



UNGASS 2010 Country Progress Report

January 2008 – December 2009

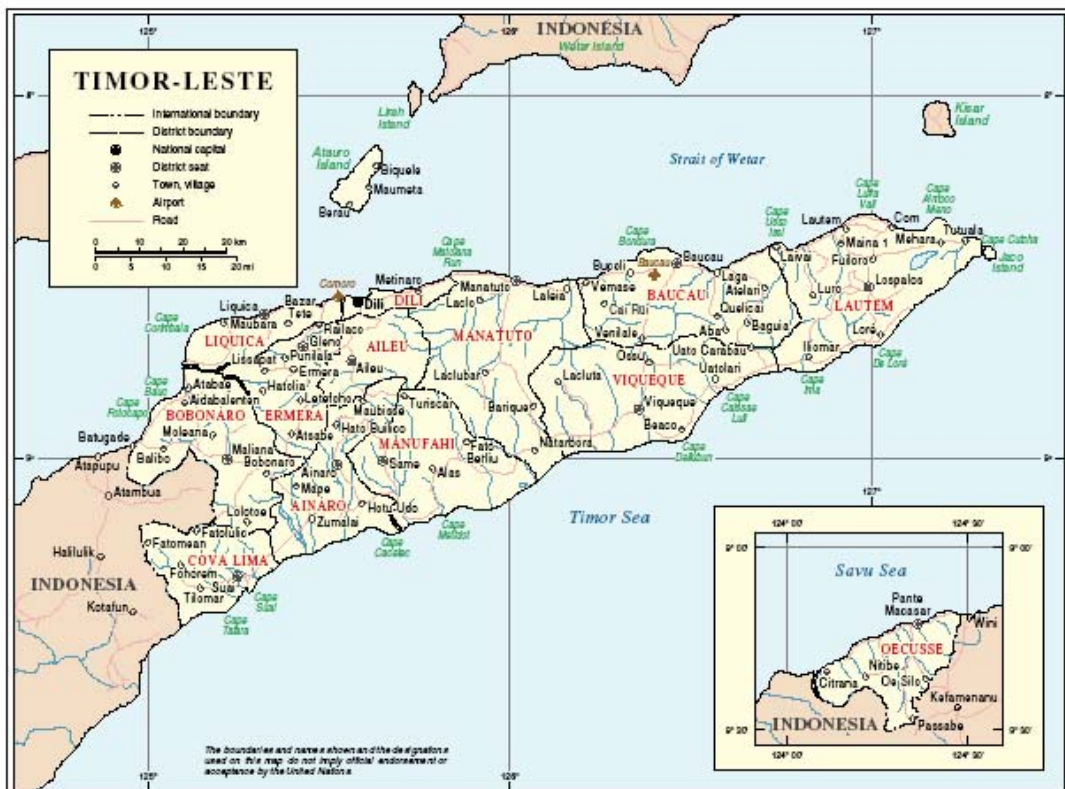


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Foreword

The Democratic Republic of Timor-Leste was officially proclaimed as a new nation on the 20th of May 2002. The country faced significant challenges common to all new nations in the early stages of national development as well as specific challenges resulting from its own unique history, culture and environment. Given the complexity of nation building in both a human resource and institutional capacity building context, HIV risk in Timor-Leste is framed by the development challenges the nation faces and behavioural, social, and cultural factors. In that nascent period, HIV/AIDS was recognized under the National Development Plan 2002. Strategies, priorities and direction were then established under the Health Policy Framework 2003; this approach is included in the overall underlying framework of comprehensive primary health care in Timor-Leste. In 2003, the National AIDS Commission was formed and approved by the Council of Ministers.

Under the National AIDS Programme, situated within the Ministry of Health, the first five-year National Strategic Plan on HIV/AIDS was developed for the time-frame 2006 through 2010 and addresses both the broader social determinants of health and the more immediate risk factors leading to HIV infection; specifically through prevention, clinical services and a multi-sectoral approach. Maintaining Timor-Leste as a low prevalence HIV nation and to minimize the adverse consequences for those infected and affected by HIV/AIDS is the overall goal of the NSP 2006 – 2010. The implementation of the strategic plan in the four years since its adoption has been considerable given the backdrop of major civil unrest and political change.

The Timor-Leste 2008-2009 UNGASS report is the first submission from the country. The preparation involved consultation with HIV stakeholders in country, including government officials, civil society and United Nations Agencies. Interviews were held with key government and civil society partners and a consensus building process was ensured. This process has enabled stakeholders to take stock of the current HIV situation as well as provide guidance on future programme needs.

The Ministry of Health took the lead in coordinating partners for the development of this report. The Ministry would like to acknowledge the contribution of all relevant government ministries, UN agencies, International and National NGOs and Civil Society and Faith Based Organizations who provided invaluable information and time in the gathering of information and data for the UNGASS report. The dedication by all stakeholders in this collaborative effort demonstrates a strong and motivated commitment to improving the response to HIV in Timor-Leste.

This report will provide a deeper understanding of opportunities, gaps and challenges related to the HIV/AIDS response in Timor-Leste at a national, global and regional level. It will also offer guidance to future HIV programming and initiatives. With the support of all HIV stakeholders, HIV programming in 2010 will see an increase in coverage and implementation of the national response as well as the strengthening of systems necessary to carry out the required services to respond to the HIV situation in Timor-Leste.

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Acronyms

ABC	Abacavir
AIDS	Acquired immune deficiency syndrome
ALT	Alanine transaminase
ARV	Antiretroviral
ART	Antiretroviral therapy
AST	Aspartate transaminase
AZT	Azidothymidine (Zidovudine)
CBC	Complete blood count
CD4	CD4+ T lymphocyte
CNS	Central Nervous System
ddI	Didanosine
EFZ	Efavirenz
FDC	Fixed dose combination
GI	Gastro intestinal
HIV	Human immunodeficiency virus
IDV	Indinavir.
IFN	Interferon.
3TC	Lamivudine
r	Low dose ritonavir boost
LPV	Lopinavir
LPV/r	Lopinavir/ritonavir
MTCT	Mother-to-child transmission of HIV
NFV	Nelfinavir
NNRTI	Non-nucleoside reverse transcriptase inhibitor
NRTI	Nucleoside analog reverse transcriptase inhibitor
NVP	Nevirapine
OI	Opportunistic infection
PCP	Pneumocystis carinii pneumonia
PI	Protease inhibitor
PLHA	People living with HIV/AIDS
PPD	Purified protein derivative
PMTCT	Prevention of mother-to-child transmission of HIV
RBV	Ribavirin
RTV	Ritonavir
SJS	Stevens-Johnson syndrome
SQV	Saquinavir
TB	Tuberculosis
TDF	Tenofovir
TLC	Total lymphocyte count
WHO	World Health Organization
ZDV	Zidovudine

1 Status at a Glance

1.1 *The inclusiveness of the stakeholders in the report writing process*

The 2008 – 2009 UNGASS Country Progress Report was prepared and consolidated through a highly participative process involving key HIV stakeholders such as government institutions, bilateral organizations and civil society and faith based organizations. The process started with a consultative meeting where roles and responsibilities were defined and tasked to the relevant individual or institution as well as defining relevant data sources. The team consisted of staff from the Ministry of Health and the World Health Organization. Data on the UNGASS indicators were gathered by the team through a variety of sources which included among others national programme monitoring and behavioural surveys,

The National Composite Policy Index questionnaire, Part A, was administered by the M&E Officers in the National AIDS Programme at the Ministry of Health to government officials at the Ministry of Health, National AIDS Commission, Ministry of Justice, Ministry of Education, Ministry of Social Solidarity and the Secretary of State for Gender and Equality. Likewise, Part B was administered by the HIV/AIDS Technical Officer at the World Health Organization and the VCT and HIV Prevention Specialist at the MoH to the key representatives in the bilateral organizations and the civil society and faith based organizations.

Compilation of the report was conducted by the HIV unit within the Ministry of Health with support from the World Health Organization.

1.2 *Status of the epidemic*

Although there is limited data on HIV prevalence rates for specific sub-populations and indeed the overall population in Timor-Leste (see Kaldor, et al., 2006; Pisani, et al., 2004; Pisani, et al., 2006) the country is considered to have a low-level epidemic, with a national HIV prevalence of less than 0.1% which is non-generalised. Most HIV infections would appear to have been acquired through heterosexual contact, with other routes of transmission likely to include homosexual contact, injecting drug use, and perinatal and blood transmission (Kaldor, et al., 2006).

Since the first reported case in 2003, a cumulative total of 151 HIV positive cases had been reported to the National AIDS Programme as of December 2009. Fifty three percent of HIV positive cases in the last 12 months were reported among 25 and 44 years old, with 48% of cases reported in men and 52% reported within women. 7.8% were among children under five years of age. National level cumulative data shows 151 cases of AIDS and 20 AIDS deaths reported. Almost all those living with HIV reside in urban areas, predominantly in Dili.

In 2004, FHI and the MoH collaborated to conduct a cross-sectional survey on knowledge, attitudes and behaviour (KAP) in relation to HIV and STIs (Pisani, *et al.*, 2004). The study also collected blood and tested for HIV and several STIs. HIV prevalence was 3% among FSW, 0.9% among MSM, and other groups such as the military showed zero prevalence. Testing occurred as part of the study rather than at sero-sentinel sites, and therefore sampling issues may have had some influence on the results. For example, the sampling of FSW was largely through networks. Foreign FSW were excluded on the assumption that they would not contribute to the epidemic in the country. While foreign and local FSW may not have close interacting networks, it is likely however that a minority of clients of FSW have sex with both foreign and local FSW. As such, either type of FSW could contribute to the epidemic.

In 2008, a behavioural surveillance study (BSS) was conducted by the University of New South Wales amongst female sex workers (Lee *et. al.*, 2009a), MSM (Lee *et. al.*, 2009b) and uniformed personnel (Lee *et. al.*, 2009c). The results indicated low levels of condom use

amongst all three groups surveyed. Briefly, consistent condom use was reported at 16% and 12% amongst female sex workers with their clients for vaginal and anal intercourse respectively; 18% amongst MSM for anal intercourse with their casual partners; and 22% amongst male uniformed personnel members with their commercial sexual partners. In addition to low condom use, MSM participants reported a high level of concurrent sexual partners within the preceding 12 months, with men who reported having regular partners having on average two partners, compared with non-regular partners who reported having an average of six partners over that period.

In addition, 10.7% of female sex workers surveyed had reported injecting drug use within the previous 12 months (Lee *et. al.*, 2009a). Sexual coercion rates were high amongst both female sex workers and men who have sex with men, with 64% and 52% of respondents from both respective groups being forced to have sex against their will within the last 12 months.

1.3 Policy and Programmatic Response

The Ministry of Health of the Democratic Republic of Timor-Leste has included HIV in its Health Sector Strategic Plan 2008 - 2012. This plan calls for inter-sectoral engagement with the education sector and support for community based organisations.

Additionally, Timor-Leste has a National HIV/AIDS and STI Strategic Plan for 2006 – 2010 officially approved by the Council of Ministers. The NSP is comprised of five program components which focus on prevention, VCT, clinical services, multi-sector approach and strategic information. A mid term review of the National HIV/AIDS Strategic Plan was undertaken by the country in August and September of 2008. In the period since the strategy was adopted, significant program infrastructure has been put in place, largely through GFATM funding. There is strong endorsement at the political level for addressing HIV as a significant issue and leadership within the Ministry of Health is being strengthened. There is an emerging leadership group within the NGO sector and an impressive body of program activity that has already been implemented. Overall there is broad consensus on basic principles of partnership, evidence based responses and a human rights approach across sectors in relation to strategy and programming.

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

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

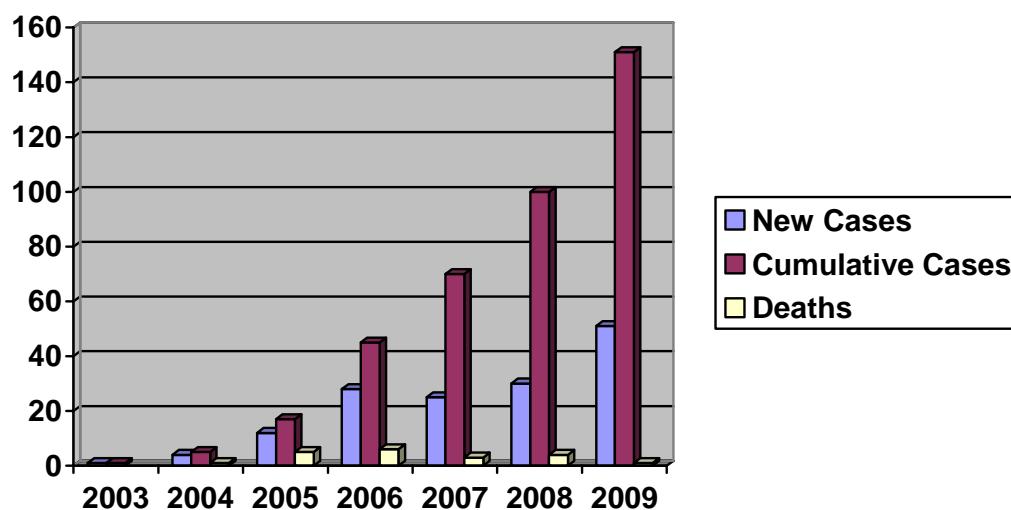
The Ministry of Health is currently developing the new National Strategic Plan on HIV/AIDS and STIs for 2011 – 2015.

1.4 UNGASS Indicators

Given the relatively new HIV/AIDS programme in Timor-Leste, not all of the twenty-five indicators are relevant for the country. Additionally, given the limited scope of the HIV/AIDS programme, not all indicators are covered, even if relevant.

2 Overview of the AIDS Epidemic in Timor-Leste

The first HIV positive infection was detected in 2003. By the end of 2009, a cumulative total of 151 people were infected, with a total of 20 deaths to date. There has been a slow but steady increase in the number of HIV infections detected during 2008 and 2009, in part due to the increase in community outreach and testing facilities. The number of females who have tested positive is 71 or 47%, while 80 males tested HIV positive or 53%. The majority of infections occur in those aged 25 - 44. Fourteen children have been tested positive through maternal vertical transmission.



Although Timor-Leste is considered to be a low prevalence country, behaviours in certain high risk groups such as the fluidity of bisexuality in MSM groups, relatively large contingents of uniformed personnel, an increase in the number of FSW, low condom use and an increase in injecting drug use, have the potential to significantly increase the rate of HIV infection across the country.

An HIV prevalence survey was conducted by National Laboratory (NL) in Timor-Leste in February 2004. During the study the sample population was selected from the Central Laboratory at the National Hospital Guido Valadares (NHGV), and two regional hospitals; Baucau and Maliana. Seven positive HIV cases were found among the 1373 people tested, indicating a prevalence of 0.51%. (WHO Report 2004)

Following the same strategy used in 2004, a second survey was conducted over three months in 2007. The survey was carried out at the National Hospital Guido Valadares (NHGV), all Regional Hospitals (RH) – in Baucau, Maliana, Suai and Oecussi hospital as well as Bairopite clinic and NL. Between 18 June and 31 August 2007, 2143 sera samples were collected. The median age of participants was 26 years. The majority of participants were female (51%, 1094/2143 female, 47% 1013/2143 male and 1.7% 36/2143 not stated). Most were married (52%, 1106/2143) and 122 pregnant women were screened.

There were four positive results (0.19%, 4/2143, 95% CI, 0.05-0.49), all male and ranging in age from 22 to 54 years. Three of the cases were diagnosed in Dili and one case was

diagnosed in a regional centre. The 2007 prevalence was not statistically different from the prevalence found in 2004 (0.5%, 7/1373 compared with 0.19%, 4/2143 p-value=0.16).

3 National Response to the AIDS Epidemic

The dynamics of HIV and its multifaceted determinants are such that HIV situations now prevailing in a country or even within a specific population may change, sometimes rapidly and dramatically. Planning for effective and relevant responses to HIV/AIDS therefore demands approaches that take into account these different and changing situations and the unique dynamics of HIV. It is also essential to make optimal use of available resources and integrate the lessons learned to date with the level of response required for scaling-up to achieve national level impact. Planning effective responses to the epidemic requires approaches that take into account the dynamics of HIV and the complex cultural, political and socioeconomic determinants that underpin its spread and influence the consequences. Such approaches are the essence of strategic planning. If there is to be a sustainable, effective national response, national governments must be responsible for setting the agenda and leading the entire strategic planning process.

The Ministry of Health is the main government body that oversees, coordinates, implements and monitors HIV programming in Timor-Leste. The Mission of the Ministry of Health is to *strive to ensure the availability, accessibility and affordability of health services to all Timorese people, to regulate the health sector and to promote community and stakeholders participation*. In 2003, the National AIDS Committee was established and approved by the Council of Ministers.

The Global Fund against AIDS, Tuberculosis, and Malaria has awarded a five year \$8.36 million grant from June 2007 through December 2011, which covers a significant portion of the activities in the Strategic Plan. The Ministry of Health as the Principal Recipient of the Global Fund Grant is implementing the National HIV/AIDS Program with its partners and sub-recipients. The National HIV/AIDS Program follows the National HIV/AIDS Strategic Plan and includes the following components—

- Strengthening HIV and STI prevention especially targeted to most at risk groups
- Monitoring of trends in the epidemic
- Providing treatment and care services
- Strengthening the health care services system, and
- Promoting a multi-sectoral response to HIV

Given the nature of HIV in Timor-Leste's, the focus of the response has been mostly targeted to high risk groups with prevention programmes and the roll out of care, support and treatment programmes. However, low HIV prevalence at present does not indicate that there is low HIV vulnerability. There are clear indications that Timor-Leste has many of the factors that increase vulnerability to HIV.

Poverty and limited opportunities for income from employment, especially for women, push people into high risk behaviour. This includes both commercial sex and transactional sex. Although it has other impacts on the epidemic, gender inequality increases both the supply and demand for commercial sex. Poverty and gender inequality along with recent increase in income from oil and gas and presence of international community, in fact, are working as double-edged sword for vulnerability to HIV/AIDS. On one hand, East Timorese women are driven to sex work by poverty. On the other hand, East Timorese men have disposable income to purchase sex raising both demand and supply in the sex industry. Timor-Leste is reported

to have extremely high levels of gender based violence which undermine women's ability to negotiate safer sex.

Progress in the Implementation of the National Strategic Plan 2006 – 2010

Prevention

Since the NSP was adopted, prevention programs have been put in place to target Most-At-Risk Groups (Female Sex Workers, Men who have Sex with Men, Clients of Female Sex workers, Military, Police), young people and the general population. Activities have also been implemented to target other groups at risk due to factors related to occupation or other situational risks.

With the help of Health Promotion Department, Ministry of Health has produced 26 products by year 2008. During 2009, a flip chart on STI was produced. The Program adopted the BCC Strategies for HIV/AIDS from the National BCC Strategy for Reproductive Health developed by the Ministry of Health with support from UNFPA. NGOs such as CVTL and MSI also produced radio messages, booklet and brochures for general population and people in uniform.

NGOs are regularly using the BCC material for their main activities. For example video trainings for MSM and FSW which are conducted by FTH, the films are used. Other printed BCC material including leaflets, brochures, flip charts are used by peer outreach for BCC related field activities. BCC messages of ABC, condom usage, awareness about HIV/ STI, misconception, stigma reduction, information about seeking services of VCT and STI treatment are communicated through BCC material.

In some selected districts 475 peer educators were trained for life skills (coping with emotions, problem solving, communication skills, interpersonal relationships, decision making and responsive behavior) during 2009, workshops with 98 facilitators with over 200 young people o field test the curriculum which is under development.

Voluntary Counselling and Testing (VCT)

VCT services have been significantly expanded and strengthened since the commencement of the strategy. In priority districts, clear referral pathways have been established between prevention programs and VCT services. Protocols have been developed to enable quality management and delivery of VCT services to occur.

Throughout the reporting period, there was an uninterrupted supply of the test kits and consumables. Lab technicians were trained and HIV testing facilities were extended to Liquica, Viqueque and Manatutu districts in the CHC set ups by providing centrifuge machine, refrigerator and cool boxes besides other consumables. Viqueque and Liquica CHC have started the VCT services; however, Manatutu district CHC has yet to provide space to initiate the VCT services.

Contrary to the National Strategic Plan, enhanced syndromic management of STIs has not been integrated into the provision of VCT services. Enhanced syndromic management of STIs is likely to have a far greater impact at a population health level on minimising HIV risk than HIV testing. However the infrastructure that has been developed for VCT can be modified to accommodate enhanced syndromic management.

There has been little progress made in providing VCT for people with multiple partners (except for clients of sex workers). Capacity to provide basic risk assessment and counselling in the context of enhanced syndromic management should be considered.

Prevention of Mother to Child Transmission

Routine HIV testing was introduced at the ANC setting of the National Government Hospital in Dili and five other referral hospitals in Ainaro, Baucau, Bobonaro, Covalima and Oecusse. The National Government Hospital is now fully equipped to provide complete ARV prophylaxis to HIV positive pregnant women to reduce the risk of mother to child transmission.

However, there are no formats developed to lay out PMTCT protocols to follow any specific system and guide the health staff to triangulate PMTCT recording and reporting. Thus, so far, there is no routine offering of PMTCT services despite its introduction as staff do not know how to carry out these services. MoH has held meetings with UNICEF officials to provide technical support on a long term basis to establish and monitor PMTCT services.

During this reporting period one HIV positive pregnant woman was successfully given a complete course of ARV prophylaxis according to national guidelines.

Blood Safety

The program ensures screening of 100% units of blood for HIV before transfusion. The blood bank initiatives are managed by local professionals who were trained by the international consultant during 2007. There is vacuum of blood bank specialist in the country although St. John of God has taken the responsibility of monitoring the quality of blood bank from the beginning of 2009. St. John of God has entered into a long term agreement with the MoH to support laboratories in Timor-Leste for an additional five years.

Laboratory Services

Currently National laboratory, National hospital Laboratory, 5 referral hospitals' laboratories and 3 CHCs' laboratories at Liquica, Viqueque and Manatutu have been equipped to perform rapid test. The laboratories have been provided centrifuge machines and refrigerators besides the test kits and other consumables so that they could perform HIV/STI and Hepatitis B testing. Manatutu CHC is still in the process of developing infrastructure to make VCT operational but all others are fully functional. The lab technicians have received induction and refresher training during 2009 and also were provided on the job hand holding and demonstrations, practice sessions for conducting required procedures for testing. All these 8 centers conduct screening using serum separation methods for HIV testing. All the sero positive samples are transported to National Hospital at Dili for the confirmatory testing. The confirmatory testing is done only at National laboratory using AxSYM Analyzer. With the technical support from St. John of God Pathology the capacity building of local laboratory staff has been done. The government health system supports the transportation of blood units by using cool boxes.

MoH is in the process of entering a long term agreement with St. John of God Pathology to provide long term technical support as the local staff still need to develop their capacity to reach an optimum level of performance.

Management of Sexually Transmitted Infections

Currently STI services are provided in the National Hospital, referral hospitals and sub district level health centers, altogether counting to 65 centers. The health providers providing STI treatment have received training during 2008. As a follow up during 2009, 3 Regional

orientation / refresher trainings on HIV/AIDS, VCT/PITC, STI, PMTCT and PEP were held and selected STI providers participated during these 3 trainings.

During 2009, the essential medicines for STI treatment were procured and supplied through SAMES through the Government budget and all health centers have received sufficient stock of medicines. STI treatment is provided as per the national guidelines and protocols for STI Syndromic and Enhanced Syndromic Management. Community Health Centers and Referral Hospitals have set up STI enhanced syndromic management facilities.

All six laboratories at national government hospital and five other referral hospitals are now reporting STI enhanced syndromic management cases. All 60 other health centers are reporting STI syndromic management cases.

Clinical Services

HIV treatment and STI syndromic treatment services have been significantly strengthened. Funding has been allocated and infrastructure, systems and protocols have been developed to enhance capacity and improve quality in the regard to laboratory services, essential commodity procurement and distribution and blood safety.

Multi-sectoral Action

Priorities of the multi-sector component of the NSP are:

- Adopt and implement policies across sectors that facilitate strategy implementation
- Strengthen activity at a district level
- Enhance the involvement of People Living with HIV and better respond to their needs

There has been little progress in policy development outside the health sector. Key issues identified during the NSP review process included protection of the rights of PLWHA and regulation of the sex industry. Furthermore, technical support is also required to develop procedures to effectively utilise policy and legislation.

Since the strategy was adopted, a well functioning PLWHA peer support group has been established and PLWHA targeted services have increased. However, PLWHA still report widespread discrimination and stigma associated with their HIV status. PLWHA have also identified needs related to transport, accommodation, nutrition support and employment.

Esperanca (the PLWHA peer support group) members also express a desire to build the skills necessary to operate as an independent organisation. While appreciative of the support provided by other agencies and supportive of continuing to work in partnership with those agencies, PLWHA are increasingly interested to speak on their own behalf.

Planning and Coordination

The broad planning and coordination framework outlined in the NSP has been implemented. The main gap in the current planning framework is a lack of integration of planning, monitoring and reporting of the work undertaken by agencies not funded through the GFATM. This is contrary to the principle of one national monitoring and evaluation framework which most agencies working in the HIV sector subscribe to.

The National AIDS Commission has been revitalised since the adoption of the National Strategy. With the support of UNDP and the Ministry of Health it now has its own premises and a secretariat. While the NAC has broad oversight of the national strategy its work is complemented by the GFATM CCM which provides oversight of program implementation.

The National AIDS Commission is tasked with ensuring a multi-sectoral response. The NAC has membership from a range of sectors. The policy development capacity of the NAC needs to be enhanced for it to provide more strategic advice in the prioritisation and development of policy and legislation across sectors.

Strategic Information

The NSP identifies routine surveillance, sentinel surveillance, behavioural studies, social research and monitoring/evaluation as the main sources of information on which to make strategic decisions.

Routine Surveillance

Since the adoption of the National Strategy, Timor-Leste has strengthened routine surveillance across all areas of disease. In some districts it is likely that the quality of routine surveillance has reached a level adequate to monitor changes in disease patterns. Through the GFATM grant, funds have been allocated for development of new protocols to improve quality of information regarding STIs, and enhancing the capacity of staff to comply with reporting procedures.

Sentinel Surveillance

Sentinel surveillance is proposed in the National Strategy at a limited number of sites, where enhanced syndromic management of STIs would be delivered, to provide a relatively accurate picture of HIV and STI incidence among Most At Risk Groups (MARGs). Sentinel surveillance is also recommended in the context of VCT for pregnant women. Advances have been made with the development of surveillance protocols and the implementation of sentinel surveillance in late 2009 among ANC, TB and STI patients. Sufficient priority needs to be given to institutionalising sentinel surveillance as a primary source of strategic information.

Behavioural Studies

Baseline surveys were undertaken among MSM and Female Sex Workers in 2008. These studies provide knowledge, attitude and behaviour measures that can be compared over time to facilitate planning and evaluation. An IBBS study is being conducted in early 2010, which will provide additional data for improved program planning and implementation.

It has been noted that behavioural studies need to be conducted among other high risk groups. Further consideration also needs to be given to conducting sexual behaviour research among the general population.

Social Research

In addition to behavioural studies, other social research is necessary to provide a more complete understanding of risk and vulnerability contexts. Such research includes mapping studies, various forms of qualitative research including formative research undertaken in designing interventions.

Since the adoption of the National Strategy a number of studies have been undertaken that have contributed to a better understanding. Funds have been allocated to develop social research skills among staff implementing projects. If capacity development is well designed, this will contribute to better planned interventions and more informative evaluation.

4 Best Practices

As a relatively new HIV/AIDS programme, while strived for, the programme has yet to demonstrate concrete best practices. It is anticipated that in the next UNGASS report, the Timor-Leste HIV program will have ample best practice cases to cite.

5 Major Challenges and Remedial Actions

5.1 Challenges in 2008- 2009 and Remedial Actions to be taken

Legal context

A review needs to be undertaken of current legislation and regulation of sex work in Timor-Leste for the purpose of assessing their impact on HIV prevention and making recommendations to address that impact.

A workplace HIV Code of Conduct and implementation program needs to be developed for the health sector (e.g. protection from dismissal because of HIV status, protection of confidentiality, HIV education).

Prevention context

More specific targeting of youth most at risk. These youth include those who are unemployed and/or most lacking in social cohesion (e.g. living away from family and home community, not engaged/connected with traditional support structures such as the church).

The need to promote condom use in programs targeting the general population as a means of disease prevention rather than relying on messages integrated into reproductive health frameworks

HIV and STI education be included in pre-service and in-service training of teachers.

Information on where to obtain condoms is included in all activities to promote condom use and that misconceptions regarding condoms (e.g. harmful for women's health) are addressed in activities to promote condom use.

General awareness of STIs and how to prevent transmission be promoted through social marketing interventions.

Specific interventions targeting young people most at risk be designed and implemented and that agencies targeting youth adopt a shared planning framework (e.g. adoption of common objectives, division of roles and responsibilities, common monitoring/evaluation arrangements).

Prevention of Mother to Child Transmission context

The existing PMTCT guidelines only focus on clinical management of ART. The guidelines need to be revised as per international standard operating procedures with monitoring formats and recording systems. SOP should also include the process of offering pre and post test counselling specifically for pregnant mothers with follow ups for long term treatment protocols. Set up ARV prophylaxis facilities for PMTCT in five Referral Hospitals.

Routine screening for HIV at ANC set up further needs to be coordinated with VCT/PITC guidelines to make sure that ANC service providers are trained on HIV pre-test and post test counselling so that patients receive proper counselling and testing and is done with informed consent of the patient.

Conduct trainings not only for the ARV prophylaxis and treatment but also for prevention as the prevalence of HIV is still very low and thus, more focus on prevention and awareness is required. Development of IEC material for PMTCT for creating demand for seeking services on a volunteering basis

Absence of HIV positive peer support groups outside Dili may be a barrier for pregnant women who will be tested HIV positive, to get necessary peer and psycho-social support and seek care and treatment. It is recommended to work with people with HIV and Churches to set up HIV positive support groups in the districts.

Take measures for further coordination between VCT and HIV screening at ANC setting. Provide necessary training to ANC service providers on counselling and national guidelines for setting up the system.

Clinical context

Though STI treatment is provided as per national standards and guidelines and also there is reporting system in place, yet, the linkages between VCT is a limitation. Conduct STI service facility assessment and improve facilities for STI service as necessary. Referrals from STI to VCT are another area which needs to be established. Further train STI service providers including training on HIV pre-test counselling so that they can offer HIV pre-test counselling (PITC) and refer clients to VCT centers.

STI service providers from some health centers need to be further trained for STI treatment as well developing linkages with VCT and for providing PITC where VCT is not possible.

Develop recording and reporting formats for establishing systematic database and referral system for supporting records of STI trends and services provided. Set up a system for quality assurance and quality improvement of STI services

An HIV and STI prevention program to be developed for people with multiple sexual partners. A cross benefit analysis needs to be conducted regarding the provision of STI enhanced syndromic management for people with multiple sexual partners and that it be integrated into the provision of VCT. Additionally, the feasibility of providing risk assessment and counselling through STI syndromic management for people with multiple partners be investigated.

Health providers are trained in the provision of non judgemental services.

Coordination

Cross sector district committees are established to provide oversight of district based HIV programs and that district based HIV programs be developed. Funding options include the possibility of GFATM round 10.

Technical support be provided to the Esperanca group to become an independent organisation and that a plan be developed for strengthening the response to the needs of PLWHA.

A joint work plan (including a common monitoring and evaluation framework) to be developed between all agencies addressing HIV and STIs and that faith based organisations be supported to play a more active role in the care and support of PLWHA.

Strategic Information

Further social research should be undertaken regarding HIV risk among women who engage in transaction based sex but don't identify as sex workers.

Standard protocols for HIV and STI prevention (including regularity of testing, use of enhanced syndromic management, referral pathways) and treatment for MSM and FSWs be developed. STI enhanced syndromic management be the standard of care for FSWs and MSM.

Social research be undertaken to investigate barriers to condom use among people with multiple partners. That in addition to promoting condoms as a measure to prevent both HIV/STIs as well as pregnancy (i.e. as part of the reproductive health strategy) they also be promoted in specifically targeted communication to prevent HIV and some STIs.

Consideration should be given to a more a structured approach for communication between stakeholders including input, review and dissemination of clinical policies and protocols.

Linking behavioural studies with HIV and STI testing (2nd generation surveillance) can strengthen evidence of contributing factors to risk behaviour. However a well developed sentinel surveillance system could achieve the same outcome. Further consideration of the possible costs (e.g. unwillingness of respondents to participate; organisational requirements) and benefits of including HIV/STI testing (at least among MARGs) in future behavioural studies should occur.

6 Support from the Country's Development Partners

6.1 Key support received

Timor-Leste's development partners provide a coordinated response to the HIV epidemic; partners include multilaterals such as WHO, UNICEF, UNFPA, UNDP, WHO, World Bank, GFATM, International and National NGOs which includes Catholic Relief Services, CWS, CVTL, MSI, and FTH. The UN Theme Group on HIV/AIDS and the CCM provides a regular forum in which coordination; implementation and resource mobilization are discussed within a wide range of stakeholders.

The majority of financial support was received from the GFATM in the Round 5 HIV/AIDS grant. The grant provides 8.36 million USD from June 2007 until December 2011 for the implementation of HIV services in prevention, clinical care and strategic information.

6.2 Actions that need to be taken by Development Partners to ensure achievement of UNGASS targets

Given that the majority of all HIV programming is currently funded through GFATM resources with no significant contributions available in the short term from other sources, development partners need to be prepared to support the development process for the GFATM Round 10 in both technical assistance and resource mobilization.

7 Monitoring and Evaluation Environment

7.1 Overview of the current M&E system

Monitoring and evaluation is built into the NSP as necessary tools for the purpose of accountability and transparency as well as program modification. Existing monitoring and evaluation of the current National Strategic Plan is systematic in the collection of information

for the purpose of monitoring GFATM funded inputs and outputs. However interventions funded by other agencies are not integrated into this monitoring framework.

Lack of baseline data was a barrier to establishing quantitative outcomes. This was probably the biggest gap in current evaluation systems. This has been somewhat rectified with improvements in the collection and analysis of strategic information.

The national HIV surveillance system is currently being established. In 2008, Ministry staff have been supported in surveillance training in Australia through the University of New South Wales. In 2003, with support from international partners, the MoH, through FHI, conducted the first cross sectional survey of HIV, STIs and behaviours in Dili and in 2008, the MoH, along with the University of New South Wales, conducted an IBBS on FSW, MSM and Uniformed Personnel. An IBBS will be conducted in early 2010 to obtain trends in HIV/STI risk behaviours and intervention exposure among FSWs, MSM and Uniformed Personnel with Sentinel Surveillance covering ANC, TB and STI patients.

7.2 Challenges faced in the implementation of a comprehensive M&E system

A monitoring and evaluation framework needs to be enhanced so that it clearly outlines assumptions and linkages between inputs, outputs, outcomes and impact. Such a framework should include quantitative targets and explicitly outline assumptions underlying targets.

7.3 Remedial actions to overcome challenges

To effectively manage current challenges within the National M&E System, a series of action plans needs to be implemented:

- Development of an HIV/AIDS Monitoring and Evaluation System, including the development of national guidelines on HIV M&E, and development of M & E Units at the district level.
- Improvement in data collection, quality of data and reporting at national and district levels; development of a national M&E database
- Understanding of how to make use of the data collected for advocacy, awareness raising and future programming
- Institutional and technical capacity building for M&E staff to strengthen data collection and analysis
- Resource mobilization to support a more robust national M&E system.