonaro, Covalima, Manatuto and Viqueque treated more than 15% of children < 5.

[5] 2010 Health Statistic Report.

For the whole country, 2010 coverage of measles immunization reached 66.2%. Three out of 13 districts (Bobonaro, Manatuto and Viqueque) have measles coverage higher than 80% and three districts (Aileu, Dili and Liquica) having measles coverage below 60%. Four districts (Bobonaro, Manatuto, Oecussi and Viqueque) have higher than 80% and Two districts (Aileu and Ainaro) having below 60%. BCG Coverage is slightly higher than measles, with 72.4%.

The 2009 coverage of DPT-HepB3 immunization (72.4%) is slightly lower than OPV3 coverage (72.2%). Two districts (Aileu and Liquica) having DPT-HepB3 coverage below 60%, and four out 13 districts (Manatuto, Manufahi, Oecusse, and Viqueque) reached DPT-HepB3 immunization more than 80%. Coverage of DPT-HepB3 immunization is slightly higher in Female than Male population.

In the case of tetanus toxoid immunization for pregnant women, 2010 coverage for the whole country for TT2+ is 32.5%. Coverage across district varies from 6.9% in Aileu to 60.2% in Viqueque.



iii. NUTRITION

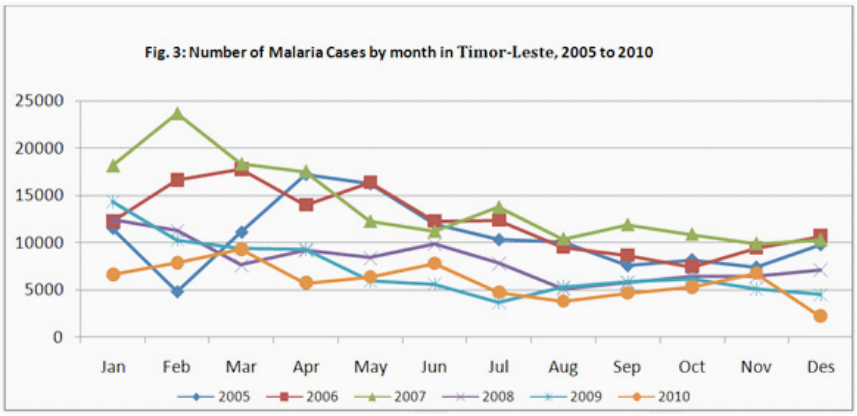
Prevalence of under-weight among children under five years old is 38.5%, with HMIS data showing different data to the one found in the DHS 2010at 52%, thus, showing once more the need to improve health management information system. The highest levels of under-weight are in Aileu and Oecusse with 50% of under-weightamong children less than five years old of age. Prevalence of Severe Malnutrition among children under five years old is 15.3%.

Malnutrition remains a very serious problem and to effectively combating this problem in Timor-Leste will require heightened attention to the nutritional needs of women during pregnancy and of children in the first two years of their lives.

iv. MALARIA

In 2010, the malaria incidence was 104,2/1,000 populations. The highest incidence rate of malaria are among children under 1 (266,5/1,000 population) followed by children 1 – 4 years of age (178,8/1,000 population).

The total cases confirmed positivewere38,6% and among the positives, 74,0% were P. Falciparum, 25,2 were P. Vivax and 0,8 were Mix.

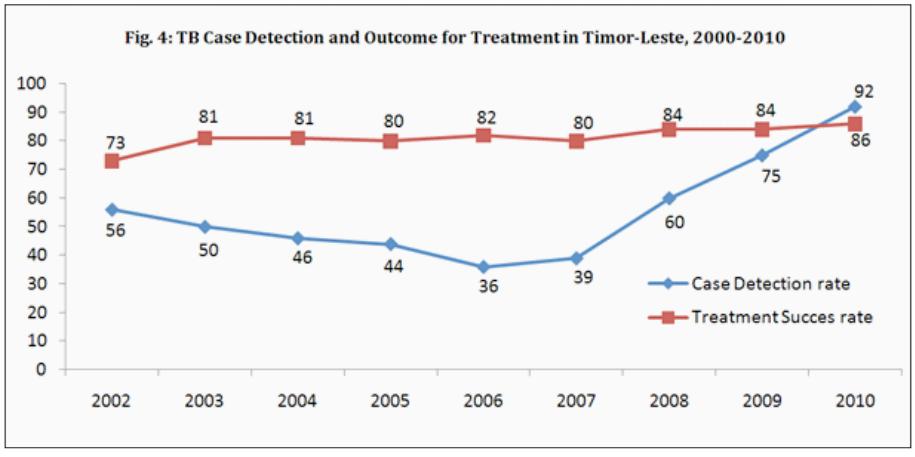


Although there are improvements in relation to previous years, the morbidity rate among pregnant women is under-reported, in 2010 shows 374 malaria cases among pregnant women reported by CHCs and HP. Manatuto (51 cases) and Dili (45 cases) districts reported number of malaria in pregnant women.

v. TUBERCULOSIS

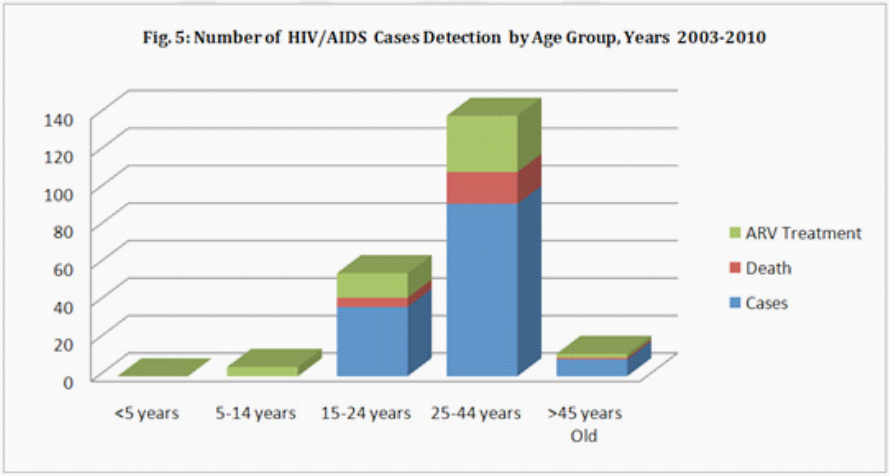
In 2010, the mortality due to Tuberculosis (TB) was reported at 47/100.000 population and 1,530 New Smear Positive (NSP) cases were registered on DOTS. The annual NSP case detection rate was 91.8% against target of 70%. The total of all types of TB case including Smear negative and extra-pulmonary TB registered on DOTS treatment for the year 2010was4,841. Out of total new pulmonary TB cases registered, 34.7% are new sputum positive cases. This is due to over diagnosis of smear negative cases based on undue reliance of X-ray as primary tool for diagnosis by medical staff and due to sub-optimal quality of sputum microscopy leading to under-diagnosis of new smear positive cases.

The treatment success rate for the cohort was 86% compared to global target of 85%. The treatment success rate could have been further improved if the default rate of 4% can be reduced through proper management of treatment, quick default retrieval, address verification at the time of initiating treatment and proper patient and family counseling by health staff.



vi. HIV-AIDS

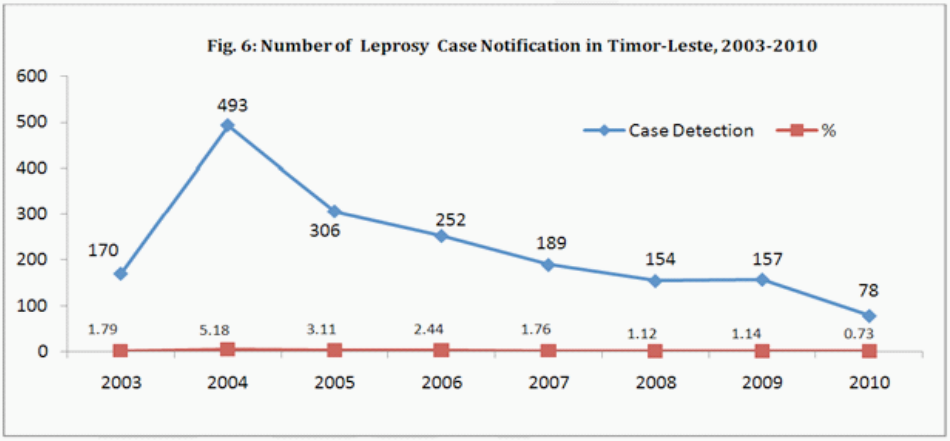
There are 211cummulative cases of HIV infection reported to the National HIV/AIDS unitby 2010, of which 23 deaths, 50 new HIV infection reported in the year 2009, and 31 cases under anti-retriviral treatment (ARV). The majority of reported HIV infections are within age group of 15 – 24 years (26.10%) and 25 – 44 years (65.9%). In 2010, there were 60 new cases identified.



vii. OTHER COMMUNICABLE DISEASES

Episodic outbreaks of dengue hemorrhagic fever (DHF) are common with the most recent one occurring in 2005 during which time the case fatality rate peaked at 14%. In January 2010, 83 cases of DHF were found in four districts: Bobonaro (65 cases), Dili (15 cases), Manatuto (2 cases), and Ainaro (1 case).

There are 28cases of PB and 59 cases of MB cases. Cases of PB and MB are high in >15 age group than in <15 age group.The average Laprosy Prevelence rate for Timor-Leste is 68.0% per 10,000 populations with case detention rate is 0.74 per 10,000 populations. Leprosy prevalence rate ranges from 0.47 in Ainaro to 7.40 in Oecusse. DIli, Oecusse and Viqueque have more than 2 prevalence rate per 10,000. The case detection rate ranges from 0.18 in Manufahi to 6.82 in Oecusse.



Leprosy, Filariasis and Frambusia are endemic in several districts in TL. The majority of cases occur in the coastal line including Oecuse, Baucau, Viqueque, Manatuto, and Manufahe.

viii. NON-COMMUNICABLE DISEASES

Mortality caused by non-communicable diseases are 663/100.000 population. Cardiovascular diseases, cancer and accidents are the causes of death in 365, 96, and 83 per 100,000 populations respectively.

Unhealthy living conditions, which include among others, overcrowding, makeshift housing, unsafe drinking water, unsafe working conditions, poor waste disposal, food insecurity are matters of public health concern. Living conditions are affected by local action, by community groups and organizations and by the work of local governments for which a system must exist to enable collaboration and coordination. Only 52% population has access to clean water and 30% to basic sanitation. This reality makes the population more vulnerable to diseases like diarrhea, malaria, dengue and others. Around 50% of households have to use groundwater susceptible to contamination by sewage and other waste.

The MoH views the marginalizing, stigmatization and discrimination of mental health from mainstream health and welfare services as an inappropriate past legacy. It regards mental health as a crucial component of primary health care that is required in ensuring that individuals realize their full potential, work productively and fruitfully to the well being of the country.

Box 2: Leading Causes of Mortality by Age of Patient Amongs Patient Admitted to Hospitals in Timor Leste, January – December 2010

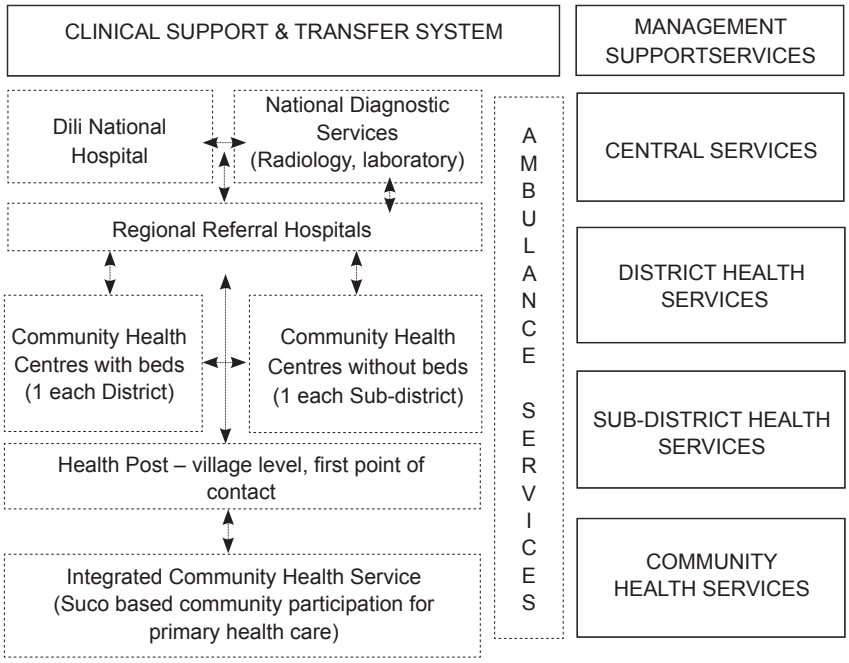
Disease	<1	1 - 4	5 - 14	15 - 45	46 and older	Total Hospital Deaths	
						No. of deaths	% of Total Hospital Deaths
Bronchopneumonia/Pneumonia	37	26	12	25	36	136	11.5
All forms of TB	3	5	18	75	75	176	14.9
Malaria	6	8	18	22	4	58	4.9
Cardiovascular Disease	1	1	1	14	21	38	3.2
Injury	0	1	5	19	9	34	2.9
Liver Disease	1	0	0	12	19	32	2.7
Cerebrovascular Disease	0	0	0	11	20	31	2.6
Renal Disorder	2	0	10	7	11	30	2.5
Diarrhoeal Diseases	10	10	1	7	1	29	2.4
Asthma Bronchiale/COPD	1	0	1	7	17	26	2.2
Meningitis/Encephalitis	2	4	4	7	0	17	1.4
Malnutrition	4	9	0	1	0	14	1.2
Anemia	1	2	0	10	0	13	1.1

I.3 ORGANIZATION OF THE HEALTH SECTOR

In order to pursue its mission objectives, deconcentration of the Ministry of Healthfunctions began while operating at four service levels – central, district, sub-district and community level.

The current health system configuration is based on a broad definition of access to publicly financed and delivered primary care, with essential referral care being provided by regional hospitals and more specialized referral services by one national hospital. In addition, the private sector provides care through these hospitals and numerous clinics, polyclinics and specialized centres.The hierarchical structure organization of the health sector provides a logical range of coverage of services.

Fig. 7: Current National Health Service Configuration



I.3. A PRIMARY HEALTH CARE

Primary health care services are provided through the District Health Service structure, with Community Health Centres, Health Posts and outreach activities servicing geographically defined populations within a framework of the BSP while incorporating an integrated community health services or SISCa. Devolution of management authority and responsibility to district health teams has been a cornerstone of the MOH during its formative years. The community based activities consist of SISCA in all villages, mobile services conducted at other sites e.g. schools, markets, community structures and “mop up” services regularly conducted according to programmatic needs.

The nearest facility based services to the community are delivered through a network of Health Posts staffed with a team of one nurse and one midwife, able to deliver a minimum package of curative and preventive/promotive care.

At Sub-district level, Community Health Centres (CHC) provide a higher level of services than the health posts, have a wider range of staff and provide mobile clinic services and technical and managerial support to health posts. The type of CHC is not the same across all sub-districts as they have outpatient services and up until now the type of services provided is according to the size of the catchment population and distance from higher referral facilities.

District CHCs provide inpatient and outpatient services, with a staff component of 10-14 including a physician (the "District Medical Officer"), and radio communications with direct access to ambulance services. Depending on the vicinity of referral hospitals, inpatients are admitted to an observation unit with two to four beds for pre-referral stabilization of severe cases, or to a ward of 10-20 beds with a set of diagnosis support equipment including laboratory with capacity for essential tests. Where there is no health post available in remote communities, CHCs should provide basic mobile clinic services on a regular basis by motorbike on a twice-per-week basis.

Services provided at the primary health care facilities differ according to their catchment areas and they provide a basic services package comprised of basic curative services, health promotion, information, education and communication activities, immunization programs, maternal and child health care, delivery of nutrition program, TB DOTs follow-up, mental health care support. Some CHCs also offer dental services, laboratory testing for ANC, malaria and TB.

Although the mission is to provide comprehensive family care, the relationship between primary, secondary, and tertiary care does not always support this mission. There are very few guidelines and agreed protocols for referral between primary, secondary and tertiary care. For example, reports on X-rays taken in primary care are often received so late as to be useless in the management of a patient's condition. Recommendations have been made to evaluate primary care services and how the services are organized and delivered.

I.3. B HOSPITAL HEALTH CARE

There are two levels of hospitals providing secondary care in Timor-Leste. Tertiary health care are currently provided overseas as a result of limited technology and specialized human resources required to perform complex interventions which are the main causes of medical evacuations abroad.

Referral hospitals are located in five strategic regions. The referral hospitals have OPD, Emergency and In-patient departments. They are staffed with general practitioners and specialists in 4 clinical areas such as surgery, paediatrics, gyneco-obstetrics and internal medicine.

The national hospital is the top tier referral facility for specialized services and has linkages for tertiary care with facilities abroad. Both national and referral hospitals provide training facilities for cadres of health workers who function at the primary care level. These facilities also serve as internship centres for all staff up to Medical Officers.

Referral arrangements between the three levels of services are linked with ambulance services, with ambulances based in hospitals and district ambulance stations. However, to promote efficiency in health service utilization the system must facilitate supportive supervision of lower

levels of care by higher levels.
Services at the secondary and tertiary levels shall be oriented to support service quality in the health facilities and to improve the performance of the referral chain and level of excellence that is expected from both secondary and tertiary health care services.

I.3. C PRIVATE SECTOR

The private sector is typically defined to comprise "all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease.

Based on the estimated number of health care workers in government facilities and in the private facilities, the MoH has estimated that private clinics may be handling a quarter of basic health service delivery. There is much greater use of private facilities amongst the non-poor, with over 29 percent using private or church facilities compared to 14 percent of the poor. The Café Timor network (Clínica Café Timor, CCT), which has its origins in looking after the health care needs of cooperatives established by workers in the coffee industry, operates eight fixed clinics providing services similar to a Sub-district CHC in the public system, and 24 mobile clinics involving 74 personnel in 5 districts and capital Dili.

There are also some 32 faith based clinics across the country. Caritas operates 27 clinics spread across the districts, with 125 mainly voluntary medical staff. Caritas clinics operate mobile clinics using vehicles and motorbikes, with no inpatient care except for deliveries. Traditional medicine continues to play an important role in Timor-Leste. There are many traditional healers and birth attendants providing services, especially in rural areas.

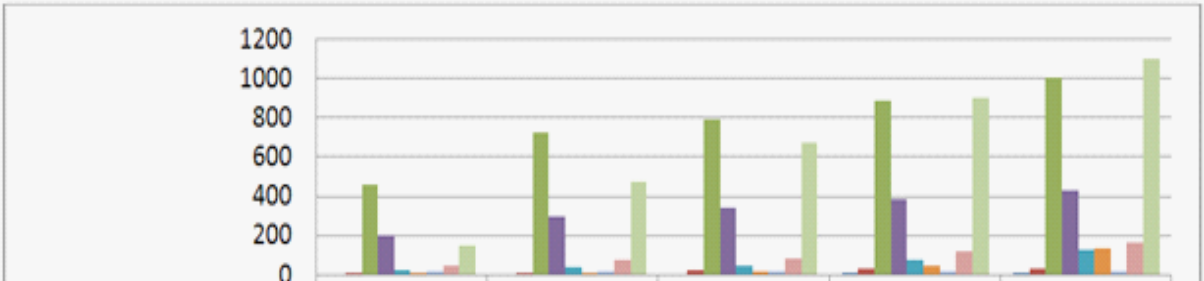
For-profit private clinics run by doctors, nurses and midwives and dentists have been established in some of the main urban areas, especially Dili and Baucau. These clinics are still to become subject to legislation and monitoring. Pharmacies and other non-specialized retail shops sell medicines to the public, often without a prescription, and managed by people with no formal training in pharmacy.

I.4 HUMAN RESOURCES FOR HEALTH

During the early years of post referendum reconstruction period (2000–01), Timor-Leste's health system had a staff complement of about 1500 as comparedwithapproximately 3540 during the Indonesian occupation. From 135 doctors workingbefore September 1999, only 20 remained after wards. International medical staffs were recruited as a temporary measure while Timorese doctors were beingtrained overseas through scholarships sponsored by donors. Nurses and mid wives were assigned to every health facility.

Significant progress was made in ensuring appropriate recruitment, distribution and training of available staffing required to fulfilling existing quantitative and qualitative gaps at both health professional and management cadres.

Fig. 8: Staff of the Ministry of Health, 2002 -2010



	2002	2004	2006	2008	2010
Medical Specialist	0	0	0	8	9
Doctor	6	13	21	29	30
Nurse	462	723	796	891	1007
Midwife	199	296	343	386	431
Lab. Technician	17	37	42	73	128
Pharmacist	5	12	14	43	137
Radiologist	12	16	16	16	17
Public Health Officers	45	71	82	115	164
Health Managers & Administrators	149	475	674	900	1101

In 2003, the Timorese Government embarked on a strong policy - decision to train around 1,000 medical students, with the support of the Cuban Government, of which, 18 have already graduated and working at the various Community Health Centres and Referral Hospitals, while nearly 500 have returned between 2010 and 2011 to Timor-Leste from Cuba to undertake their medical practice prior to graduation in 2012.

Another significant move towards human resource development was the opening of the School of Nursing and Midwifery at the National University Timor Lorosa'e (UNTL), in 2008. Training of other allied health sciences professionals such as radiologists, physiotherapists, pharmacists and laboratory technicias continues, although at much lower pace and falling short from current needs.

Health workers are unevenly distributed between urban and rural areas, and between the public and private sectors. Incentive mechanismswere introduced for health professionals in particular and for those professionals assigned to geographicaly remote areas of the country,in form of subsidies, in the hope to help feel existing gaps and retain health professionals in the rural areas.

I.5 HEALTH INFRASTRUCTURE

Box 3: Summary of Existing Health Facilities in Timor-Leste

Type/Level	Public	Private	TOTAL
Health Posts	192	0	**192**
Community Health Centres	66	26	**92**
Maternity Clinic	42	1	**43**
Hospitals	6	0	**6**
TOTAL	**264**	**26**	**290**

The Ministry of Health, with support of its development partners, engaged in an integrated infrastructure development consisting of rehabilitation and construction of health facilities, management offices and training centres, while focus was also given to resourcing these facilities with basic equipments, ambulances and vehicles, access to electricity and water supply.

I.6 SWOT ANALYSIS

In order to adequately implement the NHSSP, there are some opportunities and strengths that the MoH and health stekeholders should build on as they implement this plan. At the same time, there are weaknesses and threats that need to be contained or addressed if the NHSSP is to be implemented successfully.

Strengths

- **National Health System Structure**

Despite major bottlenecks in the health system, the national health system configuration is being implemented successfully under the leadership and stewardship of the MoH.

The delivery of health services in Timor-Leste has been fully decentralised. This enables communities to participate in health planning and management, especially in those areas where the Family Health Promoters (PSF) have been trained and are fully functional.

The availability of appropriate health structures at all levels for the delivery of basic health interventions is a major strength for Timor-Leste's health sector.

- **Policies, strategies and guidelines:**

Over the years, with leadership of the MoH, the National Health Policy Framework, Sector Investment Programme, and HSSP 2008-2012 have been developed. Other health strategic plans, policies and guidelines have also been developed, are available and are reviewed periodically as need arises.

The MoH and stakeholders have also defined a set of health services that should be delivered at each level of health care. In the context of a limited resource envelope, the sector strategic plans define a basic package of services (BSP) that should be delivered to all Timorese and the indicators and targets in the health sector have since been aligned with the PED and the MDGs.

The integrated community health services (SISCa), strategies for improving access to BSP through construction of maternity clinics and procurement of multifunctional vehicles, local development programs such as Pacote Referendum and Local Development Packages among others constitutes a major strength that MoH and other stakeholders should build on during implementation of the NHSSP 2011-2030.

- **Development of Health Human Resources**

The establishment of the Faculty of Health Sciences, at Timor Lorosa'e National University, and National Institute for Continuous Edcuation and Training of Health Professionals do play a strong role in protecting MoH objectives towards filling current human resources gap while also helping to improve the knowledge and skills of current staffing.

- **Partership:**

The MoH further recognises that it cannot implement the NHSP on its own. The donors, both bilateral and multilateral, are committed to funding the health sector. Over the years, the MoH and stakeholders in Timor-leste have demonstrated strength in mobilising external resources for the sector.

The establishment of structures such as Partnership Management Department (DPM) under the Directorate of Health Planning and Finance, Mid-Term Review Meeting and Joint Annual Health Planning Summit are all aimed at ensuring the effective delivery of national health programmes and projects.

Weaknesses

There are a number of weaknesses within the health sector that may affect the effective delivery of the NHSSP 2011-2030. These weaknesses have been identified through the Health Care Seeking Behaviour Study, Demography Health Survey, Health Costing Study, National Coordination Meetings and Mid-Term Reviews.

- Unsatisfactory implementation of sectoral policies and strategies and weak enforcement of existing legislation

While health sector policies and strategic plans exist, implementation is a major challenge. The lack of implementation and enforcement might be due to:

- The critical shortage of HRH.
- Inadequate funding to the health sector makes it difficult to effectively train, recruit, deploy and maintain and adequately motivate health care workers.
- Redundancy or limited impact/interest for the policy.

- *Weak referral system*

While the number of health facilities has increased significantly over the years, nearly a third of the people in Timor-Leste still live more than 5 kilometres from the nearest health facility; and the referral system is weak which, combined with staff shortage and regular stock-out of medicines, forces many Timorese to seek treatment from private clinics, traditional medicine and in neighbouring Indonesia.

- *A Weak Supervision, Monitoring & Evaluation System*

Even though the District Health Services provide a significant proportion of health care, the partnership with private sector and the central services is rather weak.

A system for supervision, monitoring and evaluation exists but it is weak. The late release of funds for supervision, insufficient funds, inadequate transport arrangements and lack of supervision skills affect the frequency of supervision and this impacts negatively on quality of services rendered.

The operations of the HMIS are affected by inadequate human and financial resources as well as excessive volumes of data collection that may not be relevant to the different levels of care and programme.The existence of parallel datacollection systems for vertical programs such as Malaria, HIV/AIDS and Tuberculosis puts a strain on staff.

Data analysisandutilisation for planning purposes is low and the private sector's contribution to the HMIS ismodest.

Many facilities still lack basic utilities such as water and electricity.Financial management, accountability and transparency are still weak; and there is limited absorptioncapacity for donor funds e.g. Global Fund.

Opportunities

While these weaknesses exist, there are also opportunities within the health sector that can be used by all stakeholders to successfully implement the NHSSP:

- The Government of Timor-Leste has just developed the Strategic Development Plan 2011-2030 (SDP) whose overall goal is to accelerate economic growth to reduce poverty. The SDP is an overall development plan for Timor-Leste and it is a guiding document for sector investments.

- While financial resources are limited, an opportunity exists for the country: it is a signatory to the global initiatives such as the Global Fund and GAVI and bilateral donors are *committed to funding the health sector* and supporting Government efforts to achieve MDGs. The availability of such funds and others alike the HSSP-SP willreduce the funding gap for implementation of the NHSSP 2011-2030.

- Other opportunities that need to be fully exploited include: growing involvement of the private sector; decentralisation of services to allow full participation of the communities in service delivery and management; and harmonisation of funding from different sources.

- The training and research institutions with their external alliances of reputable and experienced universities andother academic institutions canif properly harnessed and guided- support the sector as a real'think thank' involved in the process of improving access and quality of health human resources.

- The continued development of South East Asia Region and Timor-Leste's activeparticipation.

Threats

There are also threats to the implementation of the NHSSP 2011-2030:

- Although Timor-Leste has recently been classified as a Low Middle Income Country, half of its populations live below the poverty line, and the situation is further exacerbated by food insecurity and weak basic infrastructure, thus, threatening government contribution to a sustainable health sector development.

- Changes in Government may bring the potential changes in views and policy orientations.

- Poor health seeking behaviours may continue to threaten efforts for positive lifestyle changes.

SECTION II:
20 YEARS VISION FOR HEALTH

SECTION II: 20 YEARS VISION FOR HEALTH

II.1 VISION

The Constitution of the Democratic Republic of Timor-Leste addresses health specifically in several of its sections . Most significantly, in Article 57 it embeds health and medical care as fundamental rights for all citizens. In the same Article, the State is charged with the duty to promote and establish a national health system that is universal, general, free of charge and, as possible, managed through a decentralised participatory structure.

Article 19 of the Constitution specifies the state's role in promoting the health of the country's youth. In Article 53 "health" is referred to as a commodity. All citizens – as consumers or potential consumers - are entitled to health through good quality protective health care. Article 61 enshrines the right to a "humane, healthy and ecologically balanced environment" with the state responsible for protecting the environment and safeguarding economic sustainability.

As per the Constitution, Timor-Leste MOH recognises that health is influenced by a variety of determinants - education, income, housing, food, water and sanitation being among the more significant of these.

With this broad understanding of health, the Ministry's vision is for a ***"Healthy East Timorese people in a healthy Timor-Leste".***

It envisages a community enjoying a level of health that allows people to develop their potential within a healthy environment. The vision is achievable only through multisectoral efforts. The vision also reflects a fundamental aim to reduce poverty to a point where all Timorese are sufficiently endowed to cover basic needs. The Ministry believes that only a healthy community is able to achieve poverty alleviation.

The vision reflects the aim to increase life expectancy and productivity of Timor-Leste. Health can reduce poverty through improving capacity of human resources. Healthy people and good education will increase income. Finally, health gives the nation welfare.

II.2 MISSION

MOH is committed to the following mission:

- Ensuring available, accessible and affordable health care services for all Timorese people.
- Regulating the healthsector.
- Promoting community and broad-based stakeholder participation.

[6] Constitution of RDTL, 2001

II.3 CORE VALUES

The NHSSP puts the client and community in the forefront and adopts a 'client centered' approach and it looks at both the supply and demand side of health care. The following social values should be detailed in the Patients' Charter:

- *Equity*

Government shall ensure equal access to quality care according to needs for individuals with the same health conditions.

- *Cultural Awareness*

All stakeholders shall respect the cultures and traditions of the peoples of Timor-Leste that promote health. At the same time, negative practices, attitudes and behaviours shall be discouraged.

- *Professionalism, Integrity and ethics*

Health, health-allied and other professionals working in the sector (including managers, accountants, engineers etc) shall perform their work with the highest level of professionalism, integrity and trust as contained and detailed in the ethics guidelines enforced by professional bodies to which they are affiliated.

- *Excellence (right to best possible health care)*

The plan will be implemented in the context that health is a fundamental human right. The public and private health providers are obliged to ensure patients' safety and privacy and observe the required professional standards in the course of their duties. This has implications on treatment protocols, and quality of medicines, medical supplies, medical equipment and infrastructure.

- *Accountability*

At all times and at all levels, a high level of efficiency and accountability shall be maintained in the development and management of the national health system. The health sector will be accountable for its performance, including its financial management performance, not only to the political and administrative system, but, above all, to its client communities.

II.4 GOALS

Specific health goals for the next twenty years are:

1. To have a comprehensive primary and hospital care services with good quality and accessible to all Timorese people.

2. To provide adequate support system to health care services delivery.

3. To promote higher community and partnership participation in the improvement of national health system.

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II.5 OBJECTIVES

These goals translate the overall vision and mission into the following set of policy objectives that are linked to the National Development Plan, Millennium Development Goals (MDG) as well as the Government Priorities for the Health Sector. The objectives are set to correspondent to the social, economic and demographic developments of the next twenty years in trenches of five years. And they are:

- Health System Management: to strengthen the stewardship role of the Ministry of Health (policy-making, law-making, regulating, licensing, supervising, monitoring, licensing, etc…) in the development of a strong integrated National Health System able to treat, control and prevent diseases and promote sustainable healthy lifestyles in Timor-Leste.

- Health Service Delivery: a) to ensure access and quality of primary health care services to the community, with focus on the needs of children, women and other vulnerable groups; b) to develop a hospital service able to respond to the people' needs for secondary and tertiary health care.

- Human Resources for Health: to meet human resources needs to ensure an efficient and effective health services delivery at each level of care.

- Health Infrastructure: toinvest sufficiently and appropriately in health facilities, staff accommodation, medical equipments and other supplies, means of transportations and Information Communication Technologies (ICTs).

- Support Services: to strengthen health administration and management services to better respond to health defined needs and to satisfy people's expectations within the context of decentralization.

Box 4: Priotity Directions from 2011 to 2030

NHSSP Priority Directions			
2011-2015 (Conditioning)	**2016-2020 (Consolidation)**	**2021-2025 (Maturation)**	**2026-2030 (Sustainable Take-off)**
• Human Resources development and deployment for the district, hospital services, the national laboratory and health training institutions. • District Health Infrastrucure Development and logistic support. • Institutionalcapacity building at central, district and personalized health services on health planning and budgeting, information, monitoring and evaluation.	• Revision of Health Policy Framework to accommodate changes in the health status of the country. • Institutional capacity building at central, district and personalized health services on health planning and budgeting, reporting, monitoring and evaluation. • Human Resources development and deployment for the district, national laboratory and health training institutions.	• • Assessment of National Health System Configuration. • District Hospital development. • National tertiary care infrastructure development.	• Establishment of an effectively defined National Health System.

SECTION III:
MANAGING THE NATIONAL HEALTH SYSTEM

SECTION III: MANAGING THE NATIONAL HEALTH SYSTEM

III.1 BACKGROUND

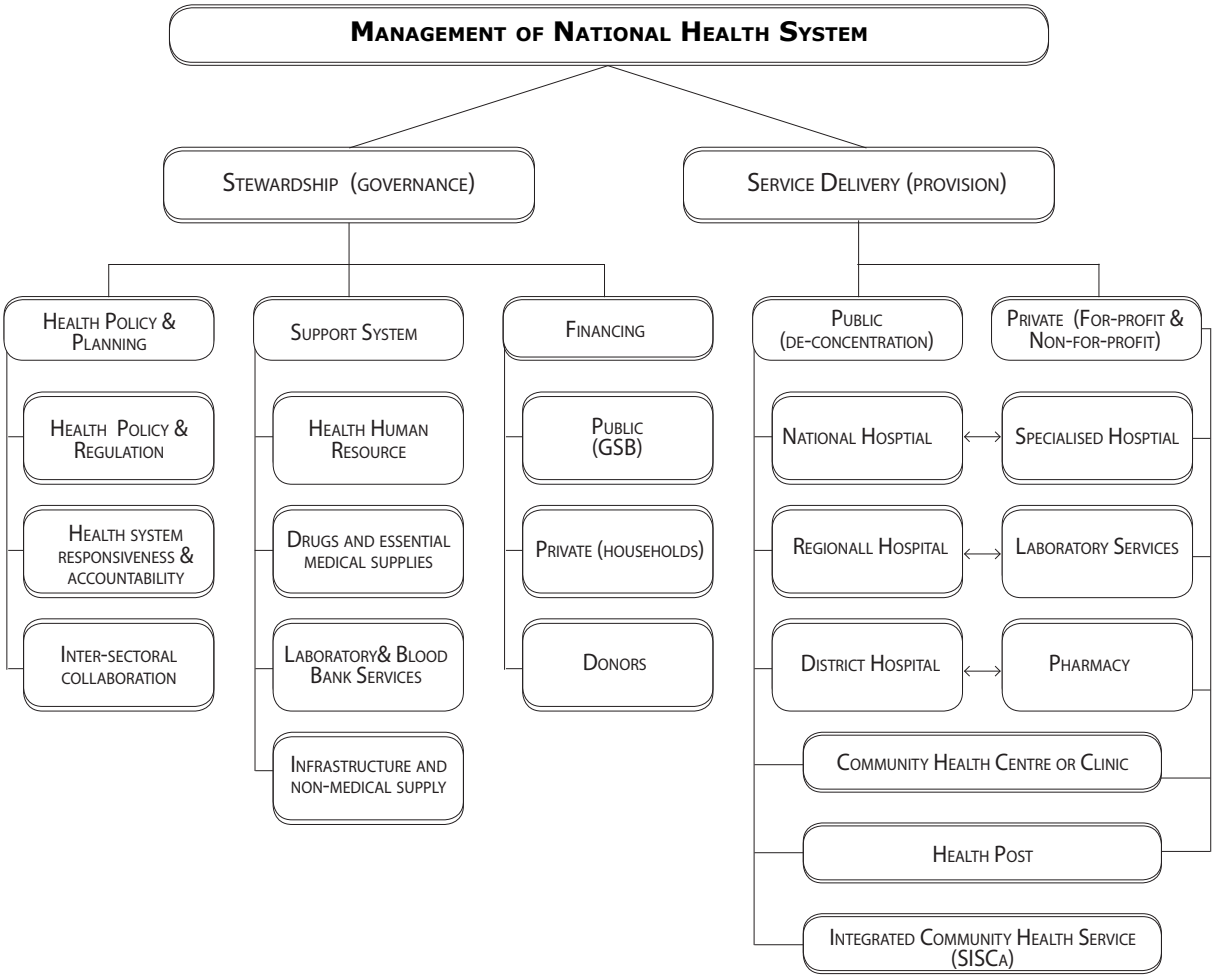
The National Constitution of RDTL provides, in its article 57, a fundamental basis for all “all Timorese citizens are entitle to health care and the State has a duty to promote and protect this right free of charge, in accordance with its capabilities and in conformity with the law”. The Constitution further states that health services shall, as far as possible, run under a decentralized participatory management setting.

The National health Policy embraces the principles of a health system unversaly adopted by the World Health Organization (WHO) , thus, defining Timor-Leste health system as harmonic and structured health system, which includes “all the organizations, institutions, and resources that are devoted to producing health actions”andwill allow for exercise of the right to health protection. This definition includes the full range of players engaged in the provision and financing of health services including the public, private sector for-profit and non-profit, as well as international and bilateral donors, foundations, and voluntary organizations involved in funding or implementing health activities.

The main feature of current organizational and institutional structure of the health sector is the decentralization of the health service delivery, through devolution of key management responsibilities and resources to district health and personalized or autonomous health services.

This is done by securing financing of the health services on a level sufficient to respond to the people needs in equitable way, thus, embracing a social oriented approach, and also through investment in infrastructure and human resources to deliver services while playing the role of a steward. Figure 1 illustrates policy direction for some of key organizational and managerial components of the national heath system in Timor-Leste.

Fig.9: Health System Framework in Timor-Leste



III.2 STEWARDSHIP ROLE OF THE MOH

i. HEALTH POLICY & REGULATION

The National Health Policy Framework provides the overall policy framework within which the health services are provided. Derived from the National Development Plan, it further articulates areas where new policies and legislations should be developed and/or revised in order to create an enabling policy and legal environment for health system development.

After more than seven years of implementing national health policies and strategies, there still remain gaps in the policy and legislative framework. The challenges ahead are for the MoH to enhance capacities for policy analysis and formulation, as well as develop appropriate mechanisms to support policy implementation.

Objective: to provide a comprehensive policy and legal framework for effective coordination, implementation and monitoring of health services.

Strategies:

1. Review and harmonize the existing policies and legislation and, where gaps exist, formulate new legislation in order to provide a legal framework that effectively supports the on-going health sector reforms;

2. Develop policies aimed at promoting interventions that are cost-effective, pro-poor and address key health priorities;

3. Disseminate all legislation and policies applicable to the health sector to all levels of the health service delivery system, community representatives and the private sector;

4. Develop a system of coordination and monitoring implementation of health sector policies and legislations; and

5. Strengthen capacity of MoH for health sector policy formulation, analysis and implementation.

Expected Results/ Key Indicators:

1. Checklist on status of the existing/required policies and legislation produced by 2011;

2. Number of policies and legislation reviewed or/and developed against checklist;

3. Number of policies and legislation disseminated and number of services or institutions reached;

4. Guidelines and procedures developed for implementation of the different health policies and legislations;

5. Guidelines for monitoring and evaluation of policy and legal implementation; and

6. Staffing levels and number of people who received appropriate training in policy formulation and analysis.

ii. HEALTH SYSTEM RESPONSIVENESS & ACCOUNTABILITY

Improved health outcomes are closely linked to health system responsiveness and accountability. Performance of health services on the supply side, and public awareness of patient rights on the demand side puts high pressure onto the system to acknowledge ensuring that all quality functions are met through different institutions within the system. These are found in various parts of the health system, for example, professional licensing, hospital and health facility accreditation, infection control committees, supervisory structures, national policy and standards committees, quality assurance committees within clinical services at various levels, and drug quality assurance authorities.

The MoH will take action to strengthen system responsiveness and accountability so that patients and the population at large are attracted to make use of national health system. Thus, contribution of health management information system and research findings definitely helps decision-making policy initiatives to ensure different situations and requirements of men and women are catered for, both in service delivery and human resources management of health staff.

Objective: to provide evidence based for planning and implementation in order to improve responsiveness to population health needs and engagement in strengthening health systems' performance at all levels.

Strategies:

1. Strengthen the capacity of health personnel to ensure accountability and responsiveness to their assigned tasks;

2. Strengthen the HMIS capacity to monitor health sector performance, particularly at the district level, through intensive training skills development, upgrading manuals and through making ICT linked by internet to a central data warehouse;

3. Improve research capacity in the MoH and mandate for National Health Research Advisory Committee in an effort to institutionalize health research at various levels of health care;

4. Establishment of a National Public Health Regulatory Authority Body which includes the Pharmaceutical Regulatory Authority; Food Safety and Quality Control Services,

5. Develop guidelines for mainstreaming gender issues in health sector planning, in line with the National Gender Policy;

6. Strengthening mechanism for coordination and harmonization of various information through epidemiological surveillance media and communication techniques;

7. Establish National Health Council that will have a quasi judicial mandate to protect the right to health, while at the same time ensure appropriate Licensing, Registration, and Professional Ethics within the National Health System;

8. Institute an Internal Audit program under the Office of Health Inspectorate that will provide a comprehensive, internationally recognized system of financial audit, fiscalization and inspection of MoH operational activities.

Expected Results/ Key Indicators:

1. Functional HMIS at all levels by 2015;

2. National Health research agenda developed by 2012;

3. National Public Health Regulatory Authority framework legally established and functional;

4. Citizens Health Charter developed and disseminated among health providers and patients throughout the country.

iii. INTER-SECTOR COLLABORATION

Stakeholders in the health sector are many. The Public and Private sectors, other Ministries and public institutions, Development Partners, Civil Society Organizations, and the community they play an important role in health. The MoH acknowledges the importance of each partner and considers partnership an important guiding principle of the national health development.

The private sector in particular, provides a relevant financial contribution to the overall health sector, improving at the same time governance, management and quality of care. Furthermore, the private sector is considered as complementary to the public health sector in terms of increasing geographical access to health services and the scope and scale of services provided.

The need to strengthen intersectoral collaboration and participation has been embraced by the Ministry of Health in all programs as a way forward to a sector wide approach to health service delivery. A minimum sector wide program of action is needed with clearly defined roles, including joint planning, monitoring and implementation key partners.

The main objective is to build consensus among different sectors and partners to commit towards a sector wide approach management and coordination required to improve health sector performance and achieve Government health priority goals.

Strategies:

1. Strengthen partnership and sector's cooperation unit through capacity building and training;
2. Promote collaboration for integrated community development throught joint planning, monitoring and evaluation;
3. To advocate for the establishment of institutions, NGOs and community based networks to promote collaboration, exchange of information and best practice;
4. To nurture public private partnership for the provision of quality services in a harmonized and complementary manner;
5. Develop and implement a system for collecting accurate information about the capabilities of the private health care providers and their activities, in order to assess and channel their contribution to national health priorities; and
6. Review and strengthen financial reporting, transparency, accountability, monitoring and evaluation of intersectoral programs and activities.

Expected Results/ Key Indicators:

1. An organizational structure on intersectoral collaboration and cooperation established and functional from 2011;
2. Existing networks for exchange of information and research findings by 2015;
3. A framework for regulating the private sector involved in delivering BSP through the public health system developed and functioning by 2015;
4. Common monitoring and evaluation mechanisms in place for public-private partnership collaborations.

III.3 ORGANIZATION & MANAGEMENT OF HEALTH SERVICES PROVISION

i. PRIMARY, SECONDARY & TERTIARY HEALTH CARE

Whilst there is natural overlapping in the different types of health care, the distinctions between Primary, Secondary and Tertiary Health Care are very important to properly understand the role and necessity of the National Health System.

Alma-Ata Declaration definesPrimary Health Care (PHC) as "...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's overall health system, of which it is the central function and main focus, and the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process."

In Timor-Leste, secondary health care services refers to those services particularly provided by five referral hospitals and one national hospital to support and complement PHC through referral services as part of the overall continuum of care starting in the community.

The Guido Valadares National Hospital is the top referral hospital in the country, and as such should see only referral cases from other hospitals or health centres. At present, the package of secondary health care services provided by hospitals depends, to a large degree, on the level of skills and equipments available, and where there are specialist surgeons, internists, obstetricians or paediatricians, more complex services can be provided. However, an estimated 80% of outpatient services at all hospitals are in fact PHC services and this situation has significant human and financial resource implications.

Tertiary health care, on the other hand, are provided overseas through a legally approved mechanism of patent referrals to neighbouring countries for complex specialized cases. Tertiary health care does involve high investments by the public sector which may, in turn, constitute changes in the dynamics of current health system. The MoH is facing the challenges of severe shortage of specialized resources – in terms of technical and human power required to provide the best health care services, the way forward in the short-term is to continue referring patients while promoting private investment in the tertiary health care.

Objectives:

1. To ensureappropriatepromotive, preventative, curative and rehabilitativeprimary health care ser vices that delivers a comprehensive family care to all age groups, with full participation and support of the community;

2. To provide accessiblesecondary health care services that delivers a minimum package of hospital services at district and stratetegicaly identified regions;

3. To ensure access to and an equitable, efficient, high quality and cost effective tertiary health care services in Timor-Leste able to cater for the needs of population in a manner that is both affordable and sustainable.

Strategies:

1. Engage Family Health Promoters, as volunteers, in the provision of Non clinical services such as health promotion and behavior change communication programs at community level;

2. Conduct a remote area mapping exercise that involves all levels of health services as well as community leaders and other sectors, in order to prioritiseSISCa activities to underserved areas;

3. Ensure that the entry point into the public health facilities be the Health Post, situated at each Suco within the Sub-districts, and providing the link to higher level referral and emergency services, while providing more responsibilities to the DHMT and Commettees to manage PHC services;

4. Strengthen Community Health Centres with fully resourced staff able to provide BSP for PHC in their Subdistrct catchment areas, while responsible for providing outreach and referral services to all Health Posts and SISCa.
5. Develop a more comprehensive package of secondary and tertiary health care services to be provided at each hospital;

6. Review hospital organizational structures following international standards for a secondary and tertiary health care facilities and deconcentratio of authority to Hospital Board of Directors to carry-out administrative, logistic support and supervision, planning, monitoring and evaluation functions that falls under their jurisdiction;

7. Promote public-private partnership in tertiary health care, with particular attention to treatment of most prevalent diseases which required.

Expected Results/ Key Indicators:

1. Behaviour change communication programs conducted among communities in the promotion of healthier lifestyles and prevention of ill-health throughPSF,SISCa, at Health Posts and CHCs;

2. Areas where large population groups are living outside the range of two hours walk from existing health facilities with appropriate staffing,SISCa activities conducted on regular basis as per plan by 2012;

3. Detailed workforce and infrastructure development plan for HPs at every Suco with a catchment area serving between 500 to 5,000 people developed, and with full implementation of Family Health Services by 2017;

4. A comprehensive package of primary, secondary and tertiary health care services developed and resourced for full implementation to begin gradually by 2012;

Significant reduction of number of deaths caused by preventalble diseases and improved record of patient satisfaction at all levels of health care by 2020.

ii. CENTRAL & DISTRICT HEALTH SERVICES

The main feature of the current organizational and institutional structure of the health sector is the devolution of key management responsibilities and resources to each levels of care. As a result, the equity consideration of accessing care articulates a service delivery structure that begins in the community and works its way to the national level for specialized services.

The Central Services is led by the Director General assisted by seven support units, Five National Directorates (Community Health Services, Hospital and Referral Services, Human Resources, Administrations and Logistics, Planning and Finance). The role and functions of the central level are to develop health policies and regulations, establishing standard for health services, setting priorities, national planning and budgeting, donors' coordination, management of national programs, monitoring and evaluation of the health system and safeguarding equity through resource allocation mechanisms such as cross subsidy.

On the other hand, thedistrict health services will take on more implementation role of national policies and strategic plans, while gradually taking charge, through the District Health Management Teams (DHMT) in developing their own "…plan, supervise, coordinate, monitor and evaluate all health activities at the district level "… which reflects specified local needs.

The journey towards institutional maturity of the MoH will requiredstrengthening of its organizational and management capacity at all levels, with clearly defined roles and responsibilities and appropriate balance between central governance functions and local service delivery functions.

The objectiveis: a) to ensure the full implementation of the stewardship role of the MoH as a policy-maker and regulator of the health system, provision of all the support services to the sector, while ensuring its appropriate financing system; and b) ensure efficient and effective organization and management of health service delivery at district level, following national priority for improving access to quality health care.

Strategies for objective a):

1. Review of current legislation on the organizational structure of the MoH to ensure appropriate implementation of its stewardship role;

2. Institutional reorganization of the Central Services through effective separation of close supervision and management of autonomous institutions, thus focusing on national health policy, regulation, coordination, monitoring and evaluation of service delivery;

3. Strengthen the role of National Health Inspectorate to oversea transparency in health system performance and accountability;

4. Introduce new management arrangements for the General Directorate of Health, focusing on corporate thinking and organizational values in promoting and institutionalizing behavior change for result-oriented actions across the central services;

5. Extend the role of Protocol and Communication Office at central and district health services for improve marketing and advocacy of health related issues and practices.

Strategies for objective b):

6. Development of Health Sector Decentralization Framework to include the following aspects: the operational objectives of decentralization; the resources, functions and authority that are to be transferred, and to which levels; the authority relationships between the various levels; adapting the organizational structure to the changes; strengthening the decentralized units; intersectoral collaboration and community participation;

7. Build appropriate management capacity at district level, especially the District Health Management Teams and Committees with consultative roles to the Government on health related development issues, health planning and program oversight;

8. Establish community health committees to voice community interests and health issues in the wider district health management networks.

Expected Results/ Key Indicators:

1. Restructuring of the health sector completed by 2012;

2. District Health Committees all established, with clearly defined roles and responsibilities by 2013;

3. Autonomous status of Personalized Health Services reinforced and strengthen by 2015;

4. Marketing and communication of major health policies and programs strengthened;

5. Corporate management culture and practices gradually introduced and strengthened at central level;

6. Health Sector Decentralization Framework fully operational by 2015;

7. District Health Management Teams strengthened and fully responsive to their roles and responsibilities by 2015;

8. Lines of communication and coordination between the district and different levels of health services defined and strengthened.

iii. PUBLIC & PRIVATE HEALTH SERVICES

Publichealthservicesencompass all health facilities owned and controlled by various levels and agencies of government. The private health sector is typically defined to comprise all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease. Private sector actions in Timor-Leste's health system include the following:

- Private providers including for-profit (commercial) and nonprofit formal health care providers (private hospitals, health centers, and clinics) and traditional and informal practitioners, including birth attendants and healers;
- Community-based organizations and civil society groups that do not directly provide health services, but provide complementary or related services such as advocacy groups, voluntary and support groups;
- Wholesalers and retailers of health or health-related commodities such as medicines, medical supplies and equipments;
- Private companies that take actions to protect or promote the health of their employees (such as company clinics or health education programs);
- Private health insurance companies that offer insurance and can also influence provider incentives via their contracting and payment mechanisms.

While the public health services lead the way health services delivery are structured, the private sector is evolving without following specific pattern or criteria which define its category. Public health services are delivered through a network of facilities distributed across the country, from an integrated community health services or SISCa, to Health Posts, Community Health Centre, District Hospitals, Referral Hospitals and finally the National Hospital providing the highest specialized services in the country.

The organizational structure of the private health service delivery, on the other hand, does not follow any specified rules or regulations to comply with national health services configuration, thus, leaving the sector to develop independently with no boundaries in terms of provision of services that characterizes primary, secondary or tertiary levels of health care.

Objective: to increase coverage and consumer choice to efficient and quality health care services through participation of the private sector in health service provision.

Strategies:

1. Review current legislation for provision of health services by the private sector;
2. Introduction of guidelines and regulation for quality control and consumer protection from private health providers under Public/Private mix arrangements as well as in other service configurations such as Private/Private or Private/Public;
3. Expand training capacity and rationalization of private sector personnel to ensure equitable distribution of qualified staff throughout the sectors;
4. Promote development of modern practice by the private sector in order to encourage competitiveness for improved quality of care;
5. Develop criteria for contracting-out services to the private sector strengthened through clear guidelines and enabling environment.

Expected Results/ Key Indicators:

1. Regulation of the private sector developed and implemented;
2. Improved quality of care due to increased partnership and coordination mechanisms;
3. % of private sector health personnel trained in the public health institutions;
4. Contracting-out services to the private sector strengthen.

SECTION IV:
DELIVERY OF HEALTH SERVICES

SECTION IV: DELIVERY OF HEALTH SERVICES

IV.1 BACKGROUND

Current health service system has been critically reviewed in Timor-Leste in order to devise a new strategy for making it more effective and accessible to as many people as possible. The analysis resulted in the conclusion that such an effort not only implies a need for closer and more intense collaboration among the existing health programmes, it also required a shift in the prevailing paradigm, which is focused on an integrated community health service delivery. The basic services package for primary health care and Hospitals in Timor-Leste (BSP) articulates a service delivery structure that begins in the local community and works its way to the national level for specialized services.

In order to succeed, however, the package requires an appropriate mix of inputs related to human resources, infrastructure and commodities to ensure delivery.

The operational goal of health service delivery is to provide a quality health care for Timor-Leste by establishing and developing a cost-effective and needs-based health system which specifically addresses the health issues and problems of women, children and other vulnerable groups such as the elderly and the disabled, in a participatory way.These priority issues require:

- Ensuring a services package that is responsive to each level' needs
- Improving coverage and utilisation of services
- Integrating national programmes at central, district and sub-district levels
- Implementing a quality and evidence-based approach to interventions
- Promoting community and private sector participation in the planning and practice of heath service delivery.

The overall **strategies** flowing from these core elements will include:

1. Review current BSP for both primary health care and hospitals in order to accommodate more comprehensive and integrated services implemented at different levels of care;
2. Review and development of current and new strategic documents for all health programme areas as to adjust to Government reforms and priority goals;
3. Revitalizing community health structures with anemphasis on prevention, active promotion of healthy lifestyles and health-seeking behavior among the population;
4. Affirmative action on the heightened needs of all vulnerable groups such as children, women, the disabled and the elderly, particularly those from rural and remote areas in an attempt to make human rights for health the basis forintervention;

5. Building capacity of clinical and public healthworkers at all levels;
6. Providing relevant and culturally adapted information to the users of the health services (increasing the demand-side);
7. Strengthening the referral system between the various levels of care;
8. Harmonize the expansion in the infrastructure with the available resources (human material and financial resources, etc.);
9. Strengthen public-private sector collaboration based on quality interventions sharing of reliable health information.

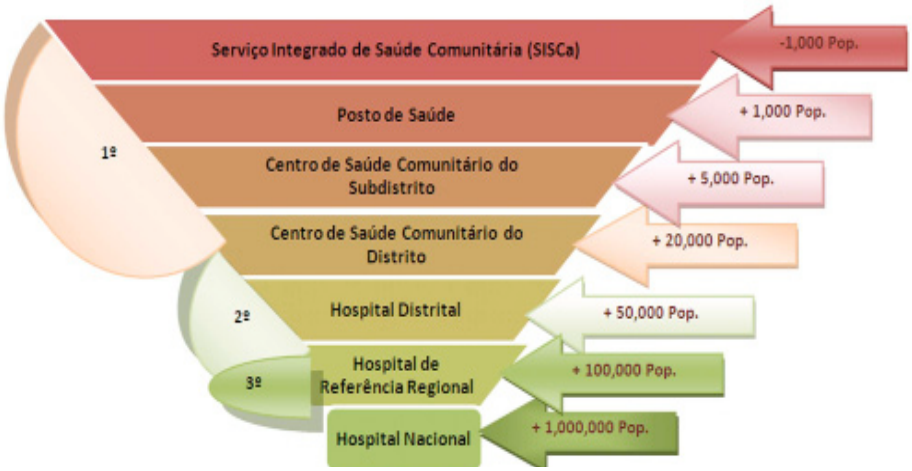
Expected Results/ Key Indicators:

1. A comprehensive package of services for all health programmesfinalized, costed and approved and implemented at all levels of health care;
2. 5 Year strategic plans developed by all health programmes, followed by District Health Plan, Business Plan for all hospitals, National Health Laboratory, SAMES, National Health Training Institution and Research Centre;
3. Standard Treatment Guidelines for priority diseases reviewd and implementation began 2012;
4. Improved access to health care for the communities; and
5. Morbidity and mortality rates for the 10 top diseases are well captured by the Health Management Information system and prioritised.

IV.2 STRATEGIC DIRECTION FOR EVERY LEVEL OF HEALTH CARE

The primary health care services for 2030 will be implemented in community and primary health care facilities, starting from SISCa in villanges, health posts at the Suco and health centers at sub districts. In all districts there will be a Policlinic or District Hospital, three Regional Hospitals will be located in Lebutu at Ermera District, Maubisse in Ainaro District and Natarbora in Manatuto District.

Fig10: Health Service Delivery Pyramid by 2030



The national hospital Guido Valadares will become atertiary care hospital located in Dili. Relevant services which are appropriate to the needs should be delivered on efficient way are defined for each level. Others components such as competent and adequate number and type of health professionas, appropriate infrastructure, medical equipments and others meaning of support are important to guarantee the quality and effectiveness of health services packages provision should be developed.

A. SISCa – Basic health services provided by CHCs reaching out to communities following the principle of community empowerment to address key health needs at aldeia level.

Objective: To allow easy and nearby access of integrated and comprehensive health assistance to communities living in very remote areas.

Strategies:

1. Strengthen community empowerment in participatingandto take lead in the identification of health issues and practices that hinders access to health services

2. Advocating for inter-sectoral collaboration and commitment in community level services

3. Strengthening linkages between the community and the different support and referral system.

Expected Results/ Key Indicators:

1. 100% of implementation of 6 tables by 2015;

2. 50% of SISCa posts implement the following functional elements: a) Database (RSF-Tab.1); b) Health Care Assistance (Tab. 2-6);

3. Routine Survey and data analysisby 2015;

4. The three functional elements of SISCa are 100% implemented by 2030 in all SISCa Posts.

	Strategy	Indicator	Target 2015	Target 2020	Target 2025	Target 2030
1.	Strengthen community empowerment in participating and to take lead in the identification of health issues and practices that hinders access to health services.	% SISCa post management led by community leaders	50%	100%	100%	100%
2.	Advocating for inter-sectoral collaboration and commitment in community level services.	Coordination mechanisms among different sectors developed and functioning in support of SISCa	100%	100%	100%	100%
3.	Standardize comprehensive health service package at SISCa levels.	% of identified rural area with access to full packages of SISCa	50%	100%	100%	100%

B. HEALTH POST

Health Post is defined as one unit of primary health care under community health center and that is the institutional entry point for service delivery to the communities at Village level. The Ministry of Health has already built 192 health posts throughout the country, most of which are currently served by one or two health staffs.

Objective:

To provide comprehensive primary health care packages, including preventive, promotive, curative and rehabilitative health care to the community

Strategies:

1. Standardize comprehensive basic service package at health post level with emphasize on basic promotive, preventive, curative and rehabilitative care following national treatment guidelines

2. Standardize human resources profile and infrastructures for health post, both type and location base on number of population and inaccessibility

3. Strengthen referral pathways for all levels of health care

4. Promote community awareness and education on general well-being and healthy lifestyle for all age groups.

Expected Results/ Key Indicators:

1. Sucoswith>2000 population fully covered with BSP before 2013;

2. Sucos with population between 1500-2000 located in very remote areas to have health post delivering a comprehensive package of services by 2015;

3. 100% staffing requirements for Health Posts fulfilled based on standards by 2020, with at least one doctor, two nurses and two midwives providing family health care to the communities;

4. 75% health post access to mobile phones and ambulance services by 2015;

5. Community Health Council established at all villages to promote community awareness.

	Strategy	Indicator	Target 2015	Target 2020	Target 2025	Target 2030
1.	Standardize human resources profile and infrastructures for HP, both type and location base on number of population and inaccessibility.	% of HP Staffs fulfilled base on standard	70%	100%	100%	100%
		Number of HP constructed	75	81	0	**0**
2.	Standardize comprehensive basic service package at HP level with emphasize on basic promotive, preventive, curative and rehabilitative care following national treatment guidelines.	% of BSP implemented at HP, following national guidelines	50%	75%	100%	100%
3.	Strengthen referral pathways for all levels of health care.	% mobile phonesand ambulance services at HP well established	75%	80%	90%	100%
4.	Promote community awareness and education on general well-being and healthy lifestyle for all age groups.	% village (sucos) health council well functioned	50%	75%	100%	100%

C. COMMUNITY HEALTH CENTRES

CHCs are defined as service delivery units under district health services which are responsible for Basic Service Package implementation at one sub district or at one coverage area.

Objectives: To provide comprehensive primary health care packages, including preventive, promotive, curative and rehabilitative health care to the community.

Strategies:

1. Standardize comprehensive basic service package at Community Health Center level with emphasize on basic promotive, preventive, curative and rehabilitative care following national treatment guidelines;

2. Standardize human resources profile and infrastructures for Community Health Center, both type and location base on number of population and inaccessibility

3. Strengthen referral pathways for all levels of health care;

4. Promote community awareness and education on general well-being and healthy lifestyle for all age groups.

Expected Results/ Key Indicators:

1. 100% of community health center providing comprehensive basic health service packages by 2020;
2. 80% health staffing requirements for CHC fulfilled base on standards by 2025;
3. 100% radio communication and multifunction vehicle well maintained;
4. All sub-district has Sub District Health Council to promote community awareness.

	Strategy	Indicator	Target 2015	Target 2020	Target 2025	Target 2030
1.	Standardize human resources profile and infrastructures for CHC, both type and location base on number of population and inaccessibility.	% of CHC Staffs fulfilled base on standard	50%	75%	100%	100%
2.	Standardize comprehensive basic service package at CHC level with emphasize on basic promotive, preventive, curative and rehabilitative care following national treatment guidelines.	% of CHC provide comprehensive BSP following national guidelines	50%	75%	100%	100%
3.	Strengthen referral pathways for all levels of health care.	% of Radio Communication and multifunction vehicle well maintained	75%	80%	90%	100%
4.	Promote community awareness and education on general well-being and healthy lifestyle for all age groups.	% Sub district health council well functioned	50%	75%	100%	100%

D. DISTRICT HOSPITAL – General hospital services providing four specialized areas as the referral for primary health care at District level.

Objective: to provide general hospital services able to complement comprehensive primary health care.

Strategies:

1. Establishment of general hospital services in each district;
2. Develop supporting mechanisms for provision of preventive, curative and rehabilitative care following national guidelines;
3. Strengthen referral pathways for all levels of health care;
4. Supporting pre-service and in-service training for health professionals;
5. Community empoweringtoparticipated in hospital quality improvement.

E. REGIONAL HOSPITAL– Autonomous regional hospitals providing eighteen specialized services as the referral for the district hospitals.

Objective: to provide specialised hospital services able to complement comprehensive primary and secondary health care.

Strategies:

1. Establishment of specialized hospital services in selected regions;
2. Develop supporting mechanisms for provision of preventive, curative and rehabilitative care following national guidelines;
3. Strengthen referral pathways for all levels of health care;
4. Supporting pre-service and in-service training for health professionals;
5. Establish health research unit;
6. Community empowering to participated in hospital quality improvement.

F. National Hospital– Autonomous national level hospital providing supra and sub specialized services as top referral hospital for the country.

Objective: to provide supra and sub specialized hospital services able to complement comprehensive primary and secondary health care.

Strategies:

1. Establishment of a supra and sub specialized hospital service for the country;
2. Develop supporting mechanisms for provision of preventive, curative and rehabilitative care at hospital level, following national guidelines;
3. Strengthen referral pathways for all levels of health care;
4. Supporting pre-service and in-service training for health professionals;
5. Establish health research and developing health technology;
6. Community empowering to participated in hospital quality improvement.

STRATEGIC DIRECTION FOR HOSPITAL SERVICES						
	Strategy	**Indicator**	**Target 2015**	**Target 2020**	**Target 2025**	**Target 2030**
1.	Establishment of district hospital services in each district	% of available four specialized comprehensive services with minimum staffing and equipments	30%	50%	75%	100%
2.	Establishment of specialized hospitals at Maubisse, Lebutu (Ermera) &Natarbora (Manatuto).	% of Regional hospitals available and with minimum staffing and equipments.	25%	50%	100%	100%
3.	Establishment of specialized hospitals at Maubisse, Lebutu (Ermera) &Natarbora (Manatuto).	% of Regional hospitals available and with minimum staffing and equipments.	50%	75%	100%	100%
5.	Strengthen referral pathways for all levels of health care	% of facilities with appropriate referral system in place.	50%	100%	100%	100%
6.	Expansion of Dili National Hospital to become the top National Referral Hospital, with a supra and sub specialized health care service for the country	% of supra and sub specialized comprehensive services available in the country	70%	100%	100%	100%

IV. 3 BASIC PACKAGES OF HEALTH SERVICES

LEVEL OF CARE	***REQUIRED SERVICE PROVISION***
SISCa	Basic health services provided by CHCs reaching out to communities following the principle of community empowerment to address key health needs at aldeia level: - Mapping of service coverage area and Family Health Registration - Ante Natal Care (ANC) - Post Natal Care - Family Planning Services - Nutritional monitoring, weighing and SFP distribution - Immunization, vitamin A and de-worming for children and pregnant women - Basic Medical Consultation to Children, Adolescent, Adult, Elderly and to the Disable - TB DOTs follow-up, case-finding and referral - Malaria testing and treatment (RDTs) - Non-communicable diseases follow-up - Health Promotion, information, Education and Communication (IEC) - Support of PSF to encourage community mobilization and education.

LEVEL OF CARE	*REQUIRED SERVICE PROVISION*
Health Posts	A unit of primary health care provision located at each Suco, under community health center that is the entry point for service delivery by the communities at Village level. - Mapping of service coverage area - ANC and Family Planning Services - Normal delivery with referral of complicated cases - Essential newborn care, including basic resuscitation - Observation services for Post Partum Care - Daily immunization program - Family Medical Services (including family files) for all age-groups; - TB DOTs follow-up, case-finding and referral - Basic Laboratory Services (Malaria and other simple blood examinations) - Cold Chain Management - Health Promotion, information, Education and Communication (IEC) in relation to behaviour change - Support of PSF to encourage community mobilization and education - Regular coordination meetings with local authority (Suco and Village heads) for improved service delivery - Submit health statistics and information to CHCs - Follow standard operational procedures for referral of patients.
Community Health Centers	Service delivery units under district health services which are responsible for Basic Service Package implementation at one sub district or at one coverage area. - Mapping of Service Coverage Area - Ante Natal Care (ANC) - Comprehensive Family Planning Services - Normal delivery with referral of complicated cases; - Provide Basic Emergency Obstetric Care - Post Natal Care and Essential New Born Care - New Born Emergency Care - Comprehensive Integrated Management of childhood Illness (IMCI) - Daily Immunization Program - Comprehensive nutrition activities, including Acute Malnutrition Management or JMAK - Treatment of malaria and dengue fever - Tuberculosis Treatment and DOTS - Diagnosing treatment of STIs/HIV - Leprosy Treatment - Mental Health Case treatment follow-up - Integrated General Medical Services - Cold Chains management - Emergency Services - In-Patient Services with maximum of 10 beds

LEVEL OF CARE	*REQUIRED SERVICE PROVISION*
Community Health Centers	Service delivery units under district health services which are responsible for Basic Service Package implementation at one sub district or at one coverage area. - Laboratory services (Malaria, TB, Urine Test and other blood examination) - Dental Services - Eye Care Services - School Health Program - Regular integrated community health services or SISCa - Outreach services to those services identified by and not available at health post - Health Education and Promotion in relation to behaviour and communication change - Surveillance epidemiology - Environmental health services (Water and sanitation, vector control and etc) - Supervise and provide mentoring to Health Post - Regular coordination meetings with local authority (Sub District, villages and sub villages) - Appropriate recording and reporting system, including consolidation of family health registration data and stablishment of family folder - Necessary Referral Services based on standards operational procedures - Laboratory services (Malaria, TB, Urine Test and other blood examination) - Dental Services - Eye Care Services - School Health Program - Regular integrated community health services or SISCa - Outreach services to those services identified by and not available at health post - Health Education and Promotion in relation to behaviour and communication change - Surveillance epidemiology - Environmental health services (Water and sanitation, vector control and etc) - Supervise and provide mentoring to Health Post - Regular coordination meetings with local authority (Sub District, villages and sub villages) - Appropriate recording and reporting system, including consolidation of family health registration data and stablishment of family folder - Necessary Referral Services based on standards operational procedures

LEVEL OF CARE	***REQUIRED SERVICE PROVISION***
District Hospitals	General hospital services providing higher level of services than the Sub-district Health Centre as well as four specialized areas as the referral for primary health care at District level. - Complicated curative cases requiring referral or in-patient treatment for children, adolescent, adult (men & women's health) and the elderly; - Newborn resuscitation using oxygen; - Basic Emergency Obstetric Care (BEOC); - Treatment for mental patients and the disabled; - Basic eye care and ENT screenings and referrals; - Dental services; - Outreach services to Sub-district Health Centres, Health Posts and SISCa Posts; - VCT activities/services and HIV testing and treatment.
Regional Hospitals	Autonomous regional hospitals providing eighteen specialized services as the referral for the district hospitals, with particular role of providing the following services: - Policlinics - Cardiac Centre - Obstetric &Gynechology services; - Pediatric Unit - Internal medicine with Specialised Services; - Specialised Surgery; - Psychiatric Unit; - Dermatology Unit - Ophthalmology Unit; - ENT; - Orthopedic Unit - Cardiac Centre; - Forensic - Radiology Unit - Physioteraphy Centre - Blood bank - Regular supportive outreach services to see referred patients at lower level facilities; - Ongoing practical training and mentoring of health centre staff in management of complicated patients; - Sound management of their own systems, to see only referred cases; - Supporting districts in establishing communication systems and protocols; - Clinical protocols for selection, documentation and care of transferees; - Return of patients when appropriate, with adequate and documented feedback.

LEVEL OF CARE	*REQUIRED SERVICE PROVISION*
National Hospital	Autonomous national level hospital providing supra and sub specialized services as a center for research, higher provision of care and top referral secondary and tertiary health services, including: - Specialized policlinics; - Obstetric &Gynechology services, including cervical cancer treatment; - Pediatric and Neonatal Unit - Internal medicine with Supra Specialised Services; - Specialised Surgery; - Psychiatric Unit; - Dermatology Unit - Ophthalmology Unit; - ENT; - Orthopedic Unit - Cardiac Centre; - Pathology Unit; - Anesthesis Unit; - ICU Unit; - Oncology Unit; - Renal and Dialysis Unit; - Hematology Unit; - Geriatrict Unit; - Forensic Medicine; - Radiology Unit; - Rehabilitation Unit with physio, speech theraphy and occupational therapy; - Contracting-out Pharmaceutical Services; - Infection Control Unit; - Quality Assurance Unit - Internship for newly graduated medical staff under direct supervision of senior health professionals; - Ongoing practical training and mentoring of clinical staff in management of complicated patients; - Sound management of their own systems, to see only referred cases; - Supporting districts in establishing communication systems and protocols; - Clinical protocols for selection, documentation and care of transferees; - Return of patients when appropriate, with adequate and documented feedback.

IV.4 NATIONAL PRIORITY HEALTH PROGRAMS

A. MATERNAL HEALTH

Maternal and newborn health in Timor-Leste has improved since independence in 2002, but much remains to be done to reduce the continuing high rates of maternal and newborn mortality.

In 2009, the proportion of women who use a skilled birth attendant for their delivery is still only 46% nationally although this is significantly improved from 2003 when it was 18%. Newborn care is particularly lacking, with only a small percentage having an early postpartum/newborn care visit by a skilled provider, and most midwives have not yet been trained in providing life-saving essential newborn care yet.

The main direct causes of maternal death are hemorrhage, infection, obstructed labor, complications of unsafe abortion, and hypertensive disorders (pre-eclampsia and eclampsia).

The key indirect causes are malnutrition, anaemia, and malaria. Although these complications cannot be predicted and mostly cannot be prevented, they can be treated with skilled care in accessible and well equipped centers[4] or hospitals. The practice of antenatal and postnatal care is not as yet common in Timor-Leste. Although more women attend ANC care, 86% according to the TLDHS 2009/10, the number of antenatal visits is radically different from district to district (70,5% in Ermera to 96% in Dili and Liquica).

Objectives: to improve maternal, ENC and newborn health through affordable, equitable and high quality continium of care services, as well as to avoid illness and diseases related to sexuality and reproduction.

Strategies:

1. Increase access and demand to high quality continium of care through pregnancy, ANC, delivery, postnatal as well as family planning health services, including hard reach population.

2. Improve emergency obstetric and newborn care through recognition, early detection and management of obstetric complication at the community and referral level.

3. Empower individual, families and community to contribute to the improvement of maternal care and reproductive health services.

4. Strengthen HMIS system at all levels through data collection and collaborative analysis.

5. Strengthen Adolescent Reproductive Health services by providing youth friendly services.

Expected Results/ Key Indicators:

1. 70% of pregnant women recurring to ANC and post natal care at least four times by 2015;
2. More than 40% of deliveries assisted at a health facility by 2015;
3. All CHCs providing BEOC and all hospitals providing CEOC Services with appropriate personnel and equipments in place;
4. Maternal death and perinatal audits are performed to all maternal deaths in all facilities;
5. Teenage pregnancies reduced by 30% by 2015;
6. Maternal mortality rates halted by 2015.

B. CHILD HEALTH

As stated in the National Development Plan, Timor-Leste is committed to improving child health. The indicators of progress by 2030 will be a reduction in the under five mortality rate from 61 to 27; a reduction in the infant mortality rate (IMR) from 44 to 21 and 15 deaths per 1,000 live births by 2030. Under five mortality means the number of children per 1000 children who died before their fifth birthday and infant mortality rate means the number of children per 1000 infants who died before their first birthday.

Objective: To improve, expand, and maintain the quality and coverage of preventive and curative services to newborns, infants and children in order to reduce infant and child mortality.

Strategies:

1. Develop a comprehensive child health policy.
2. Improve the capacity of the health system to support the delivery of integrated preventive, IMCI, essential newborn care and Community Case Management services (CCM).
3. Increase access and quality of immunization services.
4. Improve referral system in order to respond to child health specific needs.

Expected Results/ Key Indicators:

1. 100% of all hospitals provides quality pediatric services
2. Training centres for obstetric-nurses and midwives expanded for in-service programmes to specifically identified regions, with 70% of workplacement of required midwives;
3. 90% of immunization coverage maintained for BCG-POLIO-DPTHep B-Measles by 2015;
4. Infant and Under 5 Mortality Rates reduced significantly.

C. NUTRITION

The nutritional status of both children and adults in Timor-Leste remains significantly below acceptable world standards. As the National Nutritional Strategy notes, under-nutrition is brought about by a combination of broad economic, political, educational and cultural features of a society. Findings of the Timor-Leste DHS and more recent surveys highlight the enormity of the problem of malnutrition in young children and women in particular. For children:

- Almost 45% are underweight-for-age
- 15% are severely underweight-for-age
- Almost 58% of children under five years are stunted

- Almost 33% are severely stunted

Adequate nutrition in the first years of life is essential for children's physical and mental growth. Children who were malnourished as infants do not do well at school.

Overall adult nutritional status is also a concern, especially for women. More than a third of non-pregnant women aged 15-49 and a quarter of men aged 15-49 are reported to be chronically underweight with Body Mass Indexes below 18.5. Fourteen percent of women are shorter than 145 cm, at which level pregnancy and delivery complication risks increase significantly. High rates of malnutrition across all groups, but young children and women in particular, contribute to poor health status, poor educational performance, and low productivity for the nation as a whole.

These enormous nutritional challenges facing Timor-Leste require immediate and longer-term strategies encompassing inter-sectoral cooperation and operationalization at national, district and local (community and household) levels. The range of micro-policy documents that focus on aspects of nutrition provides an indication of its significance in influencing the health profile of the nation.

Objective: To reduce the incidence and prevalence of macro- and micro-nutrient deficiencies and associated malnutrition among vulnerable groups.

Strategies:

1. Promote diversity and consumption of locally produced food;

2. Improving mother and child (M&C) nutrition care practice;

3. Improve access and quality of nutrition services at facility and community levels for all live cohorts;

4. Promote advocacy, social mobilization and communication to ensure mainstream behavior change in nutrition;

5. Strengthen nutrition information management system and surveillance.

Expected Results/ Key Indicators:

1. National strategy for nutrition behavior change developed and implementation began by 2012;
2. 60% of children under 6 months old are exclusively breastfed and at least 50% of under 1 year old receives appropriate complementary foods in addition to breast feeding by 2015;
3. At least 50% of schools are implementing recommended feeding programmes by 2015;
4. Community engagement in nutrition and food security programs increased by 30%.

D. CONTROL OF COMMUNICABLE DISEASE

In recent years, vector-borne diseases have emerged as a serious public health problem in countries of the South-East Asia Region, including Timor Leste. Malaria is considered as the major vector borne disease in the country and accounts for about 95% of the all vector-borne disease cases reported in Timor Leste. Dengue, Lymphatic filariasis, chikungunya and Japanese encephalitis are the other vector borne diseases prevail in the country.

The ecology of Timor-Leste provides ideal conditions for breeding mosquitoes including those carrying disease. Climatic conditions combined with formation of breeding places suitable for vector breeding are conducive to endemic outbreaks. Not surprisingly, then, the country continues to endure an epidemiology of both endemic (malaria) and episodic mosquito-borne diseases (notably malaria, dengue, filariasis and Japanese encephalitis) second only to respiratory illnesses in terms of national morbidity and mortality.

Poorly designed irrigation and water systems, widespread poverty, inadequate housing, poor waste disposal and water storage, deforestation and loss of biodiversity, all may be contributing factors to the most common vector-borne diseases including malaria and dengue. Vector Borne disease control and prevention including vector control will be carried out under this programme as both parasite and vector control are very important components of the vector borne disease control.

i. MALARIA

Malaria is a major public health problem and the leading cause of morbidity and mortality in Timor-Leste, with approximately 200,000 clinical and confirmed malaria cases and about 20 to 60 deaths per year. The disease burden and economic loss due to the disease is enormous. Between 20 to 40% of all outpatients, and 30% of all hospital admissions present from symptomatic malaria. Malaria incidence is quite high among the under 5 years of age children group, which represents nearly 40% of the total cases. P. falciparum and P. vivaxare the major parasite species in the country and P. falciparum accounted for 64-73% of the confirmed malaria cases from 2005 to 2010

Malaria Control was improved in last two years in the country. Incidence of Malaria in 2009 was 120 per 1000 population. Number of malaria cases decreased by 34% in 2008 compared to 2007. This may be due to reduction of cumulative number of chloroquine resistant P. falciparum malaria cases who were treated as clinical malaria cases after introduction of Rapid Diagnostic Test kits which detect P. falciparum and treatment with Artemisinine Combination Therapy (Atremether/ Lumefanthrin combination therapy), improved surveillance and distribution of Long Lasting Insecticide treated nets to the high risk areas.

Considerable opportunity exists to reverse national epidemiological trends of malaria if adequate resources and human skills can be mobilized to address vector control, improvement he access to the remote areas where incidence of malaria is high and intersectoral collaboration. There is a need for vector control under the National Malaria Control Programme.

Objective: to reduce morbidity and mortality due to malaria to a level when it is no longer a major public health problem.

Strategies:

1. Enhance case management through early case detection and delivery of effective antimalarial therapies.

2. Selective application of vector control measures based on the principles of Integrated Vector management.

3. Epidemic preparedness and outbreak response.

4. Enable and promote research for improved policy formulation.

Expected Results/ Key Indicators:

1. Intregrated Vector Control Policy Developed and implementation starts in 2012;

2. Reduction of number of deaths due to malaria by less than 41 in 2015;

3. Incidence of malaria reduced to 150/1000 population;

4. 100% of health staff implement National Malaria Treatment Guidelines;

5. At least 48% of district and subdistricts focal points recruited for malaria and other vector-control diseases;

ii. TUBERCULOSIS

Tuberculosis is a public health problem in Timor-Leste. The latest estimates suggest that the incidence of new smear positive TB cases are 145 per 100,000 population annually which is second highest in the South East Asian Region. As per WHO Global TB Report 2010 the prevalence of all forms of TB is 378 per 100,000 populations.

DOTS implementation

The globally recommended DOTS strategy was introduced in the country in 2000 by Caritas Dili, a NGO through a network of catholic clinics. By 2004 DOTS expansion to the entire country had been achieved. The National TB Control Programme (NTP) was formally established within the Ministry of Health only in 2006 following the handing over of the management of TB control services from Caritas Dili during 2005.

The NTP now implements most of the Stop TB Strategy interventions in all the 13 districts and 65 sub-districts of the country. Since 2000 till December 2009 the NTP has put on treatment 36,307 TB cases on DOTS treatment. The Programme has been regularly achieving treatment success rates of around 80% since 2002 with the expectation of cohort of 2005. However, the cases detection rates have generally been below the global target of 70%. To address this issue NTP has initiated measures including strengthening the laboratory network, training of health staff, active case finding and improving referral linkage. These initiatives have shown result and case detection has shown upward trend in the later quarters of 2009.

The National TB Programme of Timor-Leste has for first time in 2009 achieved the two key global TB control targets. NSP case detection rate of 75% (1206 out of estimated 1616 NSP cases) and a treatment success rate of 85% have been achieved by the programme. A total of 4,759 TB cases (all forms) were registered on treatment.

Laboratory network

A network of 19 designated microscopy centres (DMCs) provides quality assured smear microscophy examination for all TB suspect. These DMCs are based in Community Health Centres (CHCs) and NGO facilities. Other CHCs also support smear examination and coordinate with DMCs so that TB suspects can be appropriately evaluated. The NTP has established linkages with Institute of Medical and Veterinary Sciences (IMVS), Adelaidewhich is the supranational reference laboratory supporting training and supervision along with external quality assurance of sputum microscopy. IMVS, Adelaide also provides mycobacterial culture and drug susceptibility testing facility to the NTP of Timor-Leste.

Treatment management

NTP uses three treatment regimens which include Rifampicin in the intensive phase of treatment. Direct observation of treatment is provided by health staff and community volunteers including cadre of Family Health Promoters (PSF). Quality assured drugs are provided free to all registered TB patients as part of the Basic Services Package of trh Ministry of Health.

The programme has a robust recording and reporting system that captures data on case finding, treatment outcomes and programme management parameters. The recoding and reporting system was revised in 2008 and an Excel based data management system put in place in 2009 which facilitates data entry and analysis.

MDR-TB and TB/ HIV

A MDR-TB management project was formally launched in the country on 24th March 2008. A MDR-TB management site has been established in the NGO facility of KliburDomin as a Public Private Partnership model. This NGO facility has been identified for in-patient management of MDR-TB cases for the initial phase of treatment and later if required. Till date three cases have been registered on treatment but none are currently continuing treatment.

TB/HIV coordination is being roll out keeping pace with expansion of the HIV counseling and testing sites. Currently, two sites have initiated cross referral. TB Responsible, one from each districts have been trained to identify high risk behaviour and offer HIV counseling and testing.

Partnerships

A number of NGOs are involved with the NTP providing TB services to the community. Among these are the Catholic Clinic network supported by CARITAS, the Café Timor clinics, the Catholic Relief Services, Ryder-Cheshire centre, KliburDomin and the BairoPite Clinic in Dili. The eight Catholic clinics offer diagnostic and treatment services supported by the NTP, and also run the albergues. There are 162 expatriate doctors from Cuba working in the country, under the terms of an agreement between the two Governments. General physicians are posted at all CHCs in the country. Specialists are posted in the 5 referral hospitals and in the National Hospital in Dili. The Cuban doctors are all trained and aware of NTP guidelines.

The government of Timor-Leste accords high priority to TB control interventions. TB control is a major component Basic Services Package delivered through public health care facilities. TB care is being taken to the hard to access communities in remote areas through the pioneering SISCa initiative of the Ministry of Health. SISCa focuses on reaching out to communities in remote rural areas of the country through wider and active participation of the community itself.

The major sources of funding for the NTP currently are Government resources for salaries of health staff throughout the public healthcare network and health infrastructure. External source of funding is mainly through the Global Fund Round 7 grant. Global Drugs Facility and UNITAID had in previous years provided commodity assistance in form of first and second line drugs. From 2009 anti-TB drugs are being procured from GDF. The World Health Organization provides technical support to the Ministry of Health and the National TB Programme.

Objectives: to reduce the morbidity, mortality and transmission of tuberculosis.

Strategies:

1. Enhancing access to TB diagnostic and treatment services that are accountable to clients and based on human rights approach;

2. Scale-up of response to emerging challenges of HIV-TB and MDR-TB;

3. Strengthening system to effectively deliver quality services to all TB patients with complementation from NGOs/ CBOs/ FBOs;

4. Promoting adoption of international best practices amongst all care providers;
5. Innovative community lead initiatives for delivering care and support for TB patients;
6. Research to collect relevant baseline data and monitoring efficacy of interventions in local context;
7. Adopting partnership approach to involve all national and international stakeholders working with the national TB programme.

Expected Results/ Key Indicators:

1. More than 85 % of new smear positive cases successfully treated out of new smear positive registered;
2. All health facilities reporting no stock-out of anti-TB drugs and 100% of district health facilities conducting TB/HIV intervention on PITC and cross referral is available by 2015;
3. All training institutions incorporate DOTS and DOTS Plus in pre-service training curriculum of medicine, nursing and pharmacy;
4. More than 65% of private health providers are involved in community and patient groups to ensure appropriate implementation of TB programme;
5. Significant reduction of TB Incidence and prevalence rates reported every four years.

iii. HIV/AIDS

Currently, the National HIV Program receives the majority of it's funding through the GFATM Round 5 grant. The grant covers a range of Most at Risk Group (MARG) which includes Men having Sex with Men (MSM), Female Sex Workers (FSW), clients of FSW and people in the uniformed services.

To date, there are 11 Voluntary and Confidential Counseling Centres (VCCT) available through the National and 5 referral hospitals, 3 CHC's and 2 private health clinics. HIV related services that are available to both the general population and high risk groups include HIV counseling and testing, community outreach, treatment of opportunistic infections including Sexually Transmitted Infections and socio-economic support to people infected and affected by HIV.

National and district level laboratory services work concurrently with VCCT services; additionally, community level care services, which includes VCCT, receive support from Ministry of Social Solidarity and NGOs.

From 2003 until December 31st 2009, a total of 151 cases of HIV infections have been reported, with 20 cumulative deaths (5 children, 15 adults). Data reflects that out of those 151 cases that 47% are female and 53% are male. There are currently 31 people on treatment, including 3 children, National data shows that of those who are HIV infected, 11% were children < 15 years old, 60% are between 15-29 years, 40% are between 30-44 years and 10% are greater than 45 years of age.

Most infections appear to have been acquired through heterosexual contact. Given this scenario, the program focus is twofold: to promote behaviour change communication through awareness, health promotion, SISCa and VCCT and to provide treatment, care and support to all HIV infected and affected persons through high quality treatment and care services.

Objective: to prevent further spread of HIV infection within the vulnerable populations, to limit its spread to the general population and mitigate the impact on individuals, families and the community through comprehensive treatment and care of all infected and affected persons of Timor Leste.

Strategies:

1. Strengthening National AIDS Commission (NAC) to monitor and provide oversight for National HIV/AIDS program.

2. Strengthening monitoring and evaluation and capacity building of human resources.

3. Prevention of HIV/STI infections through awareness, enabling environment and promoting behaviour change communication.

4. Establishing high quality counseling, testing and diagnostic facilities for identification and monitoring of HIV incidence.

5. Treatment and care to all HIV infected and affected individuals.

Expected Results/ Key Indicators:

1. HIV-AIDS Strategies developed and full implementation occurs in at least 50% of health facilities;

2. 100% of identified community networks have established peer education program in all districts;

3. 100% of established ART Centers providing treatment by qualified and trained health staff by 2015;

4. Community based palliative care protocol developed and implemented with 25% of AIDS patients receiving continuous care by 2015;

5. Orphan care protocols developed and implemented with 25% of orphans provided with basic health and psychosocial services.

iv. LEPROSY

In August 2002, in two sub-districts of Oe-cusse in Passabe and Nitibe, a house hold survey was conducted by The Leprosy Mission Timor-Leste (TLMI). The result indicated hyper-endemic rates of disease (Nitibe 84.7 and Passabe 28.0 per 10,000 populations, respectively).

In 2002 the Ministry of Health (MoH) in collaboration with WHO and TLMI formulated a National Strategy for Leprosy Elimination. The programme in Timor-Leste commenced slowly in 2003 and by 2007 MDT cover age had reached all 13 districts. Since that time districts have reduced the rate of leprosy.

As of 31st December 2010, the over all prevalence rate of Leprosy at national levelis 0.73 per 10,000 populations.

Objective: to eliminate leprosy at a sub national (district) level in Timor-Leste.

Strategy:

1. Continue with the National Leprosy program with particular focus on districts where prevalence>1 per 10,000 population.

2. Empower the community to seek early diagnosis and treatment.

3. Increase technical and management capacityat all levels.

Expected Results/ Key Indicators:

1. Leprosy will be eliminated at a sub district level by 2015;

2. 100% of SISCa activities delivering education on leprosy;

3. All patients requiring rehabilitation services will be appropriately referred as needed by 2015;

v. LYMPHATIC FILARIASIS

The Millennium Development Goals (MDG), in particular MDG6, refers to the benefit of controlling HIV/AIDS, malaria and TB plus 'otherdiseases'. The 'other diseases' include intestinal worms and lymphatic filariasis.

In 2002, the Ministry of Health with technical assistance from WHO and the Lymphatic Filariasis Support Center, School of Public Health, Tropical Medicine, and Rehabilitation Sciences, James Cook University in Townsville, Australia, conducted a survey to determine the magnitude of various neglected tropical diseases in Timor-Leste. The country-wide prevalence of LFwas found to be 10.6%, indicative of the need to develop a national strategy.

In 2005, in response to these findings and based on successful mass drug administration (MDA) programmes in other countries, a programme was launched aimed to eliminate LF and control

STH in Timor-Leste. The Timor-Leste programme which was known as '*Lumbriga…maklaeduni!*' or "*Worms…no way*". Unfortunately the programme continued for three years before faltering.

Objective: to establish and continue a programme for the elimination of LF and integrated with the control of intestinal parasitic infections.

Strategies:

1. Developa national strategic plan for neglected tropical diseases (NTD) by 2013;

2. Establish collaboration with development partners for the implementation of NTD programme, ensuring budget availability;

3. Ensure the implementation of integrated NTD programme by 2014.

Expected Results/ Key Indicators:

1. More than 80% of eligible people receiving yearly doses of LF treatment;

2. Patients requiring rehabilitation services are appropriately referred;

3. LF and yaws eliminated in Timor-Leste by 2020.

vi. OTHER ACUTE & VIRAL INFECTION DISEASES

Incidence other disease seen in Timor-Leste such as dengue, diarrhea/ dysentery and respiratory infections, pneumonia and skin diseases (frambusia / yaws) caused by bacteria and food poisoning can also appear at any time depending on the condition of one's personal hygiene.

The Ministry of Health, through the CDC department,has developed a work plan and strategic plan in order to respond to emerging and re-emerging diseases that have been mentioned above, and also need to develop the Human Resource in order so that the program going well according to the work plan.

Objective: to reduce the onset of emerging and re-emerging diseases.

Strategies:

1. Establish port health program and port health field offices in port of entry as part of preventing the risk of international spreading diseases through effective public health measures and response.

2. Establish international / regional networks.

3. Strengthen capacity of national health staff at Point of Entries (PoEs) on implementing the International Health Regulation (IHR).

4. Improve coverage and quality of dengue control program.

5. Improve community awareness on dengue

6. Develop of guideline and mechanism of Outbreak Response for other acute and viral infection diseases.

7. Streng then Monitoring & Evaluation.

Expected Results/ Key Indicators:

1. National Port Health Policy developed and implementation begans by 2012;

2. 50% of inter-sector and regional networks established to prevent risk of international spreading diseases;

3. All laboratory technicians and clinicians are trained on dengue detection and can treat suspected cases;

4. Emerging diseases Information System developed by 2015.

E. CONTROL OF NON-COMMUNICABLE DISEASES

i. MENTAL HEALTH & EPILEPSY

The Department of Mental Health, *Saude Mental*, is responsible for the coordinating management of comprehensive care of mental disorders, substance abuse and people with neurological disorders such as epilepsy. There are limited number ofmental health specialists working for the public health sector (1 in each district, 2 in Dili and Oecusse), as well as trained general nurses (in 25% of CHCs), adopt a bio-psycho-social-cultural-spiritual model for both aetiology and management. *Saude Mental* works closely with other relevant organizations, including mental health NGOs, hospital services, and police services, to ensure a strong referral pathway network.

The Department works to carry out its National Mental Health Strategy and National Epilepsy Protocol at all levels of the health service. Key guidelines in the strategy include: (a) the prioritization of managing severe mental illness; (b) meeting the country's mental health needs by a community-based service that is integrated into the mainstream health program and is accessible, responsive and at no cost to the population; (c) basing the mental health service on a comprehensive approach to therapeutic interventions (i.e. not restricted to drug therapy), with a strong focus on counseling and family involvement that is consistent with indigenous models of care.

The most common disorders are depression, anxiety and stress disorders. Many sufferers do not seek professional care even when it is available. Some of the less common disorders, such as the psychoses (life time prevalence of 1-2%) are the most disabling and most sufferers need extensive professional assistance. Overall, WHO estimates that between 1-2% of the population

in any country requires mental health care at any one time. This means in Timor-Leste, between 11,000 and 22,000 people require mental health assistance. In 2009, there were 3743 mental health patients in the caseload for Timor-Leste. This is 17–34% treatment coverage for mental disorders.

Constraints to the development and delivery of a mental health service in Timor-Leste include:

- The absence of a tradition of providing any mental health services prior to independence.
- Operating within the still emergent public health care services where demands for all aspects of health care are substantial.
- Consolidating commitment to mental health at all levels in society and the Ministry of Health, and translating this commitment into durable operational procedures.
- Addressing the additional vulnerabilities and special needs of a population exposed to conflict, disruption and poverty.

The implementation of mental health programmes is impeded by underfunding, stockouts of mental health and epilepsy medicines, delayed of mental health law and negative attitudes of some managers which hinder integration with other programmes.

Objectives: to provide a high-standard, comprehensive mental health service across the country and at all levels of the health system, including advocacy, education, prevention, diagnosis, treatment and follow-up services.

Strategies:

1. Improving access to health facilities and treatment for all people with mental illness or epilepsy.
2. To ensure a comprehensive multi-disciplinary team consisting of psychiatrists, psychiatric nurses, psychologists, and mental health technical professionals, who have been appropriately skilled and have reached specific standards of training.
3. Increase community awareness and understanding of mental illness and epilepsy through advocacy, education, and promotion.

Expected Results/ Key Indicators:

1. Increase % of mental disorders and epylepsi treatments, monitoring and evaluation at district and hospital services;
2. Acute Care Facility established at National Hospital and at least two established at referral and district hospitals by 2015;
3. Inclusion of Mental Health modules at D3 Curriculum for Nurse Trainign and scholarship training provided overseas;
4. 65% of health facilities have access to mental health education and promotion materials.

ii. ORAL HEALTH

Following the principles defined in the Ottawa Carter for health promotion (1980) oral health is seen as a priority within a range of essential health intervention that should be available to the population. In this sense health promotion means building healthy public policy, creating supportive environment, strengthening community action, developing personal skills and re-orienting strategy ensures people are working together within and cross sectors and communities in order to provide programs and initiatives that involve a wide range of interventions to improve oral health status.

Dental caries, periodontal, pulpties disease, perapical disease and facial infection affect most people in Timor-Leste, related primarily to diet, poor oral hygiene and less than optimal exposure to fluoride. Even preschool children commonly have decay. Oral cancer has the potential to be a major concern for older adults, due to the high prevalence of smoking and betel quid chewing. Oral diseases can largely be prevented through public health strategies and changes in personal oral health behaviours. Priority groups identified for oral health promotion in Timor-Leste include children, pregnant women, and mothers of young children, smokers and better quid chewers.

The most common oral health problem is the high incidence 40% of dental caries amongst the Timorese population 2009. This is a progressive, infection disease, which may result in tooth loss, unless timely restorative treatment is provided. A neglected carious lesion will continue to destroy the tooth, eventually resulting in pain, acute or chronic infection, and the need to extract the tooth.

Treatment of these problems is far beyond the capacity of the existing oral health workforce and the budget of the MoH. The appropriate response must therefore be to focus on oral health promotion and the prevention of oral diseases, while making emergency care available throughout the country.

Currently there are seven dentists, 40 dental nurses with an average of dental nurse per 27.018 populations. Most oral health workers are employed by the Government and worked in hospitals and health centres spread across 13 districts.

Objective: to improve oral health of the Timorese People by establishing an appropriate and affordable oral health services that is accessible to all.

Strategies:

1. To ensure access to appropriate oral health services to the population at all facility levels.

2. To reorient clinical service delivery from a curative model of care to a blend of promotive, preventive and curative interventions.

3. To promote community awareness and participation in priority target groups who are at risk of critical oral conditions.

Expected Results/ Key Indicators:

1. Increased number of scholarship opportunities to oral health professionals such as Dentists, Dental Nurses and Dental Techniciens;

2. 75% of health centres implements oral health programmes;

3. Baseline data on periodontal diseases and oral cancer in Timor-Leste registered and targets set by 2013;

4. At least 35% of primary and secondary schools participate in oral health promotion and education activities.

iii. EYE HEALTH

The 2005 Timor Leste Eye Health Survey to the national population, showed that approximately 47,000 people in Timor Leste over the age of 40 are vision impaired (worse than 6/18 better eye). Cataract and refractive error, conditions treatable by surgery or spectacles, caused approximately 90% of vision impairment.

Those people most likely to be vision impaired are older, illiterate, not in paid employment, living in a rural area and unmarried. The 2005 Eye Health Survey results indicated that although most (91%) of the sample reported a previous or current eye or vision problem, only 34% of these had ever used eye health or vision services. The most common reasons for not using services were lack of awareness of service availability (34%), being unable to afford transport (12%), feeling that having a vision problem is part of aging (9%) and that the service is too far away (9%).

Illiterate people, those living in a rural area, and subsistence farmers were less likely to report a history of an eye or vision problem, or to utilise services. Awareness of eye and vision problems, and the availability of services, was identified as a major barrier to service utilisation.

Objective: to reduce the prevalence of eye health problems by 75%.

Strategies:

1. Increase access to comprehensive high quality eye care services.

2. To strengthen and increase community participation in the eye care program at SISCa level.

3. Increase capacity of health staff to deliver eye care services.

4. Strengthening management of basic eye care services at all level.

Expected Results/ Key Indicators:

1. Developemtn of eye care medium-tem strategic plan by 2012;

2. Health facilities fully equipped and appropriately staffed to implement eye care programme increased to 25% by 2015;

3. Subspecialised eye care services available at National Hospital by 2020

F. OTHER EMERGING DISEASES

In Timor-Leste, the population of people aged over 60 years is expected to increase from 52,950 people in 2005 to 119,150 people in 2030, a rise from 5.38 to 6.05 per cent.The majorities of the ageing population live in rural areas and have more obstacles to overcome in accessing primary health care than those older people living in urban areas. They are generally not able to access the health centres due to lack of transport, geographical distance, poor infrastructure with roads in poor conditions, physical disabilities or unavailability of funds and physical help for travel.

The health policies of Timor-Leste have focused primarily on controlling communicable diseases and maternal and child health, however it is now facing a double burden with the increase in prevalence of chronic diseases. Due to lifestyle changes, poverty and environmental changes, many of the diseases and disabilities of older people are now chronic diseases. These diseases take a long time to develop and become disabling but also have lasting effects if not managed properly. As the population ages these non-communicable lifestyle-related and environment based diseases become an increasingly important component of the health needs of the population.

Chronic illness and disability impose high ongoing costs on individuals, families and societies. Poor health reduces the ability of older people to actively participate in and contribute to their families, thus increasing their isolation and dependence.

The WHO, Mortality Country Fact Sheet 2006, states the top ten causes of death for all ages in Timor-Leste, 2002, included the following chronic diseases:

- Ischemic Heart Disease
- Cerebra-vascular Disease
- Chronic Obstructive Pulmonary Diseases
- Hypertensive Heart Disease

In order to cope with the increasing burden of chronic illnesses, there needs to be an innovative approach including disease management within health care services, health promotion and disease prevention in the community.

Objectives: to strengthen and improve the provision of chronic health care services and programs in Timor-Leste.

Strategies:

1. Increase access and quality of age-friendly and old-age specific health services, with a focus on improving the skills of primary health care providers and introducing strengthening community models, such as home care programs;

2. To establish an Early Detection of Disability Protocol for children (Developmental Screening);

3. Increase skills of health staff to manage Chronic Diseases.

Expected Results/ Key Indicators:

1. 65% of existing and new facilities are built according to national standards for accessibility in order to allow easy access for disable persons and the elderly;
2. 100% of targeted population receiving home visits by 2020;

3. Cardiac centre, renal central and palliative care units established and fully operational at HNGV by 2015;

4. 100% of health facilities fully equipped and staffed for management of chronic diseases by 2020.

G. ENVIRONMENTAL HEALTH

i. Access to drinking water

Overall 53.1% of households obtain their drinking water from a protected source (either piped water, protected well or hand pump, tanker or bottle water), but this varyby districts being highest in the urban region (76.3%) and lower in the rural areas (rural east 22.3%; rural central 55.7% and rural west 60.7%, piped water is the main source of water in all regions except rural east. Springs are the main source in rural east and the second main source in rural central and rural west. For over one-third of households water was ten or more minutes away. TLSLS 2007 showed increased access to drinking water by 64.7%.

ii. Access to sanitation and hygiene

In 2003 , seventy percent of households had inadequate toilet facilities, with 51% using open areas, particularly bush/forest/yard and 19% using pit toilets. Around 30% of households had a private toilet while 2% used shared public toilets. A much higher percentage of urban households than rural households had access to a private toilet (DHS, 2003).

In one quarter of cases where a household had a well it was less than 10 meters from a cesspool. In the urban region this was true for 36% and in 55% of cases the distance was less than 15 meters. The situation may be worse than these figures imply. Nearly 20% reported not knowing. This response came primarily from respondents who did not have a well on the premises and hence were less likely to know.

Unfortunately in Timor-Leste, a significant number of the population does not relate dirty hands and unhygienic practices to disease and illness. And for many who do understand, the inability to access to washing facilities, in many homes and public places, does not allow them to do so, Schools, government, private building and public toilets are often without soap and water and public eating-places are rarely so equipped. Advice that can't be applied is useless.

iii. Food safety

The consumption of locally produced food is common across Timor-Leste. With the primarily rural population, there are few processed and packaged foods are available, with large volumes of

fresh food being traded in village and central markets. Food eaten outside the home is typically prepared by either stationary or mobile street vendors. The concern for food safety in Timor-Leste is related to poor preparation, handling and storage of food, lack of infrastructure such as potable water and refrigeration and lack of awareness about food safety and hygiene. In 2002-2009 there were 223 food-poisoning cases.

Timor-Leste has yet to develop systems and infrastructure to respond to existing and emerging food safety problems because of an insufficiency of surveillance information, a lack of trained environmental health officers and the lack of an appropriately equipped, staffed and financed laboratory.

iv. Vector Borne Diseases

In the recent Demographic and Health Survey, 2010, it is reported that a comparatively high 19% of all children had suffered from un-categorized fever in the two weeks prior to the survey. It is suspected that the majority of these cases would be related to the malaria disease. Regarding mosquito nets, nearly half (46 percent) of Timorese households own at least one, treated or untreated, mosquito net. Most of these nets (42 percent) are Insecticide Treated Nets (ITN). Ownership of any type of net is higher in urban than in rural areas.

More than two-fifths of children under age five and pregnant women (42 percent each) slept under an ITN the night before the interview. In the first 4 months of 2005, over 1100 confirmed cases of dengue were recorded in the National Hospital Dili with an alarming 39 deaths recorded. Alone these two vector borne diseases demonstrate the prevalence of mosquito borne diseases and the social and economic impact that they have on the population and development of the nation.

Observation of urban and rural areas across Timor-Leste identifies evidence of human habitats, agriculture, industrial, road-building and other developments that create mosquito breeding habitats.

v. Waste Management

Waste management practices are less than ideal in Timor-Leste. In urban areas refuse is generally placed in large open street-level bins through which pigs, dogs, goats and poultry scavenge. More waste accumulates on footpaths, streets and in other public areas. Waste is frequently raked into heaps and burnt. Amongst that which is burnt are highly air polluting plastic wastes. Storm water drains collect waste as well as being used to dispose of waste in urban areas. This waste clogs the drains and eventually flows to the sea and back onto beaches. Waste also provides breeding places for disease spreading vermin and insect vectors such as mosquitoes.

The burning of refuse produces health-damaging air pollutants, fine particulate matter, volatile organic compound and greenhouse gases. The burning of plastic wastes, as is so common Timor-Leste, is particularly damaging to health and the environment.
There is some attention to waste removal. Refuse collection contractors sweep the footpaths and streets and collect from the open street bins.

vi. Air Pollutions

Air contamination in Timor-Leste comes primarily from fires (burning domestic and landfill rubbish, clearing land and grass burning, domestic cooking) plus vehicles with high levels of exhaust emission, power plants, small industry (solvents, exhaust fumes, vapours, generators), cigarette smoking and possibly burn-off from oil refineries. Chemical spills and other industrial accidents are possible.

The vast majority of households are dependent on firewood for fuel, 93% in urban areas and nearly 100% in rural area (DHS, 2003).

This air pollution and the majority of air pollution in Timor-Leste are man-made and therefore controllable. It is generated from domestic, communal, small holding/agriculture and government facilities and can seriously affect individuals, groups and whole communities. Government regulation requires strengthening and the community, as individuals and as groups, must change behaviours through increased knowledge, better use of resources and support to enable problems to be identified and new practices introduced.

It is these two key areas that the MoH will play an important role by contributing to debate in the development of effective legislation, regulation and user-friendly guidelines in an inter-ministerial setting. In its own right, the MoH has the role to develop and disseminate behaviour change materials and opportunities such as the facilitation of effected group participation in identification of air pollution issues directly affecting them and identifying and implementing practical options for cleaner air activities.

Objective: to have improved quality of the environment in order to enhance wellbeing and reduce the risk of illness, injury and/or death.

Strategies:

1. Develop effective policy and planning system in the area of environmental health;
2. Improve resources and support system;
3. Improve environmental health service delivery;
4. Promote community involvement, gender and ensure social equality in the area of environmental health.

Expected Results/ Key Indicators:

1. 100% of policies designed and applied for sanitation, water quality, vector control, food safety and waste management by 2015;
2. Resources and support systems such as qualified staff, supplies and equipments, planning and monitoring and evaluation system in place by 2015;
3. 60% of population have access to basic sanitation and clean water by 2030;
4. 40% of household reach category B of healthy house standard (based on KUBASA) by 2030;
5. All health facilities and public have appropriate waste management system by 2020.

H. HEALTH PROMOTION

In 1986, the Ottawa charter redefined health promotion as "the process of enabling people to control over, and improve their health." It is therefore crucial for the health system to empower individuals, families and communities to practice healthy behaviours. Therefore, and as described in the Behaviour Change Communication (BCC) Framework for health promotion, the health promotion department of the MoH will use "a set of integrated interpersonal, community-based and mass communication strategies, working along with community members and organizations, local institutions, research groups, national and community radio stations, national television and newspapers, health personnel and other stakeholders at district and national levels."

Health promotion will focus on behaviour change interventions at settings, such as SISCa's, schools, churches; targeting health issues or problems, such as malaria, hygiene, immunization...; and targeting population groups, such as infants, children, pregnant mothers. Community development and adult-learning principles and approaches will be applied throughout all behaviour change interventions.

However, promoting healthy messages to communities cannot guarantee changes in behaviours if the environment in which people live is not supportive for practicing those behaviours. Health promotion should generate living and working conditions that are safe, stimulating, satisfying and enjoyable. For doing this, partnerships should be developed with civil society groups, opinion leaders, churches, public figures and other players, such as media.

As an overarching strategic imperative, health promotion must become one of the central components of the mission of the MoH. Significantly greater attention – and resourcing – needs to be given to institutionalizing health promotion as a core component of the role of all health care providers.

Objective: to improve the capacity of individuals, families, and communities to live a healthy life and to create a healthy environment that is conducive to practicing healthy behaviours, for improving the health status of the people of Timor-Leste.

Strategies:

1. Revise and update the current National Strategy for Health Promotion (NSHP).
2. Empower the community, by placing the people as partners and actors able to help each other in solving their own health problems and adopt healthy behaviours.
3. Strengthen partnerships to create a supportive environment for behaviour change.
4. Integrate the health promotion approach into health programs.
5. Build the capacity of all health promotion personnel at all levels.

Expected Results/ Key Indicators:

1. National Health Promotion Strategy updated and adoption of key healthy behavious adopted by 50% by 2015;
2. 90% of schools have a school health focal point, a handbook and curriculum by 2020;
3. 90% of health personnel trained in health promotion (including BCC).

SECTION V:
HUMAN RESOURCES FOR HEALTH

SECTION V: HUMAN RESOURCES FOR HEALTH

V.1 DEVELOPMENT OF HEALTH HUMAN RESOURCES[12]

Availability of appropriate human resources at all levels of health care is a critical factor in ensuring the delivery of efficient and effective package of health services to all.

Currently, Timor-Leste suffers from an overall deficiency of human resources for the health sector. There is a shortage of health workers and glaring skills imbalances within the existing workforce. Health workers are unevenly distributed between urban and rural areas, and between the public and private sectors.

The working environment, with deficient equipment, shortage of drugs and irregular supervision, saps morale and effectiveness. There is, as well, a weak knowledge base in skills and competencies. These problems are interrelated and hamper planning and service delivery.

In the NHSSP, human resource development refers to a broad concept. It encompasses four major areas:

- Workforce planning, focusing on initial and ongoing assessment of the need and demand for health workers and related deployment issues
- Pre-service education and continuing professional development and in-service skilling of the various occupational groups within the health workforce, and their licensing, re-certification and regulation requirements
- Personnel management and direction of human resources in the public sector in terms of performance standards and assessment, orientation/induction, conditions of work (based on job analyses and job descriptions), remuneration and motivation/incentives, and career pathways
- Occupational health & safety

Objective: to produce adequate numbers and skills of the different cadres of human resources for the health sector.

As per new projected health services configuration by 2030, thestrategyshould respond to health system strengthening by focusing both on management and clinical needs as a whole. They are:

1. Ensure the availability of HR for Health Development Plan.
2. To develop the capacity of training and education institutions on production of qualified health human resources.
3. Create enabling environment to improve performance and work motivation of existing and newly recruited workforce.

[13] Road Map for development of health professionals is attached in Annex C.

4. Develop and implement mechanisms for registration, regulation and quality control of all health practitioners.

Expected Results/ Key Indicators:

1. National human resources development plan for health elaborated and endorsed by the Government by 2012;

2. % of HR Gaps filled every five years;

3. Staff/Population Ratio clearly identified by 2013;

4. National Curriculums developed for major health sciences and health leardership management by 2012;

5. National training institutions with regionally recognized accreditations by 2015;

6. Integration of HR data into the HMIS by 2013.

V.2 MANAGEMENT OF HEALTH HUMAN RESOURCES

Effective human resource management can contribute greatly towards improvement of performance of health personnel. The MoH organizational structure callsforresponsibilities for staff management to be decentralized, with responsibility for specific tasks and decisionmaking at the local level, a focus on performance (outputs and outcomes), a patientorientation,and rewards or incentives for good performance.

Major expansion of integrated health services into the community poses a substantial challenge to the supervisory capacity of available qualified health workers to oversee the operations of a large number of less skilled community workers.

A key human resources challenge concerns compensation norms as public remunerations are often too low to motivate workers, and policy to guide international agencies to apply standardized rates is currently lacking.

Objective: to promote excellence and ethics in all cadres of health professional functions.

Strategies:

1. Strengthening leadership, management, supervision and accountability, all with a view to enhance health worker motivation and performance.

2. Redeployment of staff (over- and understaffing) addressed, in particular redeployment of nurses and midwives to accelerate BSP implementation at lower levels and redeployment of doctors to poorly staffed CHCs and district hospitals

3. Creating an enabling environment (norms, values, guidelines and tools) for health workers to improve their performance.

Expected Outcomes/ Key Indicators:

1. Mechanisms for making managers at all levels accountable for the results they are expected to achieve in their work plans designed and implemented, and tools for rewards/sanctions in place by 2014;

2. Computerized staff tracking system in place and maintained at central MoHon the basis of regular reporting by all central, districts and personalized health services by 2015;

3. Comprehensive human resource management guidelines elaborated and adopted in 2012;

4. Overall improvevement in the application of staffing rights and obligations.

SECTION VI:
HEALTH INFRASTRUCTURE

SECTION VI: HEALTH INFRASTRUCTURE

VI.1 BACKGROUND

The availability and conditions of infrastructure and non-medical equipments to support health service delivery are key priorities as currently a large bulk of health infrastructure and equipment has reached a stage where urgent repairs and replacements are required in order for the health facilities to function effectively.

It is the policy of the Government to make available at least one National Hospital which would operate as a top referral hospital to a satellite of Referral Hospitals and Community Health Centres (CHCs) in every district. Although there are currently 192 Health Posts, 66 CHCs, 5 Referral Hospitals and 1 National Hospital rehabilitated and constructed since 2001, majority of the districts do not have direct access to hospital care and there is no national hospital able to provide comprehensive secondary and tertiary care services to the Timorese population.

Additionally, every Suco will have a Health Post (HP) to improve access of services to the communities with a minimum staffing requirement of one family doctor, one laboratory technician, two nurses and two midwives providing basic health services to at least one thousand populations. Thus, planning of health infrastructure needs to be embedded in the overall strategy for the development of the health sector.

On the other hand, transport in the health sector is vital for its smooth operation. Transport includes first and foremost ambulance services that provide first aid and emergency medical care to patients who need to be treated in a secondary or tertiary health facility. It also enables the transportation of supplies and materials/commodities needed in the districts. Here, often ambulances are used because no proper vehicles are available.

Also the role of Information Communication Technologies (ICT) can no longer be ignored in health services. The health sector's relationship with information is distinct from that of other development sectors. Various reports underline its usefulness in health related efforts, especially when shortage of required Human Resources and other barriers limit the effective and efficient delivery of services.

VI.2 PHYSICAL INFRASTRUCTURE

The main challenges in this area include:

a) the need to complete the health facility infrastructure development plan in order to ease the allocation of resources as well as prioritisation of capital projects in under-served and remote areas;

b) finalisation of the health facilities (infrastructure) databank to serve as a source of information for formulation of development and procurement plans for capital/infrastructure programmes;

c) finalisation of infrastructure standards and guidelines, which will form the basis for implementation of programmes; d) approval of the draft maintenance policy, which will provide guidelines on how to manage repairs and maintenance of infrastructure;

d) the need to increase Government's and development partners commitment towards capital investment programmes; and

e) the need for capacity building at district level to interpret and implement infrastructure activities.

Objective: to significantly improve on the availability, distribution and condition of appropriate essential infrastructure so as to improve equity of access to essential health services.

Strategies:

1. Establish a health infrastructure database system that would provide essential information on the status of each health facility, at all levels of care;

2. Review the infrastructure standards and define the appropriate sizes and types of health facilities for the different levels of care;

3. Develop and implement a Health Infrastructure Development Plan, consistent with the overall national health needs, priorities and BPS, paying particular attention to under-served areas. The development of this plan will be based on the principle of "prioritization";

4. Establish a capital basket for financing infrastructure development and maintenance, including an appropriate criteria for prioritization and selection of capital projects for this basket;

5. Promote private sector participation and public/private sector partnerships in development of specialized hospitals, laboratory facilities and pharmacies in districts;

6. Ensure effective dissemination and compliance with the approved infrastructure maintenance policy and guidelines; and

7. Build appropriate capacities in the effective development and preventive maintenance of infrastructure at district level.

Expected Results/ Key Indicators:

1. Assessment of health infrastructure completed by September 2012;

2. Infrastructure database system established and operational by end of 2012;

3. Health Infrastructure Development Plan completed and launched by end 2012 and implemented from the beginning of 2013;

4. Capital basket fund established and operational by 2013;

5. Capacity-buildings needs determined. Appropriate programmes developed and implemented by January 2012; and

6. Increased number of private and public/private health facilities.

VI.3 MEDICAL EQUIPMENTS & ESSENTIAL NON-MEDICAL SUPPLIES

Efficient and effective delivery of clinical care is highly dependent on the availability of appropriate equipment and accessories in good functioning order. Medical equipments and accessories should always be properly maintained and calibrated, so as to ensure accurate diagnosis and/ or performance. The list of essential equipments and supplies need to be defined for the health post, community health centre, district, referral and national hospitals.

The main challenges as far as essential medical equipment and supplies are concerned include the need to:

a) develop standard equipment lists for all levels of service delivery;

b) develop appropriate equipment management plans whose objective would be to restock clinical centres with the right quantities of appropriate equipment;

c) develop criteria to determine human resource needs for equipment management and maintenance;

d) develop appropriate maintenance facilities, with appropriate tools and equipment; and

e) allocate adequate budget funds for maintenance activities at all levels of service delivery.

Objective: to significantly improve on the availability and condition of essential medical equipment and supplies so as to ensure effective delivery of key health services.

Strategies:

1. Develop standard checklists for essential equipment and accessories for the remaining levels, i.e. hospitals, laboratories, training and statutory institutions;

2. Establish and maintain an equipment database system which will provide information on the status and adequacy of equipment at all levels of the health care delivery system;

3. Develop and implement appropriate equipment development plans so as to ensure a planned and coordinated approach to equipment management;

4. Ensure continuous dissemination and compliance with the established maintenance policy and guidelines at all levels; and

5. Enhance capacities for management and maintenance of equipment at all levels, through training in appropriate usage, maintenance and repairs of equipment.

Expected Outputs/ Key Indicators:

1. Standard equipment checklists for all levels of care completed by December 2011;

2. Equipment database established and updated annualy;

3. Equipment development plan developed and implementation commenced by January 2013;

4. Guidelines on the monitoring of compliance with maintenance policy and guidelines developed and implementation commenced by January 2013; and

5. Capacity building programme in equipment maintenance, developed and implementation commenced by January 2013.

VI.4 HEALTH TRANSPORT & AMBULANCE SERVICES

Transport in the health sector is vital for its smooth operation. Transport includes first and foremost ambulance services that provide first aid and emergency medical care to patients who need to be treated in a secondary or tertiary health facility. It also enables the transportation of supplies and materials/commodities needed in the districts.

Transport (vehicles, motorcycles or bicycles) is needed in the districts and by the hospitals for their supportive role in transferring patients to higher levels of health care and for their supervisory functions such asmonitoring the implementation of the various programmes, taking staff to facilities that have no access to radio or other means of communication, or bringing staff to the communities where programmes are being implemented.

The overriding weakness of the public health sector's transport system is the absence of a realistic maintenance plan and the recurrent funds required to keep the transport fleet operational. This weakness has serious impact on the implementation of a variety of existing programmes, like BSP, SISCa and other outreach activities.

The **objective** of a transport system is to ensure the availability and maintenance of an adequate number and type of transport facilities that can be maintained financially.

Strategies:

1. Assess transport needs and develop a medium-term procurement, maintenance and procurement plan

2. Review transport management system and develop rules and procedures for different utilization purposes;

3. Increasing the budget allocation for fuel and maintenance of all multifunctional vehicles and ambulances.

Expected Outcomes/ Key Indicators

1. Health Transport inventory reviwed and needs assessment conducted by end of 2011;
2. A health transport maintenance plan available and a management system developed and implemention begins by 2012;
3. Specific measures endorsed to strengthen a community-based transport system (horses, bicycles and motorbikes) and multifunctional vehicles for emergency referrals;
4. Requirements to initiate a national ambulance service inventoried and implemented in Dili.

VI.5 HEALTH COMMUNICATION & ICT

Communication within the health sector has different meanings. In the HSSP it will relate to the range of communication channels that exist between the various levels of administrative responsibility (lines of reporting, horizontal and vertical) and medical care (communications needed for referral of emergencies). It will also refer to the information and communication technologies (ICTs) that are becoming increasingly essential to improve and facilitate such communication.

The role of Information Communication Technologies (ICT) can no longer be ignored in health services. The health sector's relationship with information is distinct from that of other development sectors. Various reports underline its usefulness in health related efforts, especially when shortage of required Human Resources and other barriers limit the effective and efficient delivery of services. Advantages of ICT implementation include:

1. Mitigate the shortage of health workers
2. Complement basic health services
3. Significantly reduce costs by replacing paper work with electronic records
4. Effective and timely delivery of services
5. Maximize use of scarce knowledge, limited resources and facilities
6. Life enhancing knowledge in emergencies

Computers available at the existing health care facilities (hospitals and a number of community health centers) are limited to the rudimentary local function of data input storage (many times unreliable) and basic word and spread sheet processing. Radio communication network set-up at the first years after independence are practically not functioning now, the clinical communication being done exclusively by the use of expensive and inefficient mobile telephony or paper work.

By looking at communication as a system, its imperfections and bottlenecks become clearer. In fact, much of the frustration and misunderstanding that have affected the sector could have been avoided if clear and appropriate guidelines had been in place to define how to conduct communication with the various institutions that are directly or indirectly responsible for improvement of health status of Timor-Leste.

The **objective** of this support system is to improve communications among the various actors and services operating in the health sector.

Strategies:

1. Development of a Health Communication Strategy.

2. Install communication lines linking health facilities between HPs, CHCs and Hospitalslocated within their catchment areas.

3. To develop ICT policy for the national health services and ensure that appropriate tools and mechanism are in place.

4. Adequately train staff using ICT equipments as well as ensure availability of qualified technicians.

Expected Outcomes/ Key Indicators:

1. A national health communication plan/ strategy defined by 2012;

2. Periodic health bulletin/newsletter produced regularly by MOH and distribution to all facilities begins in 2012;

3. 100% of health facilities have access to communication network for emergency evacuations;

4. MoHICT policy developed by 2011; tools and guidelines for use drafted for implementation to begin in 2012; and

5. ICT network establhised and expanded to all health service levels, with all district management teams and hospitals have access to email communication with central MOH.

SECTION VII:
OTHER SUPPORT SERVICES

SECTION VII: OTHER SUPPORT SERVICES

VII.1 DRUGS & CONSUMABLES

Access to essential medicines and supplies is fundamental to the good performance of the health care delivery system. Availability of medicines is commonly cited as the most important element of quality by health care consumers, and the absence of medicines is a key factor in the underuse of government health services.

Problems in access to drugs and essential medical supply are often related to inefficiencies in the pharmaceutical supply management system, such as inappropriate selection, poor distribution, deterioration, expiry, and irrational use. Where medicines are available, price may be a barrier for those with no income. Thus, In Timor-Leste, attention is needed for setting up – at district levels – the basic structures for quantification, stock control and warehousing, and inspection. The procurement of pharmaceuticals, their distribution and rational use, comprise a complex system of institutional, legal and policy related matters that together frustrate attempts to respond to the original aims of SAMES.

The objectives are to ensure that all medicines authorized imported and sold in Timor-Leste are effective, safe and affordable, distributed on time to all facilities and of good quality.

Strategies:

1. Strengthen the policy and legal environment governing SAMES in exercising its functions while being responsible to procure and distribute 80% of drugs and medical supplies in the country.

2. Undertake periodic baseline surveys on the use on drugs and medical supplies;

3. Ensure efficient, cost-effective and ethical procurement, storage and distribution of essential drugs and medical supplies;

4. Establish a national Logistic Management Information System to facilitate effective monitoring of the supply chain, while ensuring adequate storage of pharmaceutical and medical supplies at all health facilities.

5. Build human resource capacity in pharmacy through pre-service training, in-service training and technical assistance.

Expected Results/ Key Indicators:

1. Capitalization of SAMES realized by 2015;

2. Operationalization of the Pharmaceutical Regulatory Authority by 2012;

3. Implementation of SAMES Procurement Regulation fully by 2011;

4. % of stock-outs of drugs and medical supplies; and

5. % of pharmacy technicians trained and recruited as per the Workforce Plan.

VII.2 LABORATORY & BLOOD BLANK SERVICES

Appropriate laboratory support is a critical factor in the diagnosis and delivery of quality health care services. Health laboratory services are currently divided into public (government owned) and private laboratories. Whereas public laboratories provide more of clinical services and less public health services, the private laboratories provide only clinical services.

On the other hand, blood blank services are mandated to ensure nationwide, equitable and affordable access to blood and blood products, ethically collected and rationally used. However, people living in the rural areas usually have limited access to the laboratory and blood bank services due to limited infrastructure and also as more priority is given to clinical services thus leading to weak and uncoordinated public health services. Furthermore, there is little representation at the management level leading to marginalized allocation of funds for the laboratory services in the Annual Action plans.

In addition there is a need to strengthen the National Health Laboratory to coordinate and serve as a national reference laboratory for clinical diagnostic services, while also establishing a National Blood Bank Centre. This strategy will address the establishment of a quality control structure within the MoH for central coordination and supervision of quality laboratory systems and blood bank services in the country.

The mainobjectivesfor laboratory services are to effectively carry out laboratory and blood bank core functions as stipulated in their mandates, strategically by improving infrastructure, network and referral system, human resources that will help improve the availability of equitable quality laboratory and blood blank services to all.

Strategies:

1. Ensure adherence to laboratory protocols and standard operating procedures;

2. Strengthen supply chain management system of quality laboratory reagents and blood supplies.

3. Ensure availability of adequate and standardised health laboratory facilities and equipment at all levels.

4. Strengthen organisation and management of the laboratory services to be responsive for both public health and clinical laboratory functions.

5. Strengthen coordination and communication throughout the health sector (HNGV, SAMES, Regional Hospitals and District Health Services, private clinics and laboratories) to improve quality of laboratory services and networking.

6. Strengthen data collection, analysis and reporting from private and public health laboratories.

7. Accredit national, regional and district health laboratories on international and national quality standards.

8. Build health laboratory human resource capacity using pre-service training, in-service training and technical assistance.

Expected Results/ Key Indicators:

1. Laboratory protocols and standard operating procedures updated by 2012;

2. Quality assurance guidelines developed and implemented by 2015;

3. Planned preventive maintenance system developed and implemented by 2012;

4. Laboratory monitoring and evaluation system developed and implemented by 2012;

5. Procurement plan for essential lab equipment and consumables developed by 2012.

The **Objectives** for Blood Bank Services are to ensure nationwide, equitable and affordable access to safe blood and blood products.

Strategies:

1. Establishment of a National Blood Bank Centre.

2. Recruitment and retention of regular, voluntary non-remunerated blood donors from low-risk groups.

3. Promotion of appropriate clinical use of blood.

4. Continuous improvements in the organization, coordination and management of blood transfusion services.

Expected Results/ KeyIndicators:

1. National Blood Transfusion Centre fully resourced and operational by 2015;

2. % of blood collected that has been screened in accordance with national and WHO guidelines;

3. Guidelines on appropriate use of blood and blood products developed and disseminated by 2012;

4. Staff trained and public awareness in blood safety enhanced throughout the next twenty years.

VII.3 HEALTH RESEARCH

The current MoH structure does not provide for a Health Research Unitdespite the fact that a research office has been established under the direct auspices of the Minister of Health. Reliable national research priorities and recommendations for action must emerge from the Central and District level to be effective. Currently, the capacity at National Hospital and District Health Services to analyze, interpret and utilize data is limited. Integration and institutionalisation of research as an integral routine component of the health policy development and program implementation process is of critical importance. Mobilization of resources for conducting relevant health research is therefore important.

The development of effective mechanisms and systems in setting out MoH and national program health research priorities is almost non-existent. Therefore, it is important to develop and strengthen existing health research systems at all levels that define priorities for health research, influence national, regional and global health agendas and lobby for a more equitable allocation of resources.

Objective: to strengthen national research capacity for an informative evidence-based health policy and decision-making.

Strategies:

The proposed research strategies involve building capacities, infrastructures, competences in the relevant MoH Directorates, participation at research conferences, undertaking research and tackling policy issues and will include:

1. Strengthening of the research capacity in MoHthrough appropriate regulation and mandate for National Health Research Advisory Committee in an effort to institutionalise health research at the various levels of health care.

2. Provision of assistance and building on existing structures, efforts, research networks, and experiences to link research to policies for improving the quality and extending the coverage of key priority health programs and services.

3. Facilitate dissemination of research results to all relevant stakeholders in order to maximize utilization of research outcomes.

4. Strengthening capacity to conduct applied health research in the National Hospital, and other statutory health bodies and training institutions.

Expected Outputs/ Key Indicators:

1. Implementation of the National Health Research Policy monitored;

2. Link between health research, health policy and programmes strengthened;

3. National Health Research Agenda priorities identified and regularly updated;

4. Research institutionalised at all levels of health care; and

5. Grants/ contracts for health system research annually provided.

VII.4 HEALTH MANAGEMENT INFORMATION SYSTEM

Monitoring and evaluation in the health system is essentially based on reports from the routine Health Management Information System (HMIS), supervision visits to all services and periodic reviews. The function of M&E (including the HMIS) is twofold: to inform policy makers about the progress towards achieving targets and meeting objectives; and to assist health managers in day-to-day decision making. Alma-Ata Declaration also recognized that a concept of integrated national health information system as essential part of health system development.

In the past years following the 1999 Referendum in Timor-Leste, the Ministry of Health undertook several activities in order to establish applicable HIS in line with common international standards. However, currently the HMIS shows imperfections, as timely and comprehensive data are not available at one place in the central MOH (which should be the authoritative source for all departments to consult). In addition, the information is not performance based or output oriented as it does not yet serve decision making.

The **objectives** for HMIS are to assist health managers to make informed decisions and contribute to improve the availability, quality and use of health information for enhanced efficiency and effectiveness of health programmes.

Strategies:

1. Definition and endorsement of national policy and regulatory mechanisms on HIS related activities such as data collection from private sector, vital registration system, release of public information and use of electronic medical record.

2. Enhance capacity and capability of Health Information System Department, HIS units at district and hospital services, as well as investing in human capacity building for M & E.

3. Stimulate operational research that provides answers to service and management related questions (collaborate with research institutions).

Expected Outcomes/ Indicators:

1. National policy and regulatory mechanisms on HIS related activities such as data collection from private sector, vital registration system, release of public information and use of medical record defined and endorsed by 2015;

2. An integrated HMIS tools on service delivery and support systems developed by 2013 (for data collection, compilation, aggregation and reporting) with a set of guidelines on how they should be used;

3. Comprehensive checklists adopted by DHMTs and used in field supervision, with a standard format for supervision reports;

4. Mechanisms designed and implemented for making managers at all levels accountable for the results that they are expected to achieve in their work plans. Tools for rewards/sanctions in place;

5. An electronic data registration system available at all service levels as well as health M&E automation system at central level.

VII.5 HEALTH PLANNING & FINANCIAL MANAGEMENT SYSTEM

The Department of Planning and Finance at Central Services relies heavily on the free-balance system for general monitoring of expenditures, thus, making it difficult to know how much is spent in the health programs in order to forecast and anticipate further expenditure requirements. The different services areas are not yet able to prepare comprehensive plans that include the full resource needs because the methodology is not fully adhered to, resources are not completely community centred and most programmes still prepare their own parallel work plans with (vertical) funding of their activities.

The drive to implement the BSP and SISCa, with their emphasis on the peripheral levels of the health system, their intention to accelerate decentralization of decision making and the desire to allocate more resources to these peripheral levels, puts more pressure on the financial management system to disburse and account for resources more efficiently than ever before.

Nevertheless, MOH recognizes the limit to which it will be able to strengthen financial management on its own, as the financial system is to a large extent the responsibility of the Ministry of Finance. Hence, a robust performance-based accounting system needs to be established, designed to enable timely disbursement of funds, timely production of financial returns for reimbursements, and timely and accurate accounts for the sector. Technically, efforts should be made to link the budget with the annual inputs (through Pasta Mutin) and – to the extent possible – the expenditures with the outputs achieved (resource-based management). At the district level, the M & E system should be able to provide reliable indicators of the performance of the Community Health Centres, National and Referral Hospitals.

The **objective** of the planning and financial management of national health system in the next twenty years is to mobilise resources through efficient and sustainable means, and to ensure efficient use of those resources in order to promote equity of access to cost effective, quality health care as close to the fcommunities as possible.

Technically, efforts will be made to answer the following questions:

- How much money is needed (Costing)?
- Where to get the money from (Mobilising)?
- Where the money should be invested on (Allocating)?
- How to spend the money (Planning & Budgeting)?
- How do we know whether the money is meeting the Government Priority Goals (Monitoring & Evaluation)?

The **strategies** of the Ministry of Health for achieving this should touch different areas of the health sector, and these are:

1. To identify the costing needs of the National Health System, with particular emphasis on delivery of comprehensive health service for primary, secondary and tertiary care.

2. To strengthen resource mobilization in order to achieve national health goals.

3. To improve resource allocation as to ensure money goes to where it is most needed.

4. To improve spending by ensuring a transparent mechanism is in place to guide health management teams on how to better spent by following services action plans.

Expected Outputs/ Key Indicators:

1. Costing of National Health Systemconducted by 2013;

2. National Health Medium Term Expenditure Framework developed;

3. AAPs developed through a bottom-up approach and submitted on time for approval and incorporation into the Annual Budget;

4. Stakeholderadherence to standard financial management report (FMR);

5. Direct flow of funds to autonomous health institutions from Ministry of Finance;

6. A system of National Health Accounts Institutionalised and operationalised; and

7. Budget reports (both financial and non financial) are produced on time in standard formats agreed by stakeholders.

VII.6 HEALTH PARTNERSHIP & COLLABORATIONS

Stakeholders in the health sector are many. The Public and Private sectors, other Ministries and public institutions, Development Partners, Civil Society Organizations, and the community they play an important role in health. The MoH acknowledges the importance of each partner and considers partnership an important guiding principle of the national health development. In particular, the private sector provides a relevant financial contribution to the overall health sector, improving at the same time governance, management and quality of care. Furthermore, the private sector is considered as complementary to the public health sector in terms of increasing geographical access to health services and the scope and scale of services provided.

The need to strengthen community participation has been embraced by the Ministry of Health in all programmes as a way forward to a sector wide approach to health service delivery. SISCa promotes community participation and empowerment as an important strategyfor enabling communities to take responsibility for their own health and well-being through active participation in the management of local health services. Community participation as a strategy in health service

delivery is important as it ensures the availability of appropriate community based services and addresses barriers to accessing care.

The main **objective** is to build consensus among community and partners to commit towards achieving Government health priority goals.

Strategies:

1. To strengthen relations with other ministriesand public institutions.

2. To advocate for the establishment of institutions, NGOs and community based networks to promote collaboration, exchange of information and best practice.

3. To nurture public private partnership for the provision of quality services in a harmonized and complementary manner.

4. To strengthen collaboration between the MoH and its development partners within the spirit of the Paris Declaration and the Accra Agenda for Action.

Expected Outputs/ Key Indicators:

1. Effective and efficient approach to sector wide management through joint planning, monitoring and evaluation endorsed and implemention to begin by 2012;

2. Improved stewardship of the sector by the MOH;

3. Procedures for monitoring and evaluation of public private partnership developed by 2012; and

4. A structural unit responsible for external fund management and cooperation with development partners strengthened with appropriate management tools and resources by 2012.

SECTION VIII: FINANCING THE NATIONAL HEALTH SYSTEM

SECTION VIII: FINANCINGTHE NATIONAL HEALTH SYSTEM

VIII.1 BACKGROUND

How a country's health system is financed determine its level of health status. Countries with good financing system usually achieve better health outcomes. Health financing therefore is a key determinant of the health system.

The World Health Organization (WHO) defines health financing as the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system." It states that the "purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" (WHO 2000). In Timor-Leste, the main sources of financing health care services include:

- Allocations from the Central Government (GSB);
- Support from International Cooperation Partners through Trust Funds under the World Bank and from other international funding basket such as the Global Fund for the fight against Malaria, Tuberculosis and the spread of HIV-AIDS;
- The general population, through user fees and out-of-pocket schemes;
- Contributions from employers in form of health insurance payments or direct support to their employees; and
- Other miscellaneous receipts, including donations in kind.

A good health financing system raises adequate revenue for health services delivery, enhances the efficiencies of management of health resources and provides the financial protection to the poor against catastrophic illness. By understanding how the health system and services are financed, programs and resources can be better directed to strategically complement the health financing already in place, advocate for financing of needed health priorities, and aid populations to access available resources.

VIII.2 PUBLIC FINANCING OF THE HEALTH SECTOR

Most government health budgets are historical; that is, they are based on budgets from previous years that are adjusted annually to account for inflation or at the same rate as most other government spending. These budgets usually have separate line items for personnel, hospitals, pharmaceuticals, supplies, fuel, and training, and they finance only recurrent costs.

Over the past three years, the Government of Democratic Republic of Timor-Leste has substantially injected more resources to the health sector. Indeed the current per capita government spending on health ($27.7) is higher than that of several developing countries around the world. But the health sector's share of the national budget over the past three years shows a downward trend

7% in 2007, 6% in 2008 and 4.8% in 2009. These levels of funding are inadequate given the magnitude of challenges confronting the sector. There is, therefore, a need to implement a health financing system that will raise adequate resources and is efficient, equitable, and sustainable and sufficiently addresses the need of the poor and the vulnerable.

In terms of its financial management function, the Ministry of Health is facing complexities on institutional and individual capacity in order to improve effectiveness and efficiencies of health budget allocation and management. Duplication of budget allocation from state budget and external budget, poor budget disbursement system, weak financial reporting and information system remains amongst the key challenges that need to be addressed with appropriate strategies.

With the new health policy decision that embraces the establishment of hospitals in every district, health posts up to village level and Integrated Community Health Services (SISCa) up to sub village or "Aldeia" levels, the health sector investments and operational cost for next 20 years is expected to increase significantly.

Objective: to increase public resource mobilization to the health sector through efficient and sustainable means as to promote equity of access to cost effective and quality health services at all levels of care.

Strategy:

1. Conduct comprehensive costing analysis for the entire health sector;

2. Define Medium Term Expenditure Framework (MTEF) for the health sector in line with National Health Strategic Plan and National Medium Term Expenditure Framework;

3. Develop program base budgeting system to ensure harmonization of different health programs to the overall budget for the national health services;

4. Develop National Health Accountant System;

5. Develop Health financing in Decentralization System;

6. Establish Health Financing Information System.

Expected Results/ Key Indicators:

1. Public expenditure to the health sector increased by more than 10%;

2. Per capita spending increased by more than $30 on health;

3. Development of program base budgeting in order to examine impact of health policy and health program implementation; and

4. National Health Account introduced by 2015.

VIII.3 PRIVATE FINANCING OF THE HEALTH SECTOR

Levels of private out-of-pocket health expenditures in the South-East Asia Region are much higher than other regions, making up over 60% of total health expenditures. Millions of the people were impoverished because of out-of-pocket payments associated with poor health status and use of health services and catastrophic health care costs pushed many families below the poverty line in one year.

As a young independent state, Timor-Leste's private practice is growing rapidly throughout the country. The private health sector consists of for-profit as well as not-for-profit providers which include medical practitioner clinics, private laboratories, private pharmacies and traditional medical practitioners. This has significant contribution to the health financing for the country, particularly when considering the different nature of finance already in place such as publicly financed health services that are privately provided (public-private); privately financed and publicly provided (private-public); or services that are both privately financed and managed (private-private).

Reduction out-of-pocket expenditure is one of the Government priorities on health financing strategy for the next 20 years, thus, appropriate regulatory systems and procedures to push forward for an effective utilization of resources.

Objective: to minimize the burden of out-of-pocket expenditures on the poorest households while strengthening public private mix in health financing.

Strategy:

1. Conduct a costing study of the private financing of the sector, including out-of-pocket expenditures;
2. Private healthcare financing options identified and developed;
3. Strengthen Public/Private Sector Partnership in the districts;
4. Develop and implement a system of collecting accurate information about private health care financing;
5. Regulating private health financing and services.

Expected Results/ Indicators:

1. Study on Private Healthcare Financing conducted by 2013;
2. Private healthcare financing options identified and developed as a result of costing study by 2014;
3. Reports on private healthcare financing included in the annual health sector reports;
4. Public/Private Sector partnership strengthen in a equitable manner;
5. Laws and procedures developed for monitoring of private healthcare financing.

VIII.4 DONOR FINANCING OF THE HEALTH SECTOR

Donors finance health systems through grants, loans, and in-kind contributions. ONGs often are financed by donors and voluntary contributions. The sector-wide approach(SWAp) is a financing framework through which government and donors support a common policy and expenditure program under government leadership for the entire sector. A SWAp implies adopting common approaches across the sector and progressing toward reliance on government procedures and systems to disburse and account for all funds. Many countries with SWAp mechanisms have a diversified funding mix, including grant-funded projects.

Currently, national capacity in coordinating and monitoring donor's contribution to the health sector is very limited, thus, contributing towards indirect funding mechanism such as multi donor trust funds and direct contribution through UN Agencies, Non-Governmental Organizations and health providers.

The MoH will need, therefore, to maximize donor inputs by taking lead in the way donor financing of the health system under the SWApbasket funding. This approach differs from project financing and vertical programs, in which funds are provided for a specific purpose and may be managed independently of the government budget or priorities.

Objective: to ensure that donor's financing of the health system reflects government indentified priority areas in order to achieve national targets for a healthier Timor-Leste.

Strategies:

1. Regulate donor's financing of the health sector as to ensure that aidtransition towards government financing systems andpriorities agreed;

2. Expand existing funding mechanism to all levels of health care services delivery (including public and private), training institutions and statutory bodies;

3. Review and strengthen financial reporting, monitoring and evaluation of donor funded projects and programs; and

4. Strengthen the MoH function of managing external funds through capacity building and training.

Expected Results/ Key Indicators:

1. Norms and procedures for donor's financing of the health sector developed by 2012;

2. Establish a common basket funding mechanism to include all levels of health service delivery, training institutions and statutory bodies, by 2015;

3. Mechanism in place for harmonized financial reporting, monitoring and evaluation of dono funded projects or programs; and

4. Unit responsible for external fund management and cooperation with development partners strengthened with appropriate management tools and resources by 2012.

SECTION IX:
IMPLEMENTATION ARRANGEMENTS

SECTION IX: IMPLEMENTATION ARRANGEMENTS

IX.1 IMPLEMENTATION MECHANISM

The NHSSP will be implemented and coordinated through the existing health sector organisational and management structures, which will include: the Health Regulatory and Statutatory Boards, the MOH Headquarters at central level; the District Health Committees and District Health Management Teams (DHMTs) at district level; Hospital Management Teams at hospital level, Health Associations and faith based health institutions; and Non-Governmental institutions involved in the health sector (both public and private).Each of these stakeholders will have specific coordination and implementation functions for the NHSSP.

The MOH Headquarters will be responsible for policy and legal framework formulation, strategic decision-making, standards setting and enforcement, and the overall coordination of the implementation of this plan. In this respect, the Ministry of Health will coordinate the policy formulation and legislative changes aimed at supporting of the implementation of the NHSSP. The units of Policy and Planning of the Ministry o Health will be responsible for the overall functional and technical coordination of the implementation of the NHSSP. Explicit activities for plan coordination will therefore be an integral component of the unit's annual action plan. Concurrent to the policy formulation and coordination function, the other MOH directorates and units will be responsible for the implementation of specific aspects of the NHSSP in line with their defined roles and responsibilities.

Districts health management structures and hospitals will serve as the major implementing agencies for this plan. This will include public and faith based facilities spread all over the country. Harmonization of the district and hospital plans to match the aspirations of the NHSSP will therefore be crucial for successful implementation.

The other structures, includes private health institutions and NGOs. These institutions will be expected to significantly contribute to the implementation of this plan by effectively playing their respective roles. MOH is committed to strengthening partnerships with all these stakeholder groups and ensure synergies, through improved coordination and collaboration. In this regard, the District and Hospital Management Teams will translate the strategies provided in this plan into their annual action plans. In order to ensure that plans at this level of the health care delivery system reflect the provisions of the NHSP, the MOH shall prepare and disseminate annual planning guidelines, which will spell out areas of strategic focus by District and Hospital Management Teams.

Policies on improvement of MoH stewardship role will be adopted,witheach structure responsible for the development of annual action plans, monitoring and evaluation.Priority areas will include but are not limited to the development of strategies for:

1. Comprehensive health service delivery

2. Management and development of human resources

3. Infrastructure development plan

4. Other support services

5. Health Financing

Although the core teams will be small they will need to engage and work with multidisciplinary teams across the health and community sectors, as well as government departments and with the private sector.

IX.2 MONITORING & EVALUATION

Depending on the type and relevance of the indicators, routine monitoring will be undertaken, on a monthly, quarterly, annual and bi-annual basis. The HMIS, Family Registration and other routine systems will be the major tools for data collection. The MoH and its partners will primarily use this data and its analyses for decision making.

MoH will produce quarterly activity and financial reports for all levels of the health system for consideration at the Mini-SAG meetings. It will also produce an Annual Performance Review Report every May, on the performance of the sector against annual plans and output targets.

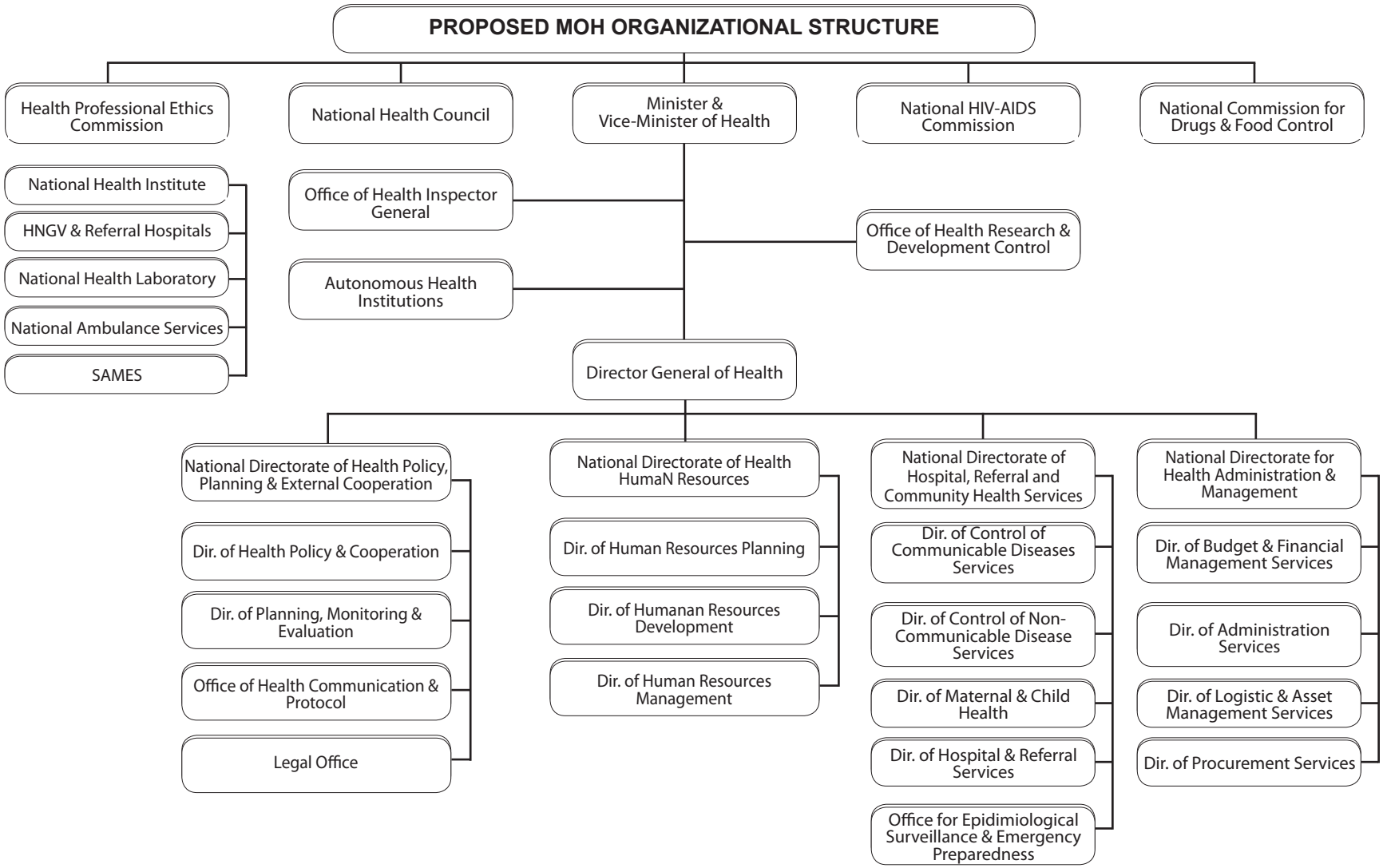
MoH will be responsible for sector performance monitoring and review. It will plan and lead the Joint Annual Reviews (JAR) first quarter every year, together with appropriate involvement and support of the parters and other key stakeholders. The findings of the JAR will be presented at the first donor coordination meeting held each year.

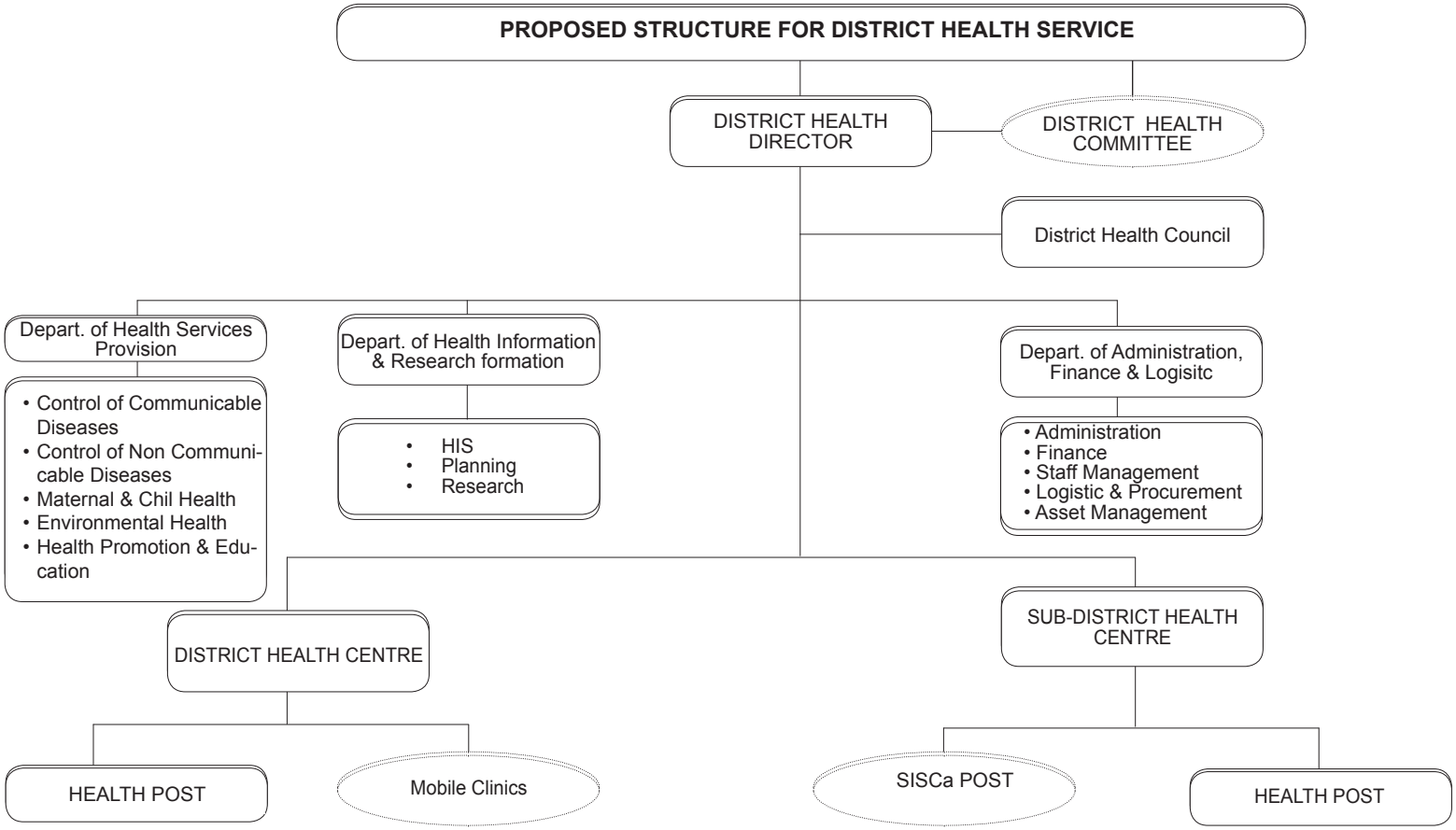
There will be twomainevaluations each year throughout the duration of this plan. These will consist of a mid-term assessment after every two first years of implementation and a comprehensive evaluation every four years. MOH will organise a joint mid-term review (MTR) before the end of the second year of NHSSP. An independent external evaluation will be undertaken after four years of NHSP. All stakeholders will agree on the timing, terms of reference and composition of these two review missions. All costs will be included in the Health Sector Budget. Where appropriate/ possible, the MTR and the NHSSP evaluations will be combined with the JAR for that year.

NHSSP is not static and should evolve and grow to meet the needs of the services andorganizations over the strategic period. The longer-term targets will be more likely to need revision in the light of changes in the service and developments in clinical practice.The mid-term assessment will focus on progress made in plan implementation and assess the appropriateness of the overall strategic direction. It will therefore be designed to inform the remaining period of the plan and recommend adjustments where need be. The final evaluation will focus on impact/outcome of the NHSSP and assist in providing the contextual framework for the subsequent planning period.

In addition, through the introduction of organizational performance management, the NHSSP will be the basis of performance reviews for individuals, departments and organizations, as the successful delivery of the changes and improvementswill be the responsibility of everyone working within the health service.

ANNEX A


PROPOSED MOH ORGANIZATIONAL STRUCTURE
Health Professional Ethics Commission
National Health Council
Minister & Vice-Minister of Health
National HIV-AIDS Commission
National Commission for Drugs & Food Control
National Health Institute
HNGV & Referral Hospitals
National Health Laboratory
National Ambulance Services
SAMES
Office of Health Inspector General
Autonomous Health Institutions
Office of Health Research & Development Control
Director General of Health
National Directorate of Health Policy, Planning & External Cooperation
Dir. of Health Policy & Cooperation
Dir. of Planning, Monitoring & Evaluation
Office of Health Communication & Protocol
Legal Office
National Directorate of Health HumaN Resources
Dir. of Human Resources Planning
Dir. of Humanan Resources Development
Dir. of Human Resources Management
National Directorate of Hospital, Referral and Community Health Services
Dir. of Control of Communicable Diseases Services
Dir. of Control of Non-Communicable Disease Services
Dir. of Maternal & Child Health
Dir. of Hospital & Referral Services
Office for Epidimiological Surveillance & Emergency Preparedness
National Directorate for Health Administration & Management
Dir. of Budget & Financial Management Services
Dir. of Administration Services
Dir. of Logistic & Asset Management Services
Dir. of Procurement Services


PROPOSED STRUCTURE FOR DISTRICT HEALTH SERVICE
DISTRICT HEALTH DIRECTOR
DISTRICT HEALTH COMMITTEE
District Health Council
Depart. of Health Services Provision
• Control of Communicable Diseases
• Control of Non Communicable Diseases
• Maternal & Chil Health
• Environmental Health
• Health Promotion & Education
Depart. of Health Information & Research formation
• HIS
• Planning
• Research
Depart. of Administration, Finance & Logisitc
• Administration
• Finance
• Staff Management
• Logistic & Procurement
• Asset Management
DISTRICT HEALTH CENTRE
SUB-DISTRICT HEALTH CENTRE
HEALTH POST
Mobile Clinics
SISCa POST
HEALTH POST

ANNEX B

LOGFRAME MONITORING DELIVERY OF HEALTH SERVICES

A. MATERNAL HEALTH

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Increase access to high quality prenatal, delivery, postnatal and family planning health care at primary health services,	Increase number of health facilities with maternity units	Health Posts with Maternity clinic established and functioning in all health facilities	100% CHC 50% HPs	75% HPs	100% HPs	
	Increase number of skilled health staff including new medical doctors to provide maternal health services (ANC, delivery, and Postpartum Care)	523 D3 Midwives recruited every five years Upgrade training conducted every three years Increase CPR to 40% by 2015; and 70% by 2030	60% Recruitment conducted for CHCs 40% recruitment to Health Post	60% Recruitment conducted for CHCs 40% recruitment to Health Post	60% Recruitment conducted for CHCs 40% recruitment to Health Post	
	Increase demand for family planning services through BCC interventions	All health services apply BCC strategy	50% implementation	100% implementation		
Improve emergency obstetric care through recognition, early detection and management of obstetric complication at the community and referral level	At Hospital level: Recruitmetgnt of specialists Provision of Comprehensive cesarean section Procurement of BEOC equipment Provision of post abortion Care Training of recruited staff At CHC level: Train recruited doctors on BEOC Provision of post abortion Care <u>At HP:</u>Train recruited staff on BEOC and CEOC	All established hospitals providing BEOC and CEOC services All CHC equipped and able to provide BEOC services C-Section Rate between 5 – 15% Procurement of BEOC equipment % of pregnant women receiving at least four antenatal care % of delivery assisted by skilled birth attendant % of postnatal women receiving postnatal care in the first 6 days after delivery % of delivery at health facilities	All Hospitals providing BEOC and CEOC Services 75%% of BEOC at the CHC are functioning All CHC provides post abortion care 70% of pregnant women receiving ANC at least four times 65% of assisted delivery 65% of women receiving postal care in the first 6 days after delivery At least 40% of deliveries at a health facility	All Hospitals providing BEOC and CEOC services 100% of BEOC at the CHC are functioning 80% of pregnant women receiving ANC at least four times 75% of assisted delivery 75%% of women receiving postal care in the first 6 days after delivery At least 65% of deliveries at a health facility	Improving quality and Maintenance 95% of pregnant women receiving ANC at least four times 95% of assisted delivery 95% of women receiving postal care in the first 6 days after delivery At least 75% of deliveries at a health facility	95% of pregnant women receiving ANC at least four times 95% of assisted delivery 95% of women receiving postal care in the first 6 days after delivery At least 95% of deliveries at a health facility
	Upgrading the skills and technology required for CEOC services at regional and national hospitals	All hospitals have appropriate personnel and equipment able to provide CEOC services.	50% of specialist doctors available 100% of all equipments purchased	Maintenance	Improving quality	

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
	Improve and expand obstetric emergency referral system	Availability of adequate communication equipments, human resources and transportation for obstetric emergency referral system Development of appropriate transportation system in coordination with the Min. Infrastructure, the FFDTL and other agencies.	All CHC has adequate equipment and means of transportation for obstetric emergency referral system	50% of maternity unit at HP level has adequate equipment and vehicle for obstetric referral system	100% of maternity unit at HP level has adequate equipment and means of transport for obstetric referral system	
3. Empower individual, families and community to contribute to the improvement of maternal care and reproductive health services	Implement maternal death audit	Maternal death audit is performed to all maternal deaths in all health facilities	Maternal death audit is performed to all maternal deaths in all hospital; and community based maternal and infant deaths surveillance is in place	Maternal death audit is performed to all maternal deaths in all hospitals and CHC	Maternal death audit is performed to all maternal deaths in all health facilities	Maintenance and improve quality
	Promote demand for maternal health care (ANC, delivery, and postnatal care) by skilled health provider	% of drop outs in maternal health care	0% of drop outs	10% of drop outs	5% of drop outs	5% of drop outs
	Promote male participation to improve health care seeking behavior	% of male participant in SISCa activities	25% of male attending SISCa actvities	35% of male attending SISCa	45% of male attending health facilities	Maintain and improve male contribution to Maternal health
4. Strengthen HMIS system at all levels through data collection and collaborative analysis	Establish network with community leaders and community based organization	No. of communities with active MSG	At least one Suco with active MSG	60% of Aldeias with active MSG	90% of Aldeias with Active MSG	Maintain
	Implement Local Area Monitoring for maternal health and family planning	No. of CHCs conducting Local Area Monitoring	Local Area Monitoring is functioning in all CHC	Maintain	Maintain	Maintain
5.Strengthen Adolescent Reproductive Health services	To perform monitoring and evaluation of maternal health services and family planning at all service levels	No. facilities with Online Monitoring System in place	100% of DHS and 50% of CHCs with online Monitoring System Revision of strategy and guidelines based on the finding of evaluation	100% of DHS and 100% of CHCs with online Monitoring System Revision of strategy and guidelines based on the finding of evaluation	Maintain Revision of strategy and guidelines based on the finding of evaluation	Maintain Revision of strategy and guidelines based on the finding of evaluation
	Provision of Information and skills to young people, family and community trough life skill and sexual & Reproductive Health training/ education	% of Teenage pregnancy No. of schools integrating Reproductive health into the curriculum	Teenage pregnancy reduced by 30% 25% of schools integrating reproductive health into the curriculum	Teenage pregnancy reduced by 50% 35% of schools integrating reproductive health into the curriculum	Maintain reduction by 50% 50% of schools integrating reproductive health into the curriculum	Maintain reduction by 50% 75% of schools integrating reproductive health into the curriculum
	Establishment of youth friendly services	No. of facilities providing youth friendly services	All hospitals providing youth friendly services	All CHCs providing youth friendly services	Improve quality and maintain	Improve quality and maintain

B. CHILD HEALTH

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Develop a comprehensive child health policy	Review and update current policies in child health and integrate them into one umbrella policy document	Umbrella policy document developed	100% of policy document developed	Update	Update	Update
Improve the capacity of the health system to support the delivery of integrated preventive, IMCI, newborn care and Community Case	Advocacy for implementation of child health policy among all stakeholders	% of decision makers adhering to child health policy at all levels % GSB allocated to child health program needs	50% of decision makers adhering to child health policy 20% of GSB allocated to child health programmes	60% 40%	80% 80%	90% 95%
	Conduct in-service and pre-service training of IMCI and neonatal emergency in all districts and health worker training institutions. Manage, supervise and champion IMCI , EPI , Newborn care, essential nutrition and early childhood development (ECD) priorities across all tiers of the health system Increase qualification of child health staffs	% health staff completed trained on IMCI,ENBC Coverage of child health intervention # staff with qualification	90 % Cut off point: 90% Nat: 4 S-1 qual. Staffs DHS: 13 S-1 qual staffs All clinical staffs hold minimum D3 qualification	Refresh Maintain Nat: 2 S-2 qual, 6 S-1 qual. 50% DPHO hold S-1 qualification Maintain	Refresh Maintain Maintain 100% DPHO hold S-1 qualification 50% clinical staffs hold S-1 qualification	Refresh Maintain Maintain Maintain Maintain
	Integrate child health topics into national curriculum for health educational institutions	% education institution integrating child health in the curriculum Annual process of curriculum review and recommendation dissemination.	100%	Maintain	Maintain	Maintain
	Establish and apply appropriate supportive supervision	% HF supervised at least 2 times a year as recorded in HMIS % HF with good client satisfaction and quality service certification Incentive mechanism in place	75% 70%	85% 90%	95% Improve quality and maintain	95% maintain

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Increase access and quality of immunization services	Develop centers of excellence in all regions for child health practice to be integrated into training system , both in-service and pre-service	No. of regions maintaining quality center of excellence training center	30 %	80%	100%	100%
	Develop local coverage plans for Immunization to reach least 90% coverage nationally	% children under one year of age receiving all vaccines per policy BCG – POLIO – DPTHep B – Measles	90%	90%	95%	95%
	Create an incentive system	% of Districts benefiting from incentive schemes	100%			
Improve referral system in order to respond to child health specific needs	Establish cold chain management system	% cold chain management system well-functioning	75%	85%	95%	95%
	Develop and implement universal and standardized referral procedures to ensure appropriate articulation of IMCI, EPI and ECD newborn and nutrition practices	Standard Referral Procedures (SRP) developed	100%	Update	Update	Update
	Delivery of quality of IMCI, EPI and ECD newborn and nutrition practices at pediatric services in all hospitals	% available hospital providing quality of pediatric services	100%	Improve and maintain		
	Counter-referral communications through ICT to all health facilities	% of health facilities utilizing ICT for counter-referral	50%	100%		

C. NUTRITION

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Promote diversity and consumption of locally produced food	Conduct research on locally produced food composition table in coordination with the Ministry of Agriculture	% of locally identified food analyzed in the food composition table	20%	50%	70%	90%
	Develop food recipes and modeling to address different needs	% of locally produced food with recipes for different needs	50%	70%	100%	maintain
		No. of surveys on food consumption con	One	One	One	One

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Improving mother and child (M&C) nutrition care practice	Promotion of exclusive breastfeeding and appropriate complementary feeding practices	% of Children <6 month exclusive breastfed	60%	70%	75%	85%
		% of children 6-12 months receiving timely & appropriate complementary foods, in addition to breast milk	50%	65%	70%	80%
	Development and implementation of regulation on breast-milk substitutes code	% Health institution implementing BMS code & BFHI	100%	Maintain	Maintain	Maintain
Improve access and quality of nutrition services at facility and community levels for all live cohorts	Increase coverage and quality of micronutrient supplementation	Micronutrient fortification legislation developed and enacted	1 guide developed	Update	Update	Update
		% of children < 5 years receiving vitamin A	80%	90%	95%	Improve
		% of children 6-23 months receiving micronutrients powders (sprinkles)	50%	75%	95%	Improve
		% of women 15-19 receiving iron folate	50%	70%	90%	95%
		% of household consuming iodized salt	75%	85%	95%	Improve
	Increase coverage of management of malnutrition	% of acute malnourished children treated	50%	60%	75%	85%
		% of emergency supplies pre-positioned	50%	60%	70%	80%
		% of school implementing feeding program monitored	90%	95%	Maintain	Improve
		% of malnourished pregnant & lactating mother receiving supplementary food.	80%	90%	95%	Improve
	Increase community engagement in nutrition interventions	% of schools with school gardens for nutrition education and school meals consumption	20%	40%	60%	70%
		% of households with home gardens	30%	50%	70%	90%
		% community members with improved nutrition knowledge	35%	70%	90%	Improve
	Increase coverage and quality treatment of nutritional related non-communicable disease	% of people living with nutritional related non-communicable disease receive intervention	25%	50%	75%	Improve

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
	Implement WRA NFS education and counseling including health seeking behavior and food taboos (before, during and after pregnancy)	% of health workers trained in adolescent nutrition	9o%%	Improve and Maintain	Maintain	Maintain
		% of pregnant and lactation women receiving counseling	50%	75%	90%	Maintain
	Introduce and implement under-two growth monitoring with counseling and MUAC screening for children 24-59 months	% of adolescent receive counseling on nutrition	20%	40%	80%	Maintain
		% of health workers who understand how to use the WHO growth chart	95%	95%	95%	95%
		% of health workers who provide counseling	75%	90%	Maintain	Maintain
		% of mothers receiving counseling through growth monitoring activities	50%	75%	90%	Maintain
		% of children screened and referred to health facilities	50%	70%	90%	Maintain
	Establish a national training centre for nutrition and food security in coordination with agriculture and education sector	Establish national nutrition training center (NNTC)	1 NNTC established	Maintain	Maintain	Maintain
		% of health staff trained on nutrition and food security	90%	Maintain	Maintain	Maintain
		% of health staffs enrolled into formal or informal program (to build leadership and technical capacity in NFS)	50%	75%	90%	Maintain
		% Hospital equipped with clinical nutritionist (dietician)	HN: 2 MD specialist diet. HD: 3 Dietacian and 1 MD dietacian	Maintain	Maintain	Maintain
		% DHS equipped with S1-nutrition	30%	70%	100%	Maintain
		% CHC equipped with community nutritionist (D3)	30%	50%	70%	100%
	Develop university level curriculum (bachelor and master degree) and faculty position in NFS	% faculty use nutrition curriculum	100%	Maintain	Maintain	Maintain
	Develop and incorporate NFS education in school curricula	% school use NFS education	25%	50%	70%	80%

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Promote advocacy, social mobilization and communication to ensure mainstream behavior change in nutrition	Develop BCC strategy for nutrition behaviour change	Nutrition BCC developed	1 strategy developed	Update	Update	Update
	Implement nutrition behaviour change intervention (BCI)	Nutrition BCI implemented	1 BCI implemented each year	Maintain	Maintain	Maintain
	Increase skill of health staffs in behaviour change communication	% nutrition staffs on behaviour change communication skills	90%	Maintain	Maintain	Maintain
Strengthen nutrition information management system and surveillance	Establish nutrition information and surveillance system and M & E (NIS&ME)	Functionality of NIS&ME	NIS&ME well-functioning	Maintain	Maintain	Maintain
		Functionality of national nutrition information system and surveillance unit	1 unit under ND well-functioning	Maintain	Maintain	Maintain
	Establish national food security information unit including surveillance and nutrition information system	Number of standardized regular surveys to monitor progress of output and outcome/ impact indicator conducted and information disseminated	1	Maintain	Maintain	Maintain
		% of Health Facilities utilizing information obtained from NIS for programmatic and decision making	100%	Maintain	Maintain	Maintain
	Conduct Scientific research and information dissemination	% of information obtained from valid scientific research utilized for policy formulation, decision making and programmatic planning	100%	Maintain	Maintain	Maintain

D. CONTROL OF COMMUNICABLE DISEASES

i. Malaria

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Enhance case management through early case detection and delivery of effective anti malarial therapies	Development of medium and long-term budgeted plans of action in line with national health and development plans.	Incidence of malaria (per 1000 population)	100	80	50%	
	Ensure Implementation of National Malaria treatment guidelines by the health staff who involve in diagnosis and treatment with emphasis on quality diagnosis and treatment	# of health staff who involve trained and implement the National Malaria treatment guide lines	100%	100%	100%	100%
	Ensure the availability of diagnostic facilities and anti-malarials at all health facility levels	# fever cases tested by microscopy	220,000	220,000	220,000	110,000
		# of fever cases tested by RDT	44,000	44,000	22,000	11,000
	Ensure prompt effective anti malarial treatment by monitoring and evaluation	% of malaria cases receiving anti malarial treatment per national guidelines	75%	85%	95%	100%
		# of Health institutions reporting stock outs more than 7 days	75% of the institutions	85% of the institutions	90% of the institutions	100% of the institutions
	Strengthening of quality control and quality assurance of diagnostic services and treatment	# of designated microscopy centers that are part of external quality assurance protocol	100%	100%	100%	100%
	To carry out therapeutic efficacy test for anti-malarials for delivery of effective treatment	# of tests carried out	one	one	One	One
	Establish capacity building in service , on the job and international training for health staff in line with national malaria control diagnosis and treatment guidelines	# of refresher training carried out on malaria diagnosis and treatment	100% of all analysts and clinicians trained	Maintain	Maintain	Maintain
	Supportive supervision to enhance quality of services	# of supervision carried out	50% of the institutions supervised and reported	60 of the institutions supervised and reported	75% of the institutions supervised and reported	80% of the institutions supervised and reported
	Ensure involvement of Community health volunteers on malaria control and prevention	# community Health volunteers trained on malaria treatment and control	100% of the Community Health Volunteers	100% of the Community Health Volunteers	100% of the Community Health Volunteers	100% of the Community Health Volunteers

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
	Strenthing community participation for effective diagnosis and treatment	% of individuals surveyed having correct knowledge of symptoms of malaria and treatment	>50%	>60%	>70%	>80%
	Ensuring adequate availability of cadre representing essential carders both at National and district level	Recruitment of district and sub-district focal points for malaria and other-vector borne disease control	38 48 % of malaria /VBDC focal points at district and sub-district level	78 100% of malaria /VBDC focal points at district and sub-district level	78 100% of malaria /VBDC focal points at district and sub-district level	78 100% of malaria /VBDC focal points at district and sub-district level
Selective application of vector control measures based on the principles of Integrated Vector management	Development of Integrated Vector Control Strategy under Vector borne disease control Policy	Integrated Vector control Policy developed	Policy developed	Policy revised if necessary	Policy revised if necessary	Development of Integrated Vector Control Strategy under Vector borne disease control Policy
	Development of National Insecticide Policy for Public health aimed at vector resistance management	Public health Insecticide policy developed	Policy developed	Policy revised if necessary	Policy revised if necessary	Policy revised if necessary
		All the insecticide suitable for public health in the country registered	All insecticides registered	All insecticides registered	All insecticides registered	All insecticides registered
		# of insecticide susceptibility tests against malaria vectors carried out	10	10	10	10
	Scaling up of distribution of Long Lasting Insecticide Treated Nets distribution to protect people who live in malaria risk areas	% of LLINs distributed to protect children under 5 years	80% of children under 5	80% of children under 5	80% of children under 5	80% of children under 5
		% of LLINs distributed to pregnant mothers	80% Of the pregnant mothers	80% Of the pregnant mothers	80% Of the pregnant mothers	80% Of the pregnant mothers
		% of LLINs distributed to people who live in high risk areas	80% of the population who live in malaria risk areas	80% of the population who live in malaria	80% of the population who live in malaria	80% of the population who live in malaria
	To carry out Entomological surveillance for implementation of evidence based vector control programme	Fully functional entomology laboratory established # of Entomological surveys carried out per month	1 2/month	4 8/month	8 16/month	14 28/month
	To carry out selective Indoor Residual Spraying in the malaria risk areas	% of houses fully sprayed with susceptible insecticide in high risk malaria areas	80% of the houses in malaria high risk areas fully sprayed	80% of the houses in the malaria high risk areas fully sprayed	80% of the houses in the malaria high risk areas fully sprayed	80% of the houses in the malaria high risk areas fully sprayed

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
	Application of chemical larvicides and eco-friendly larval control measures	# of district identified the breeding places of malaria vectors	5 districts	13 districts	13 districts	13 districts
		%. of larviciding with susceptible insecticides carried out	50% of the reachable breeding places managed	80% of the reachable breeding places managed	80% of the reachable breeding places managed	80% of the reachable breeding places managed
	Promotion of vector control and other personnel protection methods	No. Vector control education and promotion activities conducted nationally	Twice a year	Every quarter	Update tools and maintain	Update tools and maintain
	Quality assurance on insecticides, biocides and Long Lasting Insecticide treated nets	No. of bioassays carried out	15	15	15	15
	Establish capacity building in service and on the job and international training for health who involve vector control and entomology surveillance	No. of staff were given refresher training	100% of the staff	100% of the staff	100% of the staff	00% of the staff
	Strengthen community participation for implementation of sustainable vector control	% of individuals surveyed having correct knowledge of vector control methods	>40%	>59%	>60%	>70%
	Stengthening intersectoral collaboration for implementation of sustainable vector control	% of identified stakeholders participating in partnership meeting	>60%	>70%	.>80%	>90%
	Ensuring adequate availability of cadre representing essential carders both at National and district level	# of entomological and vector control teams established at National and district level	2 National /6 at districts	2 national/9 districts	2 National /13 Districts	2 National /13 Districts
	Ensure availability of entomological, vector control equipments ad insecticides	# of stock out of insecticides at dstrict level	80%	80%	80%	80%

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Epidemic preparedness and outbreak response	Strengthening reporting and recording system for quality service delivery, through the Health Management Information System (HMIS)	# of quality monthly reported sent to National	100%	Maintain	Maintain	Maintain
	Strengthening Supervision, Monitoring and Evaluation systems	a. # of institutions supervised and feed-back given b. # of monthly review meetings carried out	60%	80%	Maintain	Maintain
	Preparation of district based epidemic preparedness and out break response protocol	# of outbreaks controlled	80% of the outbreaks	100% of the out breaks	Maintain	Maintain
	Training of the staff on epidemic preparedness and out-break response	#staff who have completed trainning	80% of identified staff	100% of identified staff	Maintain	Maintain

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Enable and promote research for improved policy formulation	Ensuring adequate availability of analysts for malaria microscopy at National and District and sub-district level	# of analysts appointed at national, CHCs and Health Posts level for malaria microscopy	5 for National and referral hospitals and 65 CHCs and 40 in high risk HPs will be in place	5 for National and 5 referral hospitals and 65 CHCs and 80 in risk HPs	14 for National and 13 referral hospitals and 65 CHCs and 120 in HPs	14 for National and 13 referral hospitals and 65 CHCs and 187 in HPs
	Ensuring adequate availability of quality control analysts for quality control of malaria microscopy at National and District and sub-district level	# of Quality control analysts in place at national and district level for quality control of malaria microscopy	5 Cross checkers at National and one each at district level	5 Cross checkers at National and one each at district level	5 Cross checkers at National and one each at district level	5 Cross checkers at National and one each at district level
	Ensuring adequate availability of focal points for entomological teams at National and District	# of entomological and vector control teams established at National and district level	Two National entomological team each with 2 entomology assistant and 3 insect collectors established	Two National entomological team and 3 district teams each with 2 entomology assistant and 3 insect collectors established	Two National entomological team and 7 district teams each with 2 entomology assistant and 3 insect collectors will be established	2 National and 13 district entomology teams 2 entomology assistant and 3 insect collectors established

ii. TUBERCULOSIS

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Enhancing access to TB diagnostic and treatment services that are accountable to clients and based on human rights approach	Government commitment supported by long-term planning adequate human resources and sustainable financing • develop medium and long-term budgeted plans of action in line with national health and development plans • develop an evidence base on the impact of TB interventions	% of New smear positive registered out of estimated New smear positive cases.	75	80	85	90
		% of new smear positive cases successfully treated out of new smear positive registered.	>85	>85	>85	>85
	Case detection through quality assured bacteriology and strengthening of the laboratory network • maintain a quality assured laboratory network for sputum smear microscopy • develop capacity for culture and drug susceptibility testing at NHL • ensure availability of supplementary diagnostics modalities at appropriate levels. • ensure adherence to the recommended diagnostic algorithms by all health care providers	Number (%) of designated microscopy centers that are part of external quality assurance protocol	19 (100%)	19 (100%)	19 (100%)	19 (100%)
		Number (%) of districts reporting no stock-out of anti-TB drugs	13 (100%)	13 (100%)	13 (100%)	13 (100%)
	Access to standardized treatment, under proper case management conditions, including directly observed treatment and patient support to increase adherence, chance of cure, and reduce the risk of acquiring drug resistance • Uninterrupted supplies of quality assured anti-TB drugs and other consumables at all facilities • Accurate recording and reporting on all notified cases and their outcomes for efficient monitoring of programme performance and evaluation of impact of TB control interventions	Number of districts submitting reports on time	13 (100%)	13 (100%)	13 (100%)	13 (100%)

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Scale-up of response to emerging challenges of HIV-TB and MDR-TB	national coordinating mechanisms to guide the development of national policies / guidelines and oversee implementation of interventions for TB/HIV established develop implementation plans at national level based on national TB/HIV policies and strategies, to pilot, scale-up implementation and expand the scope of TB/HIV activities strengthen capacity of both programmes for enhanced surveillance, diagnosis and management of HIV-associated TB, including mobilizing adequate resources develop mechanisms to regularly monitor and evaluate TB/HIV interventions and their impact promote and coordinate research aimed at improving prevention, early diagnosis and treatment of TB among PLWHA. build capacity at national reference laboratories to undertake quality-assured culture and drug susceptibility testing, also paying attention to infection control in laboratory settings undertake regular rounds of drug resistance surveillance: link with network of national laboratories and regional supranational reference laboratories build capacity and secure resources to expand MDR-TB case management in line with international recommendations.	Number (%) of Districts where TB/HIV intervention including PITC and cross referral is available	13 (100%)	13 (100%)	13 (100%)	13 (100%)
		Joint quarterly review of referrals between TB and HIV	4	4	4	4
		Number of laboratory providing culture and DST	1	1	At least 1, if required 2	At least 1, if required 2
		Number of MDR-TB cases registered on cat IV treatment	10	>15	>25	>25
Strengthening system to effectively deliver quality services to all TB patients with complementation from NGOs/ CBOs/ FBOs	Incorporate DOTS and DOTS Plus in pre-service training curriculum of doctors, nurses and pharmacists Develop guidelines for standardization of infrastructure and equipment requirement for TB control	% of in-country institutions adopting and teaching guidelines Guidelines available	100% Available and reviewed	100% Available and reviewed	100% Available and reviewed	100% Available and reviewed
Promoting adoption of international best practices amongst all care providers	Engage in public and private partnerships including communities and patient groups in ensuring the provision of an essential standard of care to all TB patients Engage traditional healers in referral and DOT	% of private providers involved in the programme	>60%	>70%	>80%	>90%
		% of traditional healers involved in the programme	>60%	>70%	>80%	>90%
Innovative community lead initiatives for delivering care and support for TB patients	develop and implement advocacy and communications campaigns for dissemination of information on the burden of TB and the cost-effectiveness of TB interventions on overall health and development	% of individuals surveyed having correct knowledge of symptoms of TB and treatment	>40%	>50%	>60%	>70%
Research to collect relevant baseline data and monitoring efficacy of interventions in local context	Undertake KAP and other surveys/community based studies	Number of studies undertaken annually	2	2	2	2

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Adopting partnership approach to involve all national and international stakeholders working with the national TB programme	Strengthening partnership activities and involvement of all stakeholders	% of identified stakeholders participating in partnership	>60%	>70%	>80%	>90%

iii. HIV/ AIDS

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Strengthening National AIDS Commission (NAC) to monitor and provide oversight for National HIV/AIDS program	Develop Policies of human rights and ensure its implementation	% of health facilities implementing human rights policy	50% of health facilities following policy guidelines	75% of health facilities	100% of health facilities	100% of health facilities
	Enforcement of non discrimination/ stigma reduction regulations to people attending HIV services in all service delivery place	% of health facilities following stigma reduction regulation	50% of health facilities following policy guidelines on non discrimination practices	75% of health facilities	100% of health facilities	100% of health facilities
	Expansion of sub divisions of NAC at regional and district level	% of districts estalhing NAC Sub division	50% of districts establish NAC sub divisions and function under NAC secretariat	75% of districts	100% of districts	100% of districts
	Establishing monitoring framework for NAC	Monitoring tools and guidelines in place	Guidelines and monitoring tools implemented 100%	Revision of guidelines and monitoring tools and 100% implementation	Revision of guidelines and monitoring tools	Revision of guidelines and monitoring tools
	Greater involvement of people living with HIV	PLHIV engaged at community level for monitoring and implementation of the program	At regional and district level PLHIV involved for supporting treatment, care, advocacy, counseling and monitoring	Maintain 2015 and expand PLHIV outreach and community network at sub district level	Maintain 2020 and expand PLHIV outreach at village level as per the needs	Maintain 2025 and engage PLHIV at all decision making for HIV program

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
strengthening monitoring and evaluation and capacity building of human resources	Up scaling the educational level of HIV health workers	Education level for HIV/AIDS health workers increased	At least 6 bachelor public health/ nursing staff at regional level and 2master level staff at national level for social science and medical sciences each, 1 diploma level laboratory assistant at national level	Maintain 2015 and at least one master level staff for HIV/ STI clinical case management at regional level and at least 1 master degree at national level for laboratory	Maintain 2020 levels and upscale 6 master level social scientists for psychological social care, increase educational level of all regional level laboratory technician t o masters degree	Maintain 2025 levels and recruit one post graduate medical professional for HIV/STI at district, regional and national levels
	Ongoing appraisals and supportive supervision schedules and reports	Number of appraisals and supportive supervision activities commenced	Yearly appraisals of 100% of staff and ongoing supervision	Yearly appraisals of 100% of staff and ongoing supervision	Yearly appraisals of 100% of staff and ongoing supervision	Yearly appraisals of 100% of staff and ongoing supervision
	Preparing M&E tools and guidelines for data management of case incidence and reporting progress of the program	M& E tools , SOP and guidelines developed and continuous trainings held for the staff	50% of staff trained and tools reviewed and revised every 3 years	100% staff trained and review the existing tools and the expansion of indicators	100% staff trained and ongoing training provided with revision of tools and guidelines	100% staff trained and ongoing training provided with revision of tools and guidelines
	Trainings held for capacity building for new and existing staff	HIV/AIDS division, HR	100% staff trained and retrained as an ongoing capacity building activity	100% staff trained and retrained as an ongoing capacity building activity	100% staff trained and retrained as an ongoing capacity building activity	
Prevention of HIV/ STI infection through awareness, enabling environment and promoting behaviour change communication	Increased SISCa coverage, community outreach through interventions	% of SISCa implement HIV/AIDS prevention activity	80% SISCa coverage and community outreach interventions	100% SISCa coverage and community outreach interventions	100% SISCa coverage and community outreach interventions	100% SISCa coverage and community outreach interventions
	School based education intervention packages developed for all age groups	% of Schools integrating HIV/AIDS in the national curriculum (Pre secondary and Secondary)	School based intervention packages will be available in 25% of schools pre secondary, secondary,	School based intervention packages will be available in 35% of schools nationwide	School based intervention packages will be available in 50% of schools nationwide,	School based intervention packages will be available in 100% of schools nationwide,

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
		% of Health related university implement the HIV/AIDS curriculum	100% Public Health Faculty, Medical faculty, Nursing faculty, Midwifery, training institution, others relevant health training	100%Public Health Faculty, Medical faculty, Nursing faculty, Midwifery. etc	100%Public Health Faculty, Medical faculty, Nursing faculty, Midwifery. etc	100%Public Health Faculty, Medical faculty, Nursing faculty, Midwifery.
	Interventions in place for wider coverage of population at risk e.g. Sex Workers, MSM, Mobile people, Intravenous Drug Users (IDUs), pregnant mothers, people in prison and work place at community level	% of identified sex worker received HIV/AIDS information Number of MSM identified reached through PE Number of IDU, pregnant women prisoners and work place received HIV/AIDS information	Interventions for MARG's in place and covering 100% of identified locations.	Interventions for MARG's in place and covering 100% of identified locations.	Interventions for MARG's in place and covering 100% of identified locations.	Interventions for MARG's in place and covering 100% of identified locations.
	Peer outreach established through community network for specific population	Number of PE community network established in regional and districts levels	100% of identified community networks have established peer education program in all 13 Districts	100% of identified community networks have established peer education program in all 13 Districts	100% of identified community networks have established peer education program in 13 Districts	100% of identified community networks have established peer education program in 13 Districts
		Number of BCC strategy developed	Improved specific behaviours by 50% compared to 2014	Improved specific behaviours by 50% compared to 2015	Improved specific behaviours by 50% compared to 2020	Improved specific behaviours by 50% compared to 2025
			Condom usage increased by 50% as compared to 2014	Condom usage increased by 50% as compared to 2015	Condom usage increased by 50% as compared to 2020	Condom usage increased by 50% as compared to 2025
Establishing high quality counseling, testing and diagnostic facilities for identification and monitoring HIV incidence	Developing Voluntary and Counseling and Testing Centers, VCCT) and Provider Initiated Testing and Counseling Centers(PITC)and implementing the Prevention from Mother to Child Transmission (PMTCT) program	% of health facilities staffed with quality trained workers and implementing VCCT, PITC and PITC programs	50% of health facilities staffed with quality trained workers and implementing VCCT, PITC and PMTCT programs	75% of health facilities staffed with quality trained workers on and implementing VCCT, PITC and PMTCT programs	100% of health facilities	100% of health facilities
		% of health facilities equipped with adequate laboratory facilities and trained laboratory staff	25% of health facilities equipped with adequate laboratory facilities and trained laboratory staff	50% of health facilities equipped with adequate laboratory facilities and trained laboratory staff	75% of health facilities	100% of health facilities
		% of health facilities with reporting and recording formats and communication channels in place	100% of all health facilities stocked with recording formats and adequate communication capabilities and reporting on a timely basis	100% of all health facilities stocked with recording formats and adequate communication capabilities and reporting on a timely basis	100% of all health facilities	100% of all health facilities

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
		50% of health facilities providing referral services with TB, STI and other opportunistic infections in place	50% of health facilities providing referral services on TB, STI and OI's	75% of health facilities providing referral services on TB, STI and OI's	75% of health facilities	75% of health facilities
	Laboratory facilities developed to monitor the progression of clinical staging of HIV/AIDS	% of CD4 and other advance machines installed for monitoring CD 4 count and viral load	25% of all health facilities equipped with CD4 machine and trained staff	50% of all health facilities equipped with CD4 machine and trained staff	75% of all health facilities	100% of all health facilities
Treatment and care to all HIV infected and affected individuals	Ensuring Anti Retroviral Treatment (ART) to all HIV infected people who need to be on treatment	% of ART centers established and providing treatment by staff trained for administering the regimen	100% of established ART centers providing treatment by qualified and trained health staff	100% of established ART centers providing treatment by qualified and trained health staff	100% of established ART centers	100% of established ART centers
		% of established ART centers providing easy access for maintaining high patient attendance	100% of established ART centers	100% of established ART centers	100% of established ART centers	100% of established ART centers
		Number of patients monitored for regular uptake of treatment, side effects and adherence	Monitoring of patients for all aspects of ART at 100%	Monitoring of patients for all aspects of ART at 100%	Monitoring of patients for all aspects of ART at 100%	Monitoring of patients for all aspects of ART at 100%
		Number and type of records maintained for clients progress	Proper patient record maintenance at 100%	Proper patient record maintenance at 100%	Proper patient record maintenance at 100%	Proper patient record maintenance at 100%
	Established linkages with TB program as it is most common cause of mortality for AIDS patients.	% of health facilities with HIV related services have established identified HIV/TB linkages	100% of health facilities with HIV related services have established identified HIV/TB linkages	100% of health facilities with HIV related services have established identified HIV/TB linkages	100% of health facilities with HIV related services	100% of health facilities with HIV related services
	Established linkages with STI and other opportunistic infections occurring to HIV infected persons	Access and treatment delivery	100% of health facilities with HIV related services have established identified HIV/STI/OI linkages	100% of health facilities with HIV related services have established identified HIV/STI/OI linkages	100% of health facilities with HIV related services have established identified HIV/STI/OI linkages	100% of health facilities

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
	Community based care services for palliative care for advance AIDS cases	Number of AIDS patients receive care and support services at established centers	Community based palliative care protocol developed and implemented with 25% of AIDS patients provided with community based palliative care	50% of AIDS patients are provided with community based palliative care	5% of AIDS patients are provided with community based palliative care	00% of AIDS patients are provided with community based palliative care
	Orphan care and ongoing psycho social support for HIV/AIDS patients	Number of orphan care established and provide services for destitute HIV infected and affected children	Orphan care protocols developed and implemented with 25% of orphans provided with basic health and psycho-social services	Orphan care protocols developed and implemented with 50% of orphans provided with basic health and psycho social services	Orphan care protocols developed and implemented with 75% of orphans provided with basic health and psycho social services	Orphan care protocols developed and implemented with 100% of orphans provided with basic health and psycho social services

iv. LEPROSY

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Improve quality of national leprosy eradication program	Develop National Leprosy Eradication Policy (NLEP)	NLEP developed	NLEP developed	Updated	Maintain eradication status	Maintain eradication status
	Revise & update the manual/guidelines of leprosy	The manual/guidelines updated	Guideline updated	Updated	Maintain eradication status	Maintain eradication status
Empower the community to participate in leprosy eradication activities	Community has access to information	% SISCa delivered education on Leprosy	100%	Maintain	Maintain	Maintain
	Implement community based case findings	Reduction of prevalence	Reduced prevalence by 75%	0 new case	Maintain	Maintain
Increasing capacity at all levels in management and technical	Increase number and qualification of staffs	# staff recruited and developed	LU: 2 S-1 qual. DHS: 2 D3-qual.	LU: 3 S-1 qual. DHS: 1 S-1 Qual & 1-D3 Qual.	Maintain	Maintain
	Provide refresh training	% staff trained	100%	Maintain	Maintain	Maintain
To provide high quality comprehensive leprosy services and develop effective link at peripheral level with referral unit	Developed effective link with: eye clinic dermatologic clinic laboratory for skin smear physiotherapy for assessment &management of reaction	use regularly link to referral clinics	One hospital	25%	50%	75%

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
	MDT provided at nearest Health unit Diagnosis is timely Treatment with MDT is available free of charge referral for complication maintain simple record	MDT coverage 100%	100%	100%	100%	100%
		% patient with complication referred for rehabilitation as needed	100%	100%	100%	100%
	Ensure Availability stock of drugs in central pharmacy	% leprosy patient have access to MDT % Health facilities obtain required quantity of drugs	100% 100% 100%	Maintain 100% 100%	Maintain 100% 100%	Maintain 100% 100%

v. LYMPHATIC FILARIASIS

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
interrupting the LF disease transmission	Mass Drug Administration (MDA) of Lymphatic Filariasis and Intestinal Parasite Infection programme	% of eligible people receiving single dose of DEC, Albendazole and pyrantel pamoate	Elimination at 75% population	Elimination 100% population	Maintain elimination	Maintain elimination
	Administration of Albendazole and pyrantel pamoate to eligible people as to reduce infection	% of eligible people receiving single dose of Albendazole and Pyrantel pamoate	50% population	75% population	Maintain	Maintain
Strengthening human resource based on the needs at all levels	Recruit and develop staffs of LF programme	Number of Staff recruited	5 national S1 staffs recruited	Maintain	Maintain	Maintain
		Number of staff trained	13 district D3 staffs recruited	3 national staffs completed S2 30% district staffs S1	Another 30% districts staffs completed S1	All districts staffs completed S1
			Refresh technical training for all staffs done every 5 years	Refresh technical training for all staffs done every 5 years	Refresh technical training for all staffs done every 5 years	Refresh technical training for all staffs done every 5 years

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Extending the monitoring of LF programme by focusing on brugia timori samples and through blood sample	Night blood sample test using brugia rapid test in district which consider as brugia timori endemic	% of Blood samples are taken and examined at laboratory	100% blood samples lab-examined	Maintain	Maintain	Maintain
	Active case finding for elephantiasis and hidrosel for rehabilitation Involve community in case findings	% endemic districts implement detection of Elephantiasis and hidrosel patients	100% endemic district implemented	Maintain	Maintain	Maintain
		% patients rehabilitated	25% patient rehabilitated	50% rehabilitated	75% rehabilitated	Maintain
		% SISCa active in case findings	100% SISCa active in case findings	Maintain	Maintain	Maintain
Strengthening partnership collaboration on implementation of LF programme to ensure budget availability	Advocacy meeting and proposal for fundraising to support the needs of programme running	% allocated budget compared to the need of LF programme	30% required budget available	75% required budget available	90% required budget available	100% required budget available
		Number of partner committed to collaborate	3 partners committed	Maintain	Maintain	Maintain

vi. OTHER ACUTE & VIRAL INFECTION DISEASES

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Establish port health program and port health field offices in port of entry as part of preventing the risk of international spreading diseases through effective public health measures and response	Develop national Port Health Policy (PHP)	PHP developed and updated	PHP developed	Updated	Updated	Updated
	Review and do an assessment of National Health Regulation based on International Health Regulation	% of inter-sector/regional network established	50%	100%	Review and Maintain	Review and Maintain
	Establish Port Health field offices	% port health field offices established	50%	100%	Maintain	Maintain
	Recruit and develop port health staffs	# staff recruited at Port Health Unit (PHU) and Port Health Field Office (PHFO)	PHU: 3 S1-qual. Staffs PHFO: 2 S1- qual. staff	PHU: 4 S1-qual. Staffs PHFO: 5 S1- qual. Staff	Maintain	Maintain
		% staff trained on port health	90%	100%	Maintain	Maintain
	Organize and implement National Health Regulation based on IHR 2005	% port health field office compliance to IHR 2005	75%	100%	100%	100%

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Establish international / regional networks	Train national staff of the point of entry in implementations of public health security in travel and transport in adequately.	% staff trained on international health	30%	50%	70%	90%
	Build collaboration and develop MoU	% identified international / regional ports have collaboration in port health.	30%	5 0%	75%	95%
Strengthen capacity of national health staff at Point of Entries (PoEs) on implementing the International Health Regulation (IHR)	Conducting seminar for socializing DHF Treatment Protocol	All Timorese clinicians are socialized with the new DHF protocol	50% medical to be attended	100%	100%	100%
Improve coverage and quality of dengue control program	Develop and socialize dengue control guidelines	% focal point of dengue control socialized with the guideline	90%	100%	Maintain	Maintain
	Produce DHF Guideline (flow chart) for DHF case management	% health facility follow DHF case management	100%	Maintain	Maintain	Maintain
	Strengthen dengue diagnostic and treatment. Strengthen Laboratory capacity	% of suspect DHF cases detected at health facilities % of suspect DHF confirmed cases detected at health facilities	100%	Maintain	Maintain	Maintain
		% of people who treated for suspected dengue and DHF	100%	Maintain	Maintain	Maintain
		% laboratory technician trained on dengue detection	100%	Maintain	Maintain	Maintain
		Upgraded laboratory technology	Upgraded	Upgraded	Upgraded	Upgraded
Improve community awareness on dengue	Assess community knowledge, attitudes and behaviours / practices (KAP)	% of community with appropriate KAP	50%	75%	80%	Maintain
	Develop strategy for increasing awareness	Strategy developed	1 strategy developed	Updated	Updated	Updated
	Development of guideline and strategies for integrated intervention	Guidelines available	Strategy developed	Updated	Updated	Updated

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Develop of guideline and mechanism of Outbreak Response for other acute and viral infection diseases.	Development of Standard Operational Procedures (SOP) for outbreak prone and emerging diseases (diarrhea, dysentery, SARS,H1N1, Avian Influenza, food poisoning)	SOP and mechanism develop	1 SOP and mechanism developed	Updated	Updated	Updated
	Development and implementation of H1N1 vaccine strategy	Strategy developed	1 strategy developed	Updated	Updated	Updated
	Develop information system and public awareness on outbreak prone and emerging diseases (diarrhea, dysentery, SARS, Avian Influenza, food poisoning, H1N1 etc)	Emerging Disease Information System developed	1 system developed	Updated	Updated	Updated
	Active case finding	% active case finding of emerging diseases	75%	100%	Maintain	Maintain
Strengthen Monitoring & Evaluation	Develop standardized Monitoring and Evaluation System	Monitoring and Evaluation system developed	1 system developed	Maintain	Maintain	Maintain
	Increase capacity in monitoring and evaluation	Coverage of regular monitoring and evaluation	75%	100%	Maintain	Maintain

E. NON-COMMUNICABLE DISEASES
i. MENTAL HEALTH & EPILEPSY

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Improving access to health facilities and treatment for all people with mental illness or epilepsy	Develop and disseminate standards and guidelines for the integration of mental health into the BSP	% of mental disorders treated as a proportion of the estimated prevalence of mental disorders in that population	National, Hospital and District Level	10%	50%	80%
	Diagnosis and treatment for all people with epilepsy in a community	% of epilepsy treated as a proportion of the estimated prevalence of epilepsy in that population	National, Hospital and District Level	10%	50%	80%
	Establish Acute Care Facilities at the District, Regional and National Hospitals	Acute Care Facility established at National Hospital (12 beds)	1	3	4	5
		Acute Care Facility established at Referral Hospitals (6 beds)	2	4	6	7
		Acute Care Facility established at District Hospitals (4 beds)	2			

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
To ensure a comprehensive multi-disciplinary team consisting of psychiatrists, psychiatric nurses, psychologists, and mental health technical professionals, who have been appropriately skilled and have reached specific standards of training	Develop national mental health curriculum for all levels and begin training at ICS in coordination with the Faculty of Health Sciences	Development of National Curriculum for all levels	D3 developed	S1 Developed	S2 Developed	S3 Developed
	Make arrangements for training of psychiatrist overseas for S1, S2 & S3	No. Scholarships provided for training overseas	One per year for each course level	Maintain and expand country of training	Maintain and expand country of training	Maintain and expand country of training
	Recruit appropriate staff to provide preventive, promotive and treatment of mental health and epilepsy patients	No. of Staff recruited	D3 -50 S1 – 3 S2 – 4 S3 - 2	D3 -100 S1 – 6 S2 – 8 S3 - 4	D3 - 150 S1 – 9 S2 – 12 S3 - 6	D3 - 200 S1 – 13 S2 – 16 S3 - 8
Increase community awareness and understanding of mental illness and epilepsy through advocacy, education, and promotion.	Develop education and promotional materials for use at health facilities, schools and training institutions	% of facilities with available education and promotional materials	65%	80%	100%	Maintain
	Organise seminars and workshops among health professionals regarding mental health and epilepsy	No. or workshops and seminars conducted annually	1 each year	2 each year	Maintain and improve	Maintain
	Establish networking at community level to help identify and assist patients and their families	Establishment of Networks at district level	District network established	Subdistrict networks established	Improve coordination	Improve coordination

ii. ORAL HEALTH

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
To ensure access to appropriate oral health services to the population at all facility levels	Provision of Dental activities in preventive, restorative and curative techniques according to standard treatment protocols	% of health facilities implementing oral health guidelines	75%	100%	100%	100%
	Provision of oral health preventive, curative and promotive services at primary health care level	No. of HP-s and SISCa activities providing oral health promotion and education	75% Health Posts and SISCa	100%	100%	100%
	Training of General Dental Doctor Dental Nurses and Dental Technician through scholarships	Increase No. of HR on oral health	19 Dentists 45 Dental Nurses 4 Dental Techniciens	38 Dentists 90 Dental Nurses 8 Dental Technicians	57 Dentists 117 Dental Nurses 12 Dental Technicians	76 Dentists 144 Dental Nurses 16 Dental Technicians
	Reorient clinical service delivery from a curative model of care to a blend of promotive, preventive and curative interventions;	Reduction in caries, periodontal disease and oral cancer in Timor-Leste	Baseline reported	Target defined		

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
To promote community awareness, and participation in priority target groups who are at risk of critical oral conditions;	Development of IEC materials on oral health to raise awareness about oral health risk factors and appropriate means of oral health care	% of Improved oral health knowledge, attitudes and behaviours relating to caries, periodontal disease and oral cancer.	35% of population	50% of population	60% of the population	70% of population
	Establish inter-sector networking and links with community based organizations for oral health campaigns	% communities supporting oral health campaigns	50%	70%	75%	80%
	Ensure student participation in oral health promotion and education activities	% of schools participating in oral health promotion and education activities	35% of primary and secondary schools participate	50%	65%	75%

iii. EYE CARE

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
To increase access to comprehensive high quality eye health care services.	Create a network of services to support the implementation of the eye health program at all levels.	% International and local NGO's working together with MoH to implement eye health programs	3	4	4	5
	Develop and implement a Basic Eye Treatment Protocol for all levels of health facilities	% Health Facilities implementing the Basic Eye Treatment Protocol	25 %	50 %	100 %	100 %
	Provide and maintain equipment for Eye Health Care treatment	% Health Facilities fully equipped with Eye Health Care equipment	25 %	75 %	100 %	
	Establish Eye Health Care Clinics at the district level and Eye Operation Centre at the hospital level	% Health Centres with Eye Health Care Clinics	20%	40 %	60 %	100 %
		% Hospitals with Eye Operation Centres	-20 %	-40 %	-60 %	100 %
To strengthen and increase community participation in the eye health program at SISCa	Conduct coordination meetings with community leaders	% community leaders participating in the coordination meetings	5o%	50%	75%	100%
	Coordinate services with leaders from: church groups, women, youth, elderly to mobilise the community to participate in eye health programs.	% community groups participating in community mobilisation	50 %	50 %	75 %	100%
	Provide basic eye care treatment training for PSF	% PSF received training on basic eye care treatment	25 %	50 %	75 %	
	Develop IEC material for the eye health program at SISCa	% SISCa using IEC material for promotion of good eye health care	50 %	100 %	100 %	100 %

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Increase the capacity of health staff to deliver eye care services at all levels	Provide training for Eye Health Nurses	% Eye Health Nurses participating in training	25 %	50 %	75 %	100 %
	Increase the number of general nurses studying the D1 ophthalmology	# eye health care nurses working in health facilities	65 ps	90 ps	90ps	90ps
	Increase the number of eye care doctors working at hospitals	# eye care doctors working at the hospitals	1	4	5	7
	Participate in a comparative study tour	% eye care staff participated in study tours	20%	40 %	70 %	100 %
	Establish on the job training for eye care nurses and all health facilities	% nurses receiving on the job training for eye health care	25 %	50 %	5 %	100%
Strengthen management of basic eye health services at all levels	Strengthen supervision and monitoring of the eye health program at all levels	% health facilities receiving monitoring and supervision of the eye health program	100 %	100 %	100 %	100%
	Introduce an eye care consultation registry at all health facilities	% health facilities using an eye care registry	50%	100%	100%	100%
	Introduce a monthly reporting format for the eye health program for all levels	% health facilities reporting monthly for the eye health program	50%	100%	100%	100%

F. OTHER EMERGING DISEASES

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Increase access and quality of age-friendly and old-age specific health services, with a focus on improving the skills of primary health care providers and introducing strengthening community models, such as home care programs.	All new and existing health facilities are built in accordance with national standards for accessibility.	# of Health Facilities that are applying National Standards for accessibility	65%	100%		
	Implement a Home Visit Program for those elderly and people with disabilities that are unable to visit health facilities.	% of target population receiving home visits Non CDC, DHS	100%	100%	100%	100%
	Together with the Ministry of Social Solidarity, develop and implement Community Based Services for the elderly and people with disabilities.	# of community based centres available at each sucu	25%	50%	75%	100%
	Introduce a module on basic Geriatric Care for the Nursing Diploma.	% general health nurses trained in basic geriatric care	35%	60%	100%	100%
	Provision of geriatric services for national and referral hospitals.	# of referral hospitals and national hospital providing geriatric services		50%	100%	100%

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
	Establishment of Chronic Disease Unit facilities	# of Cardiac Care Unit established	HNGV			HN
		# of renal care Units established	HNGV			HN
		# of Palliative Care Units established	HNGV			HN
	Recruitment/training of Cardiac Specialists	# Cardiac Specialists recruited/trained	1		2	
	Recruitment/Training of Endocrinologists	# Endocrinologists recruited/ trained	1		2	
	Recruitment/Training of Oncologists	# Oncologists recruited/ trained	1		2	
To establish an Early Detection of Disability Protocol for children (Developmental Screening)	To develop and implement Developmental Screening for children 0 – 5 years.	# health facilities implementing the Early Detection of Disability Protocol.	13 districts	50%	90%	100%
		% PSF trained in the Early Detection of Disability Protocol	100%	100%	100%	100%
	To introduce Physiotherapy and Occupational Therapy outreach service at all District Community Health Centres	# of SISCa providing preventative and promotive physio and OT services	25%	75%	100%	100%
	To increase the number of physiotherapists and Occupational Therapy at all hospitals to provide inpatient services.	# of physiotherapists and occupational therapists available at hospitals	1 physio/ HR, 1 OT/ HR, 1 physio/ HNGV, 1 OT HNGV	1 physio/ HR, 1 OT/ HR, 1 physio/ HNGV, 1 OT/HNGV	1 physio, 1 OT DH	
	To ensure required equipment is available to provide physiotherapy and occupational therapy services for inpatient and outpatient services	% of facilities fully equipped to provide therapy services	50%	100%		
Increase skills of health staff to manage Chronic Diseases	Introduce Chronic Disease and management into the Nursing Diploma	% general health nurses trained in Chronic Disease and management	100%	100%	100%	100%
	Provide on the job training for Chronic Disease and management for nursing staff at all health facilities	% nurses receiving on the job training in Chronic Disease and management	100%	100%	100%	100%
	Provide required equipment to ensure management of Chronic Diseases (e.g. Glucometer, Blood Pressure Monitor)	% of health facilities fully equipped for Chronic Disease Management	100%	100%	100%	100%
	Establish Self Help/Peer Support Groups for Chronic Diseases	% HP and CHC with Self Help Groups available for the patients with Chronic Diseases	50%	100%	100%	100%

G. ENVIRONMENTAL HEALTH

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Develop effective policy and planning system	Revise and update the current National policy for environmental health interventions	% policies signed and applied (for sanitation, water quality, vector control, food safety and waste management)	100%	Policy updated	Policy updated	Policy updated
		Policy on Environmental Impact Analysis (AMDAL) signed and applied	Policy on AMDAL signed	Policy updated	Policy updated	Policy updated
Improve resources and support system	Recruit and develop human resources of environmental health staffs	Availability of qualified-staffs at all level and health facilities	EHD staffed with 1 S2-staff and 11 S1-staff	3 S2-staff and 10 S1-staff	4 S2-staff and 9 S1-staff	Maintain
			S1 qualification of all DPHOs	Maintain	Maintain	Maintain
		Functionality of environmental health educational institution	All CHC have D3-sanitarian	50% sanitarians have S1 qualification	Maintain	MoH in collaboration with university held S1-study program on environmental health
			All hospital have D3-sanitarian	Academy of Env. Health established	Maintain	
	Develop Planning, Monitoring and Evaluation (PME) system	Functionality of PME system	Computer based system set up	System updated	System updated	System updated
Improve environmental health service delivery	Increase coverage and quality of sanitation and water quality interventions	% population have access to basic sanitation and clean water	60%	80%	90%	95%
		% public place compliance to criteria of environmental health standard (category B onward)	75%	95%	Maintain	Maintain
		% household reach category B of healthy house standard (based on KUBASA)	40%	50%	60%	70%

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
	Increase coverage and quality of food-safety interventions	Functionality of National Food-safety Board (NFB) and monitoring system	NFB and monitoring system well-functioning.	Maintain	Maintain	Maintain
		Functionality of Food-safety laboratory		National laboratory Food-safety established Maintain	Food-safety lab. Technology upgraded	Food-safety lab. Technology upgraded Foodsafety municipal laboratory established
		% public place producing food compliance to MoH standard	90%			
	Increase coverage and quality of vector control interventions	% population have access to reliable vector control methods	95% VCL established	Maintain VCL Technology upgraded	Maintain VCL Technology upgraded VCL networked at regional level.	Maintain VCL Technology upgraded Maintain
		Functionality Vector Control Laboratory (VCL)		2 National entomologist (S2) available	1 entomologists available at Municipal level	MoH in collaboration with university held S1-study program unit on vector control
	Increase coverage and quality of water quality interventions	Functionality of Water quality monitoring system	Water quality monitoring system well-functioning	Maintain	Maintain	Maintain
		Functionality of Water Quality Laboratory (WQL)	WQL established.	WQL technology upgraded 2 S2-experts available.	WQL technology upgraded Municipal WQL 1 S2-expert (S2) available at all municipal	WQL technology upgraded WQL networked at regional level.
	Increase coverage and quality of waste management interventions	Functionality of waste management monitoring system	Waste management monitoring system well-functioning.	Maintain	Maintain	Maintain
		% population have domestic waste place	50% population have domestic waste place.	60% population have domestic waste place.	70% population have domestic waste place.	80% population have domestic waste place.
		% health facilities have waste management system (with appropriate human resource and equipment).	100%	Maintain	Maintain	Maintain
		% public place have waste place	90% public places have waste place.	Maintain	Maintain	Maintain
Promote community involvement, gender and ensure social equality	Implementation of community based, gender sensitive and right based approached environmental health intervention (CGR)	% Suco implement CGR	50%	95%	Maintain	Maintain
		% Suco implement non-subsidy sanitation interventions	50% reach ODF status	95% reach ODF	Maintain	Maintain

H. HEALTH PROMOTION

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Develop Policy on Health Promotion	Advocate to decision and policy makers for healthy public policies	National heath promotion policy developed and updated	Policy developed	updated	updated	updated
Revise and update the current National Strategy for Health Promotion (NSHP) document	Review and update the existing national health promotion strategy (NHPS)	Updated NHPS	NHPS updated	NHPS updated	NHPS updated	NHPS updated
Empower the community, by placing the people as partners and actors able to help each other in solving their own health problems and adopt healthy behaviours	HP through health topics Organize activities at SISCa and other settings Organize community development activities at village and sub-district levels Assist health programs in managing behaviour change for specific health problems and populations	% programs developed a BCC component integrated in their strategies	25%	50%	75%	100%
		% adoption of key healthy behaviours	Improved by 50% compared to 2010	Improved by 50% compared to 2015	Improved by 50% compared to 2020	Improved by 50% compared to 2025
		Health facility visit rate (per capita per year)	1	2	3	3
		% community has access to information	40%	50%	70%	90%
		% program developed BCC materials	50%	75%	90%	Maintain
		% SISCa well-functioning (Category B onward)	80%	100%	Maintain	Maintain
		% aldeia supported active trained PSF	100%	Maintain	Maintain	Maintain
		% PSF are properly supporting SISCa and conducting household level BCC	80%	90%	Maintain	Maintain
		% schools have a school health focal point, a hand book and curriculum	90% PS	Maintain	Maintain	Maintain
		% public place promote behaviour change	90%	Maintain	Maintain	Maintain
Strengthen partnerships to create a supportive environment for behaviour change	Develop partnerships with relevant organizations	% suco have functioning KJPS	70%	80%	90%	Maintain
		% identified health promotion implementing organization work in partnership with MoH	90%	Maintain	Maintain	Maintain
	Develop an integrated action plan for HP with all partners	Functionality of online-based planning system	System well-functioning	updated	Updated	Updated

STRATEGIES	ACTIVITIES	OUTPUT INDICATORS	IMPLEMENTATION TIMEFRAME			
			Target 2015	Target 2020	Target 2025	Target 2030
Integrate the HP approach into health programs	Develop integrated computer based annual plan	% programs include health promotion aspect into Annual Health Plan % health interventions apply BCC model	100% 50%	Maintain 100%	Maintain Maintain	Maintain Maintain
Build the capacity of all health promotion personnel at all levels.	Develop capacity development strategy	Health promotion capacity development strategy (CDS) developed and updated	CDS developed	Update	Update	Update
		A training needs assessment (TNA) developed every 5 years and updated every 2 years	TNA developed & updated	Maintain Maintain	Maintain Maintain	Maintain Maintain
		% HP personnel trained in health promotion (including BCC) Education level for HP staffs increased	90% DPH: 2 S2-qual., all S-1 qual. DHS: S1 for all DPHOs	Maintain 2015 Municipal: 1 S2-qual	Maintain 2020 levels PH faculty has formal links for HP subjects with foreign universities	Maintain 2025 levels
	Improve management system in HP: planning, implementation, including supervision, monitoring and evaluation	M&E guidelines and tools developed for SISCa and PSF programs SISCa/PSF guides revised every 5 years, as well as other relevant existing HP documents School health and thematic BCC strategies developed	Guidelines and tools developed and revised every 2 years Guides revised and updated School health strategy developed	Maintain Guides revised and updated	Maintain Guides revised and updated	Maintain Guides revised and updated
	Develop infrastructure	Functionality of IEC/BCC resources centre (RC) (including materials, curriculum and researches)	RC well-functioning	Maintain	RC networked with overseas	Maintain
		Functionality of Health Promotion website	Website developed regularly updated	Maintain and regularly update	Maintain and regularly update	Maintain and regularly update

ANNEX C

ROAD MAP FOR DEVELOPMENT OF HEALTH PROFESSIONAL

A. HEALTH POST (SUCO LEVEL)

The Structure of the Services	Current situation	Expected configuration by 2030	2011-2015					2016-2020					2021-2025				2026-2030					Grand Total
			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	30	
Minimum Configuration	193 health post: 187 delivering regular services, and 6 HP twice a week	442 health posts with comprehensive health services Package	187	187	193	213	263	313	363	442												442
Human Resources Deployment		1 Doctor: 442			193	213	263	313	363	442												
	Deployment		13	13	50	50	50	50	23													249
	1 Nurse: **125**	2 Nurse 884	125	275	350	388	425	505	585		745	825	884									
	Deployment			150	75	38	37	80	80	80	80	80	59									759
	1 Midwife: **80**	2 Midwife 884	80	123	198	273	348	423	503		663	743	823	884								
	Deployment			43	75	75	75	80	80	80	80	80	80	61								809
	Lab-technician :0	1 Lab-tech 442					20	40	60		120	160	200		280	320	360	400	442			
	Deployment						20	20	20	40	40	40	40	40	40	40	40	40	22			442

The Structure of the Services	Current Health Services Delivery Configuration	Expected configuration by 2030	2011-2015					2016-2020					2021-2026					2026-2030					Grand Total
			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29		
Minimum Configuration	66 CHCs : 7 CHCs 24 beds, 59 without beds	73 CHCswith 10 admission beds.	67	67	67	67	67	69	69	69	69	69	71	71	71	71	71	73	73	73	73	73	73
Human Resources Deployment	1 Doctor: 0	2 Doctor: 146		18	146																		
	Deployment			18	128																		146
	1 Dentist: 4	1 Dentist: 73	2	2	2	2	2	2	2	12	32	52	73										
	Deployment									13	22	22	16										73
	4 nurses: 306	10 Nurse: 730	306	306	306		361			541	601	660	730										
	Deployment						28	60		60	60	59	70										354
	4 midwives: 191	10 Midwife: 730	191	191	191	191	191			371	431	491	551	611	660	730							
	Deployment							60		60	60	60	60	60	49	70							469
	1 Dental nurse: 17	1 Dental nurse: 73	17	17	17		66	73															
	Deployment						39	7															59
	Eye: 1	1 eye nurse: 66	1		23		43		73														
	Deployment			12	12		12	12															72
	2 lab. Technician: 72	2 Lab-technician: 146	72	72	72	72	92			146													
	Deployment						20	20		14													74
	1 Pharmacy Tech: 25	2 Pharmacytech: 146	25		98	146																	
Human Resources Deployment	**Deployment**			40	40	41																	121
	1 Public Health:	4 Public Health: 292	65	125	185	264	292																
	Deployment		65	60	60	75	32																292

B. DISTRICT HOSPITAL (DISTRICT LEVEL)

The Structure of the Services	Current Health Services Delivery Configuration	Expected configuration by 2030	2011-2015					2016-2020					2021-2026					2026-2030					Grand Total
			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
Minimum Configuration	3 Hospitals, 24 beds (Maliana, Oecusse and Suai&Baucau) with 6 specialists	13 hospitals, with capacity between 5o - 75 beds	4	4	4	4	4	4	6	9	13												9
Human Resources Deployment	General Doctor : 0	8 General Doctor : 96						96															
	Deployment							96															96
	1 Dentist : 1	1 Dentist : 13	1	1	1	1	1	1	5	7	10	13											
	Deployment								4	3	3	3											13
	1 obstetrician :0	1 Obstetrician: 13						6	13														
	Deployment							6	7														13
	1 Pediatrician :0	1 : Pediatrician: 13						6	13														
	Deployment							6	7														13
	1 Internist :0	1 Internist 13						6	13														
	Deployment							6	7														13
	1 Surgeon : 0	1 Surgeon: 13						6	13														
	Deployment							6	7														13
	1 Anesthetic : 0	1 Anesthetic: 13						6	13														
	Deployment							6	7														13
	1 Radiologist : 0	1 Radiologist : 13						6	13														
	Deployment							6	7														13
	nurses : 46	60 Nurse : 780	46	46	46	46	46	86	126	166	206	246	286	226	266	306	346	386	426	466	506	546	
	Deployment							40	40	40	40	40	40	40	40	40	40	40	40	40	40	40	600
	midwives : 31	16 Midwives : 192	31	31	31	31	31	71	111	151	192												
	Deployment							40	40	40	41												161
	Dental nurse : 3	2 Dental nurse : 26	3	3	3		15	21	26														
	Deployment					6	6	6	3														21
	Eye nurse : 1	2 eye nurse : 26	1	1	1		13	19	26														
	Deployment					6	6	6	7														25
	Anesthetic nurse : 9	3 Anesthetic nurse : 39	9		19		29	39															
	Deployment			5	5	5	7	10															32
	lab. Technician : 9	10 Lab-tech : 130	9	9	9	9	19		39	49	69	79	89	89	89	130							
	Deployment						10	10	10	10	20	20	10	10	10	11							121
	Tec. Radiog : 3	2 Tec. Radiog : 26	3	3	3	3	3		11	15	19	26											
	Deployment							4	4	6	6	5											25
	Pharmacy Tech : 3	5 Pharmacy Tech : 65	3		15		15		30	45	60												
	Deployment			7	5			10	10	15	15												62

The Structure of the Services	Current Health Services Delivery Configuration	Expected configuration by 2030	2011-2015					2016-2020					2021-2026					2026-2030					Grand Total
			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
Human Resources Deployment	Physiotherapist : 2	2 Physiotherapist : 26							10	20	26												
	Deployment								10	10	6												26
	Public Health (Clinical Nutritionist/HMIS /Environment Health)	3Public Health : 39					10		39														
	Deployment						10	10	9														39

C. REFERRAL HOSPITAL (REGIONAL LEVEL)

The Structure of the Services	Current Hospital Services Delivery Configuration	The expected configuration by 2030	2011-2015					2016-2020					2021-2026					2026-2030					total
			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
Configuration	3 Hospitals (Dili, Baucau, and Maubisse) with 7 specialists	5 Referral Hospitals (Baucau, Natarbora, Dili, Maubisse, Lebutu) with 18 specialists	3	3	4	4	4	4	4	4	4	5											2
	Doctor : 32	24 Doctor : 120	32	32	32	32	50	63	120														
	Deployment						18	13	57														88
	1 Dentist : 4	2 Dentist : 10	4	4	4	4	4	4	4	8	10												
	Deployment									4	2												6
	1 obstetrician : 2	2 Obstetrician : 10	2	4	4	4	4	4	10														
	Deployment			2			2		4														8
	Pediatrician: 2	2 Pediatrician: 10	2	2	2	2	2	2	8	10													
	Deployment								6	2													8
	Internist : 2	2 Internist 10	2	2	2	2	2	2	8	10													
	Deployment								6	2													8
	Surgeon : 1	2 Surgeon : 10	1	1	1	1	1	1	8	10													
	Deployment								7	2													9
	1 Anesthetic : 0	2 Anesthetic : 10					1	3	3	6	8	10											
	Deployment						1	2		3	2	2											10
	1 Radiologist:0	2 Radiologist : 10							3	6	8	10											
	Deployment								3	3	2	2											10
	Psychiatry : 0	1 Psychiatry		1	1	1	1	1	1	1	1	4	5										

The Structure of the Services	Current Hospital Services Delivery Configuration	The expected configuration by 2030	2011-2015					2016-2020					2021-2026					2026-2030					total
			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
	Deployment			1						2		2											5
	Dermatologist: 0	1 dermatologist: 5										4	5										
	Deployment											4	1										5
	Ophthalmologists: 1	1 0phthalmologist: 5	1	1	1	1	1	1	1	1	2	5	5	5	5	5	5						
	Deployment										2	3	1	1	1	1	1						10
	ENT Specialist: 0	1 ENT Specialist : 5									2	5											
	Deployment										2	3											5
	Orthopedist: 0	1 Orthopedist: 5	1	1	1	1	1	1	1	1	2	5											
	Deployment		1								2	2											5
	Urologist: 0	1 Urologist: 5									2	5											
	Deployment										2	3											5
	Cardiologist: 0	1Cardiologist: 5									3	5											
	Deployment										3	2											5
	Neonatologist: 0	1 Neonatologist: 5									3	5											
	Deployment										3	2											5
	Pulmonologist	1 Pulmonologist: 5									3	5											
	Deployment										3	2											5
	Rehab-Medic Specialist	1 Rehab-Medic Specialist : 5									3	5											
	Deployment										3	2											5
Human Resources Deployment	Forensic Specialist	1 Forensic Specialist : 5									3	5											
	Deployment										3	2											5
	Dentist Specialist	1 Dentist Specialist : 5						1	2	3	4	5											
	Deployment							1	1	1	1	1											5
	Nurse Specialist	16 Nurse Specialist : 5							10	20	30	40	50	60	70	80							
	Deployment								10	10	10	10	10	10	10	10							80
	Nurses : 280	160 Nurse: 800	280	280	280	280	280	300	320	340	360	380	400	420	440	460	480	500	520	540	560	580	
	Deployment							20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	300
	Midwives : 63	40 Midwives : 200	63	63	63	63	63	63	63	83	103	123	143	163	183	200							
	Deployment									20	20	20	20	20	20	17							137
	Dental nurse : 5	3 Dental Nurse : 15	5	5	5	5	9	9	9	9	15												
	Deployment						4				6												10
	Eye nurse : 1	2 Eye Nurse : 10	1	1	6	6	6	6	6	6	10												
	Deployment		1		5						4												10
	Anesthetic nurse :	4 Anesthetic Nurse : 20	22																				

The Structure of the Services	Current Hospital Services Delivery Configuration	The expected configuration by 2030	2011-2015					2016-2020					2021-2026					2026-2030					total
			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
	Deployment																						0
	lab. Technician : 16	20 Lab-Technician: 100	16	16	16	16	16	26	40	50	60	80	100										
	Deployment							10	14	10	10	20	20										84
	Radiographist: 10	8 Tec. Radiologist: 40	10	10	10	10	10	20	30	40													
	Deployment							10	10	10													30
	Pharmacy Tech18	8 Pharmacy Tech: 40	18	18	24	24	24	24	24	40													
	Deployment				6					16													22
	Dietist /clinical nutritionist	Dietist/Clinical Nutritionist : 5					3	5															
Human Resources Deployment	**Deployment**						3	2															5
	Physiotherapist: 3	8 Physiotherapist: 40	3	3	4	4	4	4	10	20	30	40											
	Deployment				1				6	10	10	10											37
	Electro-medical Technician: 2	Electro-medical Technician:10	2	2	2	2	2	2	4	6	8	10											
	Deployment							2			2	2											6

D. NATIONAL HOSPITAL

The Structure of the Services	The expected configuration by 2030	2011-2015					2016-2020					2021-2026					2026-2030					Total
		11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
Configuration	One national Hospital, with 37 specialist																					
Human Resources	70 Doctor :												5	70								70
	3 Dentist :												1	3								3
	4 Obstetricia												1	4								4
	4 : Pediatrician												1	4								4
	4 Internist												1	4								4
	4 Surgeon												1	4								4
	5 Anesthetic												1	4								4
	3 Radiologist												1	3								3
	3 Psychiatry												1	3								3
	2 Dermatologist												1	2								2
	2 Ophthalmologist												1	2								2
	2 ENT Specialist												1	2								2
	3Orthopedist											1	2	3								3
	3 Urologist											1	2	3								3
	2Cardiologist												1	2								2
	2 Neonatologist												1	2								2
	3 Pulmonologist												1	3								3
	1 Rehab-MedicSpecialist													1								1
	2 ForensicSpecialist												1	2								2

The Structure of the Services	The expected configuration by 2030	2011-2015					2016-2020					2021-2026					2026-2030					Total
		11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
	2 DentistSpecialist												1	2								2
	3 ClinicPathologist												1	2								2
	1 Radiotherapist												1									1
	1 Traumatologist												1									1
	Dietist												2									2
	1 Gastro-enterologist												1									1
	1 Rheumatologist												1									1
	Oncologist												1									1
	Geriatric												1									1
	Anesthesia												4	12								12
	Perinatology												4	8								8
	Pulmonolgy:12												4	8								8
Human Resources	Cardiology:2												1	2								2
	Psychologist													2								2
	Physiotherapist													8								8
	300 Nurse						20	40	60	80	100	120	140	160	180	200	220	240	260	280	300	
	Deployment Plan						20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	300
	80 Midwives						10	20	30	40	50	60	70	80								
							10	10	10	10	10	10	10	10								80
	4 Dental nurse													4				4	4	4	4	4
	30 Lab-technician												20	30								30
	16 Tec. Radiologist:												2	16								
	16 PharmacyTechnician:													16								16
	4 Electro-medicalTechnician												2	4								
	2 Health Management Information System												1	2								2
	2 Sanitarian/ Waste Management													2								2
	4 Electro-medicalTechnician												2	4								

ANNEX D

ROAD MAP FOR DEVELOPMENT OF HEALTH FACILITIES

The Structure of the Services	Current situation	By 2030	2011-2015					2016-2020					2021-2025										Total
			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
Health Posts	187	442	187	187	193	213	263	313	363	442	442	442	442	442	442	442	442	442	442	442	442	442	
Construction Plan				5	20	50	50	50	50	48													442
Specifications			3 consultations rooms, 1 emergency room, maternity unit with 4 observation beds, laboratory room, 2 toilets, 2 waiting areas, drug dispensary, storage room, reception room, kitchen, staff room.																				
Staff Accommodation			a compound with 5 residences with: two bedrooms with toilets, one dining room and one sitting room, a kitchen and toilet for visitors, and a varanda																				
Community Health Centre	66	70	66	66	66	66	68	70	70	70	70	70	70	70	70	70	70	70	70	70	70	70	Total
Construction Plan (expansion)				20	20	20	5	5															70
Specifications			Emergency unit room with 4 observation beds, maternity unit with birthing rooms and 4 observation beds, dental unit, ophthalmology unit, mental unit with emergency care, VCT unit with HIV treatment room, public health unit, drug dispensary unit, laboratory unit, waiting area, inpatient unit with 10 beds, toilets for staffs and public, waste management area, Administration unit.																				

The Structure of the Services	Current Situation	By 2030	2011-2015					2016-2020					2021-2025					2026-2030					Total
District Hospital			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
	3	13	3	3	3	3	3	3	6	10	13												13
Construction Plan									3	4	3												
Specifications			Referral Emergency and ambulances unit, policlinics for specialized services units, waiting areas, internal medicine services unit, pediatrician unit, obstetrician/gynecology unit, surgery unit, medical rehabilitation unit, radiology unit, laboratory unit, pharmacy and dispensary unit, warehouse for logistics, laundry and dining launch, kitchen, ICT and medical record unit, waste management, biomedical unit, general administration unit, parking lot.																				

The Structure of the Services	Current Situation	By 2030	2011-2015					2016-2020					2021-2026					2026-2030					Total
			11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
Regional Referral Hospital	3	5	3	3	3	3	3	3	3	3	4	5											5
Construction Plan											1	1											
Specifications			The infrastructure should incorporate: emergency unit, ambulance unit, Obstetrician services, pediatrician services, internist services, surgeon services, anesthetist services, psychiatrist services, dermatologist services, ophthalmologist services, ENT specialist services, orthopedist services, urologist services, cardiologist services, neonatologist services, pulmonologist services, rehab-medic services, forensic-specialist services, dental specialist services, radiologist services, unit, laboratory services unit, pharmacy and dispensary unit, laundry, kitchen and dining launch, ICT and medical record, waste management, biomedical unit, administration, Parking lot.																				

The Structure of the Services	Current Situation	By 2030	2011-2015						2016-2020					2021-2026					2026-2030					Total
			11	12	13	14	15	16	17	18	19	20	21	22	23		24	25	26	27	28	29	30	
National Hospital	0	1															1							1

Specification	The infrastructure of National hospital should include: emergency unit, ambulance unit, specialized policlinics, Obstetrician unit, pediatrician unit, internist unit, surgeon unit, anesthetist unit, psychiatrist and emergency unit, dermatologist unit, ophthalmologist unit, ENT specialist unit, orthopedist unit, urologist unit, cardiologist unit, neonatologist unit, pulmonologist unit, rehab-medic unit, forensic-specialist unit, dental specialist unit, radiologist unit, plastic surgery unit, pathology clinic unit, pediatric pulmonologist unit, endocrinologist unit, pathology anatomy unit, pediatric surgery unit, radiotherapy unit, traumathologist unit, pediatric nutrition unit, Gastro enterologist unit, digestive surgery, hand surgery, head-neck surgery, infertility treatment unit, pediatric neurologist unit, rheumatologist unit, oncologist unit, geriatric unit, cardiovascular surgery unit, hematologist clinical/ pathologist unit, laboratory services unit, pharmacy and dispensary unit, laundry, kitchen and dining launch, ICT and medical record, waste management, biomedical unit, administration, Parking lot.

ANNEX E

Ministry of Health
Public Financial Management Roadmap 2011- 2015

Introduction

Ministry of Health(MoH) acknowledges that strong financial management systems are essential to delivering equitable and efficient health services throughout the country. Accordingly,financial management, which includes procurement,has been identified as an area to be strengthened within the National Health Sector Strategic Plan (NHSSP) 2011-2030. There have been a number of reviews on financial management and procurement undertaken by MoH to identify the issues, with the main focus on how to improve the flow of funds and other core resources to the District Health Services, given they are responsible for providing services to the majority of the population of Timor-Leste.

A public financial management (PFM)'roadmap' has been prepared based on the findings of these reports, as well as from consultation with MoH departments, Ministry of Finance, and development partners working in the health sector. All district health teams provided input to the PFM roadmap through a series of regional workshops in mid 2012. The workshops were part of the consultations for developing the new NHSSP-Support Project (NHSSP-SP) which will assist the MoH to develop and implement these core PFM systems and practices that are necessary for the accountable use of public resources and improved service deliveryin Timor-Leste. The NHSSP-SP will support MoH to implement the required improvements under the first stage of the NHSSP through to December 2015.

The roadmap has been split between Central Services and District Health Services, and covers the period 2011 to 2015, there is a summary of each roadmap, and a more detailed step by step report included as an annex to the roadmaps.

PFM and National Health Sector Strategic Plan

In order to achieve the aims of the NHSSP, PFM Reform and capacity is required within MoH. The overall objective of PFM in the NHSSP is "to increase public resource mobilisation to the health sector through efficient and sustainable means as to promote equity of access to cost effective and quality health services at all levels of care" . Therefore linking PFM to the NHSSP logically leads to the following key reforms for PFM in MoH:

- Improving the control and flow of funds to District Health Services;
- Documenting and implementing strong financial internal controls and systems across the MoH;
- Improving the budgeting and planning processes through bottom up budgeting and linking plans to budgetworking towards One Plan, One Budget, and One Sector Monitoring and Evaluation Framework;

[1]Steps to Health Sector Wide Policy, Management and Improved Coordination towards a Sector Wide Approach (SWAp) in Timor Leste, Ann Canavan May 2009. District Health Directors Public Financial Management and Performance Improvement Workshop, Kathy Wimp September 2010. Mid Term Review , Joao Olivio da Silva, 2010.
[2]Procurement considerations for a Roadmap on PFM, John Blunt, May 2011.
[3]The primary development partners for NHSSP-SP are Australia (through AusAID), the European Union (through the European Commission) and the World Bank

- Ensuring that the Health Sector is adequately funded, equitable and efficient; and
- Improving the capacity of financial staff within MoH.

The expected outcomes from PFM reforms and implementation of the roadmap are:

- The MoH will have improved capacity in financial management at both the central and district levels;
- The MoH will have adequate well-functioning financial systems at both central and district levels;
- The MoH will be in a stronger position to receive sector budget support by 2016 under its One Plan, One Budget and One Sector Monitoring and Evaluation Framework.

Public Financial Management

In order to manage finances effectively health managers need to be able to answer the following questions:

1. How much does MoH need to fund Health Services?
2. Who provides the funding/who pays for the Services?
3. Where are the funds being allocated/what services are funds paying for?
4. Who controls the expenditure of the funds?
5. How are the funds spent? i.e. through Procurement, Pasta Mutin, Salary & Wages
6. Who reports on expenditure? When how and to whom?
7. What quality of services does MoH receive/provide for funds spent?
8. Has performance improved? Health service delivery indicators

In order to answer the questions listed above, managers must be competent in understanding financial reports and most importantly they should be able to rely on the financial system and finance staffto provide the relevant information for them to make informed decisions. It is imperative that finance staff have the skills and capacity to manage, control and report on the finances of the division/ministry.

The roadmap for PFM in MoHcan be linked to Managers being able to understand and answer the identified questions, as per the table below. While managers should be able to answer the questions, it is difficult in a centralised system for each Manager to be able to answer adequately, as they have little control over their budgets and expenditure; therefore the roadmap is structured to enable this by the end of 2015.

[4]Draft National Health Sector Strategic Plan 2011-2030

Management Question	Objective	How to get there?
How much does MoH need to fund health services?	Health is adequately funded to deliver services & achieve outcomes of NHSSP	■ Costing of Services- costing priority areas of NHSSP through a medium term budget framework, showing health sector resources, financing gaps and setting key financial indicators ■ Improved processes around Annual Budgets and Planning – linking annual budgets to medium term budget framework and annual operational/implementation plans. One annual planincorporating all activities and funding (one plan, one budget).
Who provides the funding?	MOH aware of total resource envelope	■ GoTL allocation to health in line with NHSSP indicators ■ Relevant, timely information about DP funds to health
What is the money being spent on? Are funds allocated to appropriate divisions per NHSSP?	Equitable allocation of funds	■ Primary vs Secondary and Tertiary ■ Resource allocation method ■ Rational allocation to line items ■ Efficiency gains – particularly for drugs where the cost of procuring emergency/ short term quantities.
Who controls the expenditure of money?	Budget Holder has authority to spend money	■ Budget holders responsible for Virements ■ Delegation authorities/decentralisation
How is the money spent?	Appropriately qualified and capable finance staff	■ Appropriately skilled staff ■ Ongoing training and support ■ Finance Manuals
Who reports on expenditure (when, how and to who)?	Robust Financial management system capturing information	■ Regular and timely reporting
What quality of service does MoH get for our money?	Quality health care services	■ Management information that links administration and financial data ■ Internal audit unit to carry out performance audits
Has performance improved?	Improvement in health indicators/ targets met.	■ Links policies with budget ■ Service Delivery milestones

Implementation of PFM Roadmap

Ministry of Health will set up a PFM Roadmap working group to manage and monitor the implementation of the roadmap. The working group will consist of senior staff from MoH, Ministry of Finance and DPs. It is envisaged that the working group will meet monthly in the first twelve to twenty four months of implementation of the roadmap. Furthermore, MoH has identified a senior civil servant to be the champion for the roadmap.

The roadmap will be reviewed annually by the working group and adjusted according to needs, progress and any changes in Government financial management. In particular, the Government has stated that decentralisation is a priority area; however at the time of preparing the roadmap, no formal policies on what this really means for District Health Services and how and when it will be implemented have been prepared. The roadmap will need to be updated for decentralisation once Government policy has been set.

MoH will need continued support to implement the PFM roadmap. In particular a close working relationship with Ministry of Finance is essential to implement the roadmap. This support may come in the form of existing technical assistance, additional short term technical assistance and accounting firms, training support from Ministry of Finance, training provided by NGO's operating in districts and by other means. The assessment of finance staff skills and the development of training plans will guide the support required. Support will be provided through the NHSSP-SP which will commence mid 2012.

MINISTERIO DA SAUDE - PUBLIC FINANCIAL MANAGEMENT (PFM) ROADMAP - CENTRAL

2011

Set up PFM Working Group including MoF, MoH, DP's as per TOR. Identify champion for roadmap	Assess finance and procurement staff skills & develop training plan	Access to Freebalance (input & reporting)	Develop template for monthly reports budget vs actual, include all DP funds managed by MoH (Global Fund, NHSSP-SP etc)

2012

Access to Freebalance DP funds NHSSP-SP, Global Fund	Finance & procurement manual prepared & training provided extract for districts produced including design of new chart of accounts with MoF	Costing NHSSP priority areas for 5 year period (MTEF discussion)	Develop budget templates for linking plans to budget (program based budgeting2013) incorporating new chart of accounts program based reporting in Freebalance. Establish budget review committee within MoH.

2013

Continued training as per plan	Program based reporting begins monitoring & support required	Adopt resource allocation method based on NHSSP/MTEF indicators/modelsready for 2014 budget	Continue to strengthen budgeting processes (one plan, one budget for 2014)

2014

Internal Audit Committee set up in MoH	Continued training as per plan	Asset monitoring system introduced	Continue to strengthen budget and reporting processes

2015

Introduce performance reporting Including performance auditing	Continue to strengthen Budgeting process	Continued training as per plan

MINISTERIO DA SAUDE - PUBLIC FINANCIAL MANAGEMENT (PFM) ROADMAP MOH - DISTRICTS

2011

Develop system for reporting and monitoring pasta mutin (including procurement rules for pasta mutin)	Develop system for reporting and monitoring fuel usage	Monthly reports on budget vs actual provided by MoH Central reading & understanding finance report

2012

Assess finance skills Develop & deliver training (note training will be over longer Period than 2012)	Finance & procurement manual prepared & training provided	Open bank accounts	Budget templates for linking plans to budget introduced (program based budgeting 2013)

2013

Continued trainingF as per plan	reebalance access and training	Districts receive budget envelope from MoH Central – budget submission by program presented to MoH(one plan, one budget)

2014

Districts enter data Directly into Freebalance	Districts prepare quarterly activity reports to MoH	Asset monitoring system introduced

2015

Continue to strengthen Budgeting process	Continued training as per plan	Introduce performance reporting

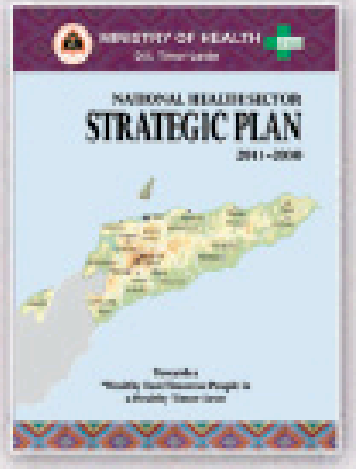
Detailed Steps for Implementing Roadmap – Central & District Services – to be read in conjunction with Summary

Reform/Tasks as per Roadmap	Indicator/Target	Responsible Division and Officer	Resources Required	Timeline
Set up PFM Working Group as per attached Terms of Reference Identify champion for PFM Roadmap within MoH	Working Group meeting monthly	MoH Finance – Director Planning and Finance	Nil	December 2011
Assess finance and procurement skills in Central Services and develop training plan: ■ Document number of staff ■ Qualifications of staff ■ Job Descriptions of staff ■ Survey on skills to be developed ■ Training plan to be developed Survey of staff skill set to be undertaken, basic numeracy/book-keeping training to be provided to staff at Health Posts, CHC's and District Health Services. Ongoing training and support to be prvided by MoH Central	Training plan developed % of staff with job descriptions % of staff trained	MoH Finance – Director Planning and Finance with TA support MoF – access to training	Existing TA support Cost of training plan NGO agreement to deliver district training District Finance advisors	March 2012 September 2012
Access to Freebalance: - covering both MoHGoTL and NHSSP-SP, Global Fund ■ Meeting with MOF to review connection status; ■ Review staff access to Freebalance and skill set for producing reports and utilising Freebalance ■ Development of chart of accounts for HSSP-SP ■ Discussion and development of chart of accounts – Global Fund ■ Training in Freebalance for staff	MoH utilising Freebalance Timeline for NHSSP-SP & Global Fund to move to Freebalance	MoH Finance with TA support from NHSSP-SP & Global Fund	Existing TA support Cost of access to Freebalance system for NHSSP-SP & Global Fund	February 2012 February 2011
Develop template for monthly reports ■ MoH Central to provide monthly finance report to all divisions by 15th of each subsequent month ■ Format for monthly report to be developed – may be straight from Freebalance ■ Training in how to read and understand finance reports to be delivered to all finance staff and directors ■ Consolidated quarterly report for MoH Executive to be prepared by 15th of month following end of quarter ■ Template for format on consolidated report to be developed, must include all sources of funds – template to be provided to DP's to ensure consistency in reporting ■ DP Funds to be reported (budget vs actual) to MoH Central on a quarterly basis by 10th of month following end of quarter	Monthly reports prepared	MoH Finance with TA support	Training costs	February 2012
Access to Freebalance DP Funds, NHSSP-SP, Global Funds: ■ Data entry of transactions ■ Reports being prepared	Using Freebalance 1/3/12	MoH Central, DPM	Trained finance staff	March 2012
Finance and Procurement Manuals prepared and training provided: ■ Develop a finance manual for MOH covering internal controls as listed below and provide training on manual. Prepare a simple extract of manual for districts. SAMES to determine accounting basis (cash or accrual) and manual to be developed for SAMES. ■ Basis of accounting as per GoTL ■ Internal Controls ensure separation of procurement and finance – Basic forms to be used; – Monitoring of expenditure and procurement – Internal Audit Function – External Audit Function	Finance manual % of finance staff received training on manual	MoH Central, with TA support	Accounting firm to prepare manual and undertake training TA Finance to SAMES TA to Procurement Training funds	Manual prepared by June 2012 Training completed by September 2012

■ Budgeting and budget control: – Virements for all divisions must be approved by Head of division (including District Health Directors – Virements for all divisions must be approved by Head of division (including District Health Directors – Basic approval form to be developed – Develop simple excel budget control spreadsheet for districts to monitor & manage budget (Vote control) – Delegation authorities/decentralisation ■ Expenditure – including: – Purchasing limits to be set, including nature of purchase i.e. capital items to be procured centrally – Fuel - Districts determine amount of fuel required per annum and delivery dates - this to be incorporated into contract and districts receive a copy of contract. – Contract management and monitoring to be strengthened. – Current system of purchasing emergency fuel to be continued through pasta mutin. – System for monitoring & managing fuel distribution from districts to be developed. – Drugs – system to monitor and report on drug supply * Payment for drugs to SAMES to be discussed more based on nature of SAMES (refer below) * Stocktaking; * Forms control; * Delivery dates – buffer stock ■ Revenue/User Fees – System for ensuring collection of fees receipted and banked appropriately ■ Salary & Wages – Robust system for approving overtime; – Monitoring leave entitlements, attendance etc ■ Cash Control – Pasta Mutin: * Imprest tracking and acquittal process for all divisions of MoH, including district health centres and health posts. – Bank Accounts: * District Health Services to hold bank accounts (to be discussed with MoFT) ■ Assets - Asset policy to be set in accordance with GoTL system. – Asset monitoring and tracking system to be developed. Freebalance asset module to be utilised, training and access in module required. In absence of or while preparing for access to Freebalance simple excel or manual system to be developed. ■ Procurement and logistics – Skill assessment, job descriptions and procurement capacity development plan to be developed – Annual MoH procurement plan to be prepared – Procurement Manual to be developed covering: * Procurement structure within MoH and links to GoTL procurement systems; * Improve specification setting for tenders eg fuel * Standard Bidding documents; * Procurement delegations; * Procurement processes for NCB, ICB, Competitive bidding * Evaluation and reporting mechanism * Complaints mechanism ■ Contract Management – training in how to manage contracts: – Improve communication between logistics, procurement and budget holders for major contracts eg fuel				

Reform/Tasks as per Roadmap	Indicator/ Target	Responsible Division and Officer	Resources Required	Timeline
■ FMIS/Freebalance – IT Skills to be assessed and training provided where applicable – Purchase International computers drivers license (or similar program) to provide basic IT skills to District Staff. – Ensure adequate computers, printers and UPS in districts. – MoH intranet to be introduced and used to send reports and share data (refer IT unit MOH) ■ Data input into Freebalance (currently MoH central) to move to Districts. Access to Freebalance required and training in Freebalance. Discussion with MoFT re whether this can be directly to Health or through MoFT District Treasurers				
Costing of NHSSP Priority Areas ■ Preparation of Medium Term Expenditure Framework costing out NHSSP (five year period), utilising normative costing where applicable: – Five Year MTEF – Capturing all resources in sector – Funding Gaps highlighted – Sets Finance Indicators (refer MTEF): * % of GOTL allocation to health * % recurrent expenditure per capita for BSP * Per capita allocations by district * % of recurrent expenditure on hospital * % of recurrent expenditure on support services (incl. Systems strengthening) ■ Set targets to reduce reliance on DP funding for key health inputs eg drugs over 5 year period ■ Capacity Building approach to producing MTEF, including District input ■ MTEF to be updated annually prior to budget setting ■ MTEF to be used as basis for resource allocation to divisions/districts	NHSSP costed for 5 year period by Sept 2011	MoH Central Finance & planning units MOF MoH Central & all Divisions MoF (Budget Unit, Planning and Freebalance Unit)	Technical Assistance DP assistance (in providing data)	June 2012
Develop budget templates for linking annual plans to Budgets ■ Budget envelopes to be set by MoH central based on MTEF, resource allocation method. ■ Annual budget and planning timetable to be set by MoH. ■ Budget and planning manual to be developed, including templates linking plans to budgets. ■ Training on budget/planning to be provided to all ■ MoH to review and amend current chart of accounts with MOF to move to activity (output) based structure for 2013 budget. ■ Discussion with MoFT Freebalance ■ Basic spreadsheet to be developed to ensure that costing of activities (as included in annual plans) – begin for 2012 budget. ■ One annual plan to be prepared for each division, incorporating all activities and funding (one plan one budget). ■ MoH Central set up budget review committee, annual plans and budget submissions to be presented by budget holders, feedback and amendments to budget submission discussed with budget holders. ■ Additional bids for funds to MOFT Budget unit based on gaps identified and resource ■ Managers to receive approved budgets within 2 weeks of budget being passed (MoH to produce annual budget and plan book	Template prepared Resource allocation adopted Annual timetable set Manual produced and training provided	MoH Planning and Finance	TA support District finance advisors support Cost of Training	Begin 2012 – support provided through to 2015
Internal audit unit to be strengthened ■ Training/linking with internal audit to be investigated (eg NT Internal Audit undertake performance audits based on Canadian model of performance auditing) ■ PER/other expenditure reviews ■ Internal audit unit to carry out performance audits	Annual internal audit plan Audit committee functioning	MoH, MoF	Training costs TA	2014

MINISTRY OF HEALTH
Dili, Timor-Leste



NATIONAL HEALTH SECTOR
STRATEGIC PLAN
2011-2030

MINISTRY OF HEALTH
Dili, Timor-Leste