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Country Cooperation Strategy
2009-2013
Timor-Leste



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The first WHO Country Cooperation Strategy document for Timor-Leste was published in 2004 and during the last three bienniums WHO has developed its workplans according to the priorities identified in the first CCS.

Timor-Leste is a post-crisis country, which is now in development stage. The health sector faces new challenges in providing health care services to the people. Some of the health challenges have continued to exist over the years. It is the time to revisit and revise the Country Cooperation Strategy of WHO in Timor-Leste for us to align our programmes in order to assist the Government to address those challenges.

The Ministry of Health of Timor-Leste has developed a Health Sector Strategic Plan 2008-2012. The key focus of this plan is on the needs of mothers and children and the poor, and on strengthening of health services, with emphasis on implementing a revised Basic Services Package for primary health care and for hospitals. In addition, for involving the community in health activities, the Government has focused on strengthening SISCa (integrated Community Health system) activities.

This second Country Cooperation Strategy has prioritized the approaches of WHO under six major areas and will closely align with the goals, working principles and strategies of the Ministry of Health. This has been developed following a comprehensive review of the health situation of the country. A wide range of consultations with various key stakeholders and partners in health development have taken place to identify priority areas of work for WHO in Timor-Leste.

As a WHO Representative, it is my pleasure to present this document to the Ministry of Health and the other ministries and development partners concerned. I am confident that in focusing our work on the priority areas WHO will continue to provide the greatest possible contribution to the health development of Timor-Leste.

Dr. Paramita Sudharto

WHO Representative to Timor-Leste



Message from the Ministry of Health



MINISTÉRIO DA SAÚDE

Gabinete do Director Geral

Dili, 09 July 2009

Message from the Ministry of Health

Betterment of the health of the citizens is the core goal of the health policies of our nation. Considerable progress has been made since we became the first independent country of the Twenty-first century. Still, far too many children suffer and die from acute respiratory infections and diarrhoeal diseases, malnutrition, and other vaccine-preventable diseases. Pregnant mothers suffer due to lack of assistance during pregnancy and childbirth. The morbidity and mortality due to communicable diseases like TB, Malaria, and other vector-borne diseases, along with the emerging non-communicable diseases, are a serious threat to the health of the nation and the productivity of its citizens.

Population growth in the country is high at 3,9%; total fertility rate is 6.7 per woman in her childbearing age and more than 50% of the population is under 15 years of age. More than 40% of the population lives below the national poverty line. These demographic and social factors pose further challenges for the health-care delivery system.

The Ministry of Health is determined to provide responsive, equitable and quality-assured health-care services to all people without discrimination by gender, age, economic or social status. The challenges are daunting and the resources constrained. However, through evidence-based and context-specific policy formulation, meticulous and timely implementation, and intense monitoring and supervision we hope to make a positive change to the quality of life of the people. The key factors to achieving these goals are strengthening of primary health care, integration of health assistance through SISCa, community mobilization, health manpower development and mobilization of resources through sustainable partnerships.

The World Health Organization continues to be the leading technical partner for Timor-Leste from the earliest period of our nationhood. We have worked closely with WHO and have gained considerably from our partnership.

The WHO Country Cooperation Strategy (CCS) 2009-2013 is a road map for expanding our partnership in the coming years and elucidates strategic priorities and focus areas for health development. The WHO CCS 2009-2013 has been developed through a consultative process and has the acceptance of the Ministry of Health and other partners.

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Executive summary

In consultation with the Ministry of Health and external development partners, the WHO Country Office for Timor-Leste developed its first Country Cooperation Strategy (CCS) for 2004-2008, which has since served as the basis for WHO's technical cooperation with Timor-Leste.

The WHO Country Cooperation Review in September 2008 analysed WHO's contribution to and influence on the national health development agenda and recommended, in the new CCS 2009-2013, to adjust the current priorities, and to support the Government in achieving national health objectives including health-related Millennium Development Goals (MDGs).

The WHO CCS 2009-2013 has been drafted in the context of the Health Sector Strategic Plan 2008-2012, which identifies health priorities focused on health system strengthening, communicable diseases prevention and control, maternal and child morbidity and mortality, adolescent pregnancy, malnutrition, health promotion and health determinants.

The WHO CCS 2009-2013 was developed in a participatory and interactive process of consultations with all major stakeholders in Timor-Leste.

Demographic and socioeconomic developments influence present and future health challenges. These challenges are related to health infrastructure, available human and other resources, access to quality health services, burden of communicable diseases, risk factors related to communicable and noncommunicable diseases, high maternal and child mortalities, malnutrition, health awareness of citizens (especially adolescents and youth), preparedness and response to emergencies, and collaboration and partnership of all partners in health.

WHO applies its core functions to address these challenges within the context of its organizational mandate, WHO's Eleventh General Programme of Work and the Regional Policy Framework.

For the period 2009-2013, key principles for WHO Strategic Priorities are based on the national health objectives, which include achieving health-related MDGs and universal access to primary health care. WHO's role has begun to shift from implementing specific health programmes to supporting the MoH to build in-country capacity to formulate evidence-based contextually relevant policies and plans, and strengthen health systems for effective service delivery.

Through a consultative process, six strategic priorities have been jointly agreed for WHO's cooperation with the Government of Timor-Leste for 2009-2013.

In each of the strategic priorities, main focus areas for action have been identified along with strategic approaches to address the challenges while taking into consideration expected impact on the country's capacity, based on WHO's technical and financial contribution.

In *health policy and systems (Strategic Priority 1)*, strategic approaches will include strengthening district health systems and health management information systems, as well as supporting a senior consultant to work in the MoH in this area.

In *disease prevention and control (Strategic Priority 2)*, there are resources provided by the Global Fund and other partners, and WHO would facilitate the Government's coordination of multiple actors and build capacity for effective implementation of these programmes, focusing also on elimination and eradication of some communicable diseases and on diseases of public health concern. Enhancing the integrated disease surveillance would require continuous support.

Efforts to reduce *maternal and child mortality (Strategic Priority 3)*, will focus on support for the immunization programme and related activities, and on effective interventions, focusing on the health workforce, facility-based deliveries, quality of care, contraceptive choice, health education and Integrated Management of Childhood Illnesses (IMCI). A High malnutrition rate among children below five years and inadequate nutrition in pregnant mothers leads to low birth weight, stunting and also high maternal and infant mortalities in the country. The approach will be to strengthen nutrition and supplements and related interventions delivered through the district and community health centres.

In *overall capacity building (Strategic Priority 4)*, the focus of WHO's work will be on strengthening of national capacity based on the national strategic plan and policy framework and transfer of technical skills to national officials.

In *partnership and coordination (Strategic Priority 5)*, WHO will increase its support to facilitate partnership coordination, leverage with donors by building on existing mechanisms, and facilitating the Government's involvement in partnership and coordination of external resources for aid effectiveness.

The country is prone to natural and complex emergencies, including emergencies such as floods and epidemics. WHO will enhance its support to ensure adequate *emergency preparedness and response (Strategic Priority 6)*.

Compared to the period of the CCS 2004-2008, there are some major issues that may have implications for the WHO Secretariat, which include (i) shift in priorities from supporting the implementation of specific programmes to supporting the MoH to build its own capacity; (ii) staff profile of WHO Country Office (the WHO Country

Office will review the current staffing needs and post descriptions, in order to better support its priority areas in the years to come), funding allocation (WHO's efforts to strengthen national capacity and health systems would require addressing the funding gaps for these priorities, possibly by using the global health initiatives – GFATM, GAVI), logistics/infrastructure and connectivity (WHO must be more responsive, flexible and timely in its response to MoH requests for assistance); and (iii) Regional Office and WHO headquarters would play a key role in technical support for priority areas and in mobilizing resources for priority areas where the assessed contribution is limited.

The World Health Organization (WHO) became involved in health development programmes in Timor-Leste soon after the country's independence. In 1999, WHO established a field office with a Special Representative of the WHO Director-General. Timor-Leste became a formal member of WHO in May 2003, after which WHO established a Country Office with a WHO Representative as Head of the Country Office and Chief of Mission.

The Country Cooperation Strategy (CCS) is WHO's mechanism for alignment with national strategies and priorities as well as for harmonization with other United Nations (UN) agencies working in health and its development partners. It clarifies the roles and functions of WHO in supporting the National Health Plan. The CCS is an Organization-wide reference for country work, which guides planning, budgeting, and resource allocation. It is based on the country's health situation, government health policy and plans, work of the key partners, and lessons from WHO's work in the country. The CCS is meant to assist in mobilizing human and financial resources for strengthening WHO support to Timor-Leste in order to contribute optimally to national health development.

In April 2004, WHO developed the first CCS for the period 2004-2008, which served as the basis for technical cooperation with Timor-Leste. The CCS identified four priorities for the period as follows: (i) support for health policy and legislation development; (ii) donor coordination and partnership for health development; (iii) health systems development; and (iv) interventions for priority health problems. These priority areas were used as the basis for planning and implementation of the WHO Country Programme Budget 2004-2005, 2006-2007 and 2008-2009.

In September 2008, a review of WHO's country cooperation was conducted to analyse WHO's contribution to the national health development agenda and goals, including the health-related Millennium Development Goals (MDGs), during 2004-2008. The lessons learned from the implementation of the CCS have been used for development of the second WHO CCS, 2009-2013.

The Ministry of Health's (MoH) Health Sector Strategic Plan (HSSP) 2008-2012, is designed to guide the ministry and its partners in ensuring that all people in Timor-Leste will have equitable access to good quality basic and essential health services at well-equipped facilities, provided by competent health professionals. In addition, there

will be sufficient information that empowers people to make choices about matters affecting their health and well-being, and that of their families and communities.

The HSSP identifies the following health priorities to be addressed during 2008-2012:

- Health system strengthening and building overall national capacity to address health sector issues and challenges;
- High rates of neonatal, infant and child mortality and morbidity from acute respiratory infections (ARI), diarrhoeal diseases, vaccine-preventable diseases, malaria, dengue and malnutrition;
- High maternal mortality due to pregnancy and obstetric complications;
- High rates of malnutrition in women and young children;
- High burden of mortality from infectious diseases, particularly tuberculosis, malaria and dengue;
- Widespread unsafe sexual behaviour, minimal knowledge on HIV/AIDS and STIs;
- High fertility and population growth rates and health-related demographic factors;
- Health issues and challenges related to determinants of health, including noncommunicable diseases.

The WHO CCS 2009-2013 has been developed in the context of this national plan and its priorities, taking into consideration WHO's strategic directions and the Organization's core functions.

The WHO CCS in Timor-Leste 2009-2013 coincides with the United Nations Development Assistance Framework (UNDAF) cycle and considers the priorities of UNDAF in order to harmonize WHO's work with other UN agencies. WHO has been pro-active in the UNDAF process and the areas where WHO would play a significant role have been identified, particularly in the UNDAF Outcome 3: *"By 2013, children, young people, women and men have improved quality of life through reduced malnutrition, morbidity and mortality, strengthened learning achievement and enhanced social protection"*.

The WHO CCS 2009-2013 was prepared through a participatory and interactive process of consultations and dialogue with major stakeholders from the government, UN agencies, development partners and WHO staff from the Country Office, the Regional Office and WHO headquarters.

Country health and development challenges 2

2.1 Demographic and socioeconomic development

Measured by both income and human development indicators, Timor-Leste is one of the world's least developed countries. Per capita GDP was estimated at US\$ 469 (2008). The Human Development Index (HDI) was estimated at 0.512, showing an improvement from the HDI value of 0.395 in 1999.

More than 40% of the population lives below the national poverty line on less than US\$ 0.55 per day; however, there are significant variations between districts, since the vast majority, 85% of poor people, live in rural areas.

Administratively, the country is divided into 13 districts and 65 subdistricts with a projected total population of 1 047 632 (2007), and a land area of 14 610 square kilometres. The country has a high population growth rate of 3.9%, with more than 50% of the total population under 15 years of age. The total fertility rate is 6.7 per woman in her childbearing age (2006-2007) and the percentage of contraceptive users - contraceptive prevalence rate¹—was 19.8% in 2007. Life expectancy at birth was 59.5 years in 2006, 58.6 years for males and 60.5 years for females. Whereas 75% of women and 45% of men are illiterate, the net enrollment ratio at primary schools was 77% in 2005. Awareness about gender equity and gender mainstreaming is limited.

2.2 Health challenges

The major health challenges in Timor-Leste include (i) health system strengthening; (ii) prevention, control, elimination and eradication of diseases; (iii) health of mothers, adolescents and children; (iv) health promotion and health determinants; and (v) emergency preparedness and response.

2.2.1 Health system strengthening

The events in 1999 led to a near total destruction of the health system through the exodus of most senior managers and health staff, and the damage to the health infrastructure. The country has gradually re-established its health system through rehabilitation of the infrastructure, redeployment of staff, and by establishing health management systems at all levels.

¹ The number of married women of child-bearing age using any method of contraception per 100 women of child-bearing age

The Ministry of Health (MoH) is the steward as well as the major service provider. It manages health system functions through its five directorates (Administration/Logistics, Finance/Planning, Human Resources Development, Community Health, and Hospital & Referral Services), and also oversees the overall technical implementation of health programmes. In addition, the MoH directly supervises three organizations, namely the Institute of Health Sciences (IHS), providing in-service training; Servico Autonomo de Medicamentos e Equipamentos de Saude (SAMÉS), responsible for drug procurement, storage and distribution, and the National Laboratory.

The public health care delivery facilities in the 13 districts of Timor-Leste include 65 Community Health Centres (CHC), 183 health posts, and 162 mobile clinics, which are all providing primary health care to the community. The CHCs are linked with six referral hospitals providing mainly secondary and tertiary care. These health facilities are currently resourced by about 2500 Timorese health workers with the support of around 300 Cuban doctors.

About 60 % of these health workers are providing health services in primary health care settings. While the MoH is the major provider of health services at all levels of health care, the NGO sector, especially the Catholic Church and Coffee Cooperative structures, also provide substantial care. In the urban setting, the private sector is prevalent. Additionally, efforts are being made to outsource to NGOs on a pilot basis, to ensure access to basic health services in some districts.

The health workforce is one of the key challenges in the health systems, where an acute shortage of different categories of health workforce persists. A comprehensive Human Resources for Health (HRH) plan has been developed and is being updated to reflect health workforce needs for the next decade.

The government has set up the Faculty of Health Sciences (FHS) in the National University of Timor-Leste (UNTL) under the Ministry of Education, for training of medical doctors, nurses and midwives. The training of medical doctors in the country is conducted in collaboration with the Government of Cuba. In addition to those studying medicine in UNTL, more than 600 Timorese have been sent to Cuba for medical training. These trainees in Cuba who will begin returning in 2009 will complete their final year of medical training at the School of Medicine in UNTL and complete their internship in the home country.

In addition to the undergraduate training at UNTL, the Institute of Health Science (IHS) under the Ministry of Health is responsible for the pre-service and in-service training of the health workforce, including nurses and midwives. There is also a private university producing public health graduates.

The entire public health system is financed through the state budget and external resources. While out-of-pocket expenditure does occur, there are no data available on the level or proportion of out-of-pocket costs against total health expenditure. The

government has given more attention to the health sector. The public expenditure as a percentage of government spending on health has increased from 12% in 2000 to 19% in 2005 (latest data is not available). Per capita total health expenditure is around US\$ 45 (2005).

The East Timor Policy Framework and the subsequent policy and strategy documents had consistently advocated for Sector-Wide Approach (SWAp). Despite the weaknesses of the governance system in Timor-Leste, the MoH had prepared the necessary conditions for moving towards SWAp in the health sector. In this regard, the Health Sector Strategic Plan 2008-2012 and the Medium Term Expenditure Framework (MTEF) are being used as tools for all stakeholders to agree on spending priorities, while closing gaps, avoiding duplication as well as encouraging donors not only to co-finance, but also to harmonize and align funding mechanisms with government systems.

The government is committed to moving towards political and administrative decentralization, and it is expected that, by 2010, newly established municipal assemblies will vote on the municipal planning and budgets, including those for health. The government is now promoting an Integrated Community Health System (SISCa), which would improve accessibility and acceptance of basic health services with stronger community participation.

The constraints and challenges related to health system strengthening may be summarized as follows:

- Substantial resources have been invested, and more are needed to re-establish the entire health infrastructure, especially in remote areas.
- Substantial resources are also needed for development of human resources. There is a scarcity of human resources for health including health managers, doctors, nurses, midwives and paramedical staff. Apart from capacity building of human resources for health there is a need for strengthening training institutions in the country.
- Lack of trained human resources in the public health system is a major constraint in reducing health problems including maternal and under-five mortalities, in preventing and controlling communicable and non-communicable diseases and risk factors and in increasing awareness of health problems, particularly among women, adolescents and young people.
- Shortage of midwives to work in remote locations is a challenge.
- Shortage of essential drugs and adequate equipment is common in health facilities.
- No special health services address the adolescent's special needs, where there are a significant percentage of young people.

- The capacity of laboratories is limited, both at the peripheral and central levels.
- There are gaps in community awareness of services available.

2.2.2 Prevention, control, elimination and eradication of diseases

Malaria is highly endemic in all districts, with more than 200 000 reported cases in 2007, indicating an incidence rate of about 200 per 1000 population. It is the second major cause of admissions to the national hospital and the second highest in incidence among notifiable diseases. The highest malaria morbidity and mortality rates are reported in children. *Plasmodium falciparum* was diagnosed in more than 60% of the cases. However, the Timor-Leste Survey of Living Standards (TLSLS) indicated an improvement in the use of insecticide-treated nets as a measure of effective prevention toward malaria.

Regarding tuberculosis (TB), an in-depth analysis of the national programme data set since 2000 through 2007, indicated that the incidence of new sputum positive cases was 145 per 100 000 in 2008 compared to 250 in 2006. Similarly, the prevalence of TB has been estimated at 447 per 100 000 in 2008 compared to 789 per 100 000 in 2006.

Data from the National TB Programme (NTP) show that, since 2000, there have been cumulatively 25 026 cases registered and started on treatment using the WHO recommended drugs combination. Of these, 7699 cases were new sputum smear positive, 478 were re-treatment cases, and 16 849 cases were included in other categories including children and extra-pulmonary tuberculosis. Treatment results have improved year by year since the beginning of the NTP from a success rate of 65.4% in 2000 to 79% in 2006. In 2001, DOTS centres were established in all 13 districts. In 2002, the programme was expanded to the 65 health centres, and all these centres were covered in 2004. In 2008, the programme launched treatment for multidrug resistant TB.

Available data indicate that acute respiratory infections and diarrhoeal diseases are among the most common childhood illnesses with high mortality rates among young children.

Currently, the number of reported HIV/AIDS cases is relatively low; however, available data on incidence of sexually transmitted diseases from some districts and a limited knowledge and awareness about HIV/AIDS and STI among the general population, and among adolescents and young people in particular, suggest risk of HIV/AIDS epidemics in the future.

Avian influenza (AI) is endemic in neighbouring Indonesia. If AI is introduced into Timor-Leste, there is a high risk of it becoming endemic due to the marketing chain (live poultry trade), low levels of biosecurity in households rearing poultry, and limited

capacity for early intervention. The government and its partners, including WHO, have undertaken a number of preparatory and contingency steps in the last few years. The Ministry of Health and WHO acknowledge that there are gaps in the preparations and national contingency plans. Capacity building is a major component of AI preparedness planning but lack of national professionals and basic infrastructure are obstacles in implementing the plan. Additionally, the coordination between Ministries and partners needs to be strengthened.

Other communicable diseases such as dengue, lymphatic filariasis and intestinal parasitic infections remain a challenge. Timor-Leste has yet to achieve the goal of eliminating leprosy as a public health problem. Also, Timor-Leste remains one of two countries in the Region to eliminate yaws. The main constraints are limited funding, understanding of public health aspect controlling the diseases and commitment at the national level.

Available hospital-based data indicate the existence of Japanese encephalitis (JE). Once the recently developed protocol for sentinel surveillance of JE and acute encephalitis syndrome is implemented, the magnitude of the JE burden will be better defined.

International Health Regulations - 2005 is a legally binding agreement for international health security. Primary assessment of existing national core capacities for implementation of IHR was conducted in 2007 and gaps identified.

2.2.3 Health of mothers, adolescents, children

The quality of reproductive health care in Timor-Leste, including pre-delivery, delivery and post-delivery care, needs special attention. This is reflected in the high maternal mortality ratio (660 per 100 000 live births) in spite of the relatively high skilled birth attendance rate (41% of the total births were attended by skilled health personnel in 2007). High maternal mortality is, among others, a consequence of high total fertility rate and low contraceptive prevalence rate. Contraceptive prevalence in 2007 among currently married women 15 to 49 years of age was only 19.8% (Source: 2007 TLSLS). There is limited knowledge about birth-spacing and family planning methods. There is an increasing trend in teenage pregnancy which is also a risk to reproductive health.

In 2006, the estimated infant and under-five mortality rates were high at 88 and 130 per 1000 live births, respectively, although some declining trends may be observed since 2001. The main causes of under-five deaths are: neonatal causes (30%) and approximately 20% each for diarrhoea and acute respiratory infections (ARI). Prevalence of malaria is also high in under-five children. Some smaller studies indicate that the causes for the high neonatal mortality rate are similar to those experienced in many developing countries – newborn babies die or are affected because of birth asphyxia, trauma or infections. The risk of dying is markedly higher in rural than in urban areas and particularly in the highland regions of the country.

The TLSLS 2007 showed that 80% of mothers were reached by antenatal services, but data from the Health Management Information System (HMIS) indicate that only 50% of women giving birth within the past 12 months were protected against neonatal tetanus. Conditions are less deficient in urban areas, and particularly in the major urban centres. Approximately 41% of mothers were assisted by trained birth attendants. In more isolated rural and upland regions only a minority of women are getting access to medical services or receiving adequate protection against neonatal tetanus. The vast majority of women (80%) did not receive a postnatal check up. The interventions to bring services closer to these women and to stimulate demand for their use have been identified as a high priority.

The total fertility rate is 6.7 per woman in her child-bearing age (data for 2006-2007). This level of fertility is consistent with extremely short birth intervals of well under three years. Fertility regulation through the use of family planning is very low. Over 60% of women and 70 % of men fail to recognize any common method of contraception. Along with a general lack of knowledge of methods of family planning, 75% of women had no knowledge of where to obtain the information (MoH, 2007).

The immunization programme is well established. The Annual Health Statistics Report: January-December 2007 (Department of HIMS, 2008) gives immunization rates for 2007 as follows: BCG – 74.1%; DPT3 – 69.8%; measles – 62.5% and Tetanus Toxoid 2+ (TT) for pregnant women 50%. The major constraint to further increasing immunization coverage is inadequate human resources and the difficulty of access to about 30% of the population even though there are substantial financial resources.

Malnutrition is a serious problem, contributing to a high level of under-five deaths (Ministry of Health, 2007). The TLSLS 2007 indicates that for the under-five age group:

- 50.3% are underweight, of which 11.9 % are severely underweight;
- 49.9% are stunted, of which 17.7% are severely stunted;
- 18.8% are wasting, of which 2% are severely wasted.

Although not quantified, there are reports of high prevalence of anaemia, particularly in women.

2.2.4 Health promotion and health determinants

There are health challenges related to known health determinants, which include behavioural, social, economic and environmental determinants. Some determinants of health are outside the health sector, yet impact directly on the health of the people and on the incidence of communicable and noncommunicable diseases.

There is low awareness in the communities about determinants of health and health promotion. Limited expertise in the area of health promotion in the country is a constraint. Training of both health and non-health professionals in health promotion is severely limited across sectors. The health-seeking behaviour study for developing a health promotion programme is being conducted. The health promotion strategic plan (2003-2008) needs a revision. No school health policy has been established. Strengthening the capability of the Institute of Health Sciences (IHS) to build the human resource capacity for health promotion remains a major need.

In addition to social and economic determinants mentioned in subchapter 2.1, the external tobacco industry has an influence on promotion and sponsoring various events. Smoking is extremely common, particularly among the poor and less educated. Fifty percent of the schoolboys aged 13-15 years and 20 % of 13-15 year old school-girls regularly smoke. Cigarettes are readily available in small shops or from street vendors to anyone regardless of age. Although the government has ratified the WHO Framework Convention for Tobacco Control (FCTC), the awareness amongst decision-makers and stakeholders is still limited.

Prevention of injuries is an important challenge, taking into consideration the magnitude of the problem. Trauma and traffic accidents are among the ten highest incidences among diseases in the country. In addition, injuries are an important health issue during disasters. The challenges are inadequate expertise in the country on pre-hospital trauma care and non-availability of a focal point in the MoH of health injury prevention.

There is a culture of gender inequity in Timorese communities. The basic services package emphasizes gender sensitivity and there are legislative efforts to address domestic violence. However, addressing gender issues remains a challenge.

As per the WHO/UNICEF Joint Monitoring Programme of Water Supply and Sanitation Report 2008, about 68% of the total population have access to an improved water source; however, only 41% have access to proper sanitation facilities, with significant differences between urban and rural populations. These, in addition to housing and workplace conditions, are among other outstanding public health issues contributing to acute and chronic health conditions.

2.2.5 Emergency preparedness and response

In this important area, building capacity for emergency preparedness and response at all levels is a challenge. This includes national and subnational capacity to respond to natural and human-generated emergencies as well as outbreak response to epidemic-prone diseases, which would also address preparedness for an avian influenza outbreak. The challenge is to respond to major natural and complex emergencies.

2.2.6 Partnership and coordination

The contribution of health development partners has been remarkable. These include UN agencies, bilateral partners, international nongovernmental organizations (NGOs), and public-private global health partnerships. The partners' contribution is critical; however, the challenge is to harmonize the efforts and align the partners focus with the government's priorities.

Development assistance and partnership 3

In addition to its own resources, the Ministry of Health receives substantial direct financial and technical assistance for various health priority programmes. This assistance is provided through bilateral aid, multilateral agencies, the UN agencies and the global partnerships such as the Global Fund for AIDS, TB and Malaria (GFATM). The contribution of foreign assistance is significant; nearly 50% of the Ministry of Health's budget is being financed through external resources.

This assistance has generated a huge volume of work load and numerous challenges. In order to effectively manage the volume of assistance, the Ministry of Health recently established the Department of Partnership Management. The department is steadily being strengthened to enable it to play its role. The main responsibilities of this department include maintaining a register of development partners and its technical assistance, organizing regular meetings between the development partners and their counterparts in the government, and managing the administrative and financial aspects of specific projects, such as GFATM, the World Bank, EC, and AusAID etc. In addition, the department also functions as a focal point for coordination and information-sharing with development partners, managing approval for proposals from NGOs, and serving as a secretariat for the Annual Health Sector Review and for planning meetings.

In addition, the Ministry has established a Health Sector Coordination Group for further strengthening overall donor coordination in the health sector. The group consists of 15 members, chaired by the Director-General, Ministry of Health. International agencies, such as AusAID, the World Bank, USAID, EC, UNICEF, UNFPA, WHO, one representative from the NGO sector, and a representative from the Ministry of Finance are the members of the group. Specifically, the Health Sector Coordination Group will work to achieve:

- Alignment of donor priorities with national priorities, including the alignment of the planning cycle of the government and the planning cycles of the donors and all agencies.
- Consensus on policy of adhering to areas of comparative advantage and competence.
- Mobilization of financial and technical resources in support of agreed national priorities and in conformity with MoH plans, but with the focus on covering critical gaps.

- Consensus on an annual calendar of key national level coordination, planning and evaluation activities, such as the Joint Annual Health Sector Review, Annual Health Planning Summit, missions of donors and partners on matters of policy/strategy, and the Development Partners' Meeting organized by the Ministry of Finance.

There have been several strategic documents which are important tools for the coordination of all stakeholders working for health in Timor-Leste. These are (i) Health Sector Strategic Plan 2008-2012; (ii) Medium Term Expenditure Framework; (iii) Workforce Plan; and (iv) Ministry of Health Circular in Donor Coordination.

Several coordination mechanisms are in place, such as the Joint Annual Health Sector Review and Planning Summit, which resulted in the Comprehensive Annual Health Sector Plan. Others are: Quarterly Health Coordination Meetings, Technical Working Groups (such as for Reproductive Health, Nutrition), and district level coordination meeting addressing the implementation issues.

WHO's role as the main partner in health in Timor-Leste is well recognized. WHO continues to provide technical support and has been considered as a neutral and privileged partner who can facilitate partnership processes among the development community in Timor-Leste.

Past and current WHO cooperation 4

4.1 Challenges and opportunities

WHO began its humanitarian assistance a decade ago, in 1999. Over the years, WHO's cooperation in and with Timor-Leste has been growing in terms of technical and financial capacity. In the recently developed United Nations Development Assistance Framework (UNDAF) 2009-2013, WHO has indicated a resource mobilization target (for WHO) of US\$ 16 million.

The Country Office staff increased from two in 1999 to the current number of 24. This includes seven international professionals (three fixed-term including the WHO Representative, and four term-limited staff), 17 nationals (10 technical and 7 support staff). (see Annex 2.)

The products and activities in the workplans of the last two bienniums have been quite consistent with the 2004-2008 CCS priorities. The priorities were:

- Support for health policy and legislation development
- Donor coordination and partnership for health development
- Health systems development
- Interventions for priority health problems

A substantial proportion of the budget (72%) has been allocated to interventions related to priority health problems. Combined, the budget for priority health interventions and the determinants of health account for 75% of the total allocated budget. Health policy and legislation development, under *health priorities, systems and products*, has been allocated approximately 8% of the budget. The *partnership and coordination* component has no explicit budgetary allocation, although it is included under WHO country presence, which also includes the time the WHO Representative devotes to dealing with other partners.

There are a number of reasons why the budgetary allocation to priority health interventions has been so remarkable. The CCS priorities were developed in response to ambitious national health plans and strategies, under the assumption that WHO would be able to mobilize voluntary contributions to implement these priorities. Not all priorities identified in the CCS as mentioned above were fully implemented, although these were the basis for biennial workplans. WHO was able to mobilize voluntary

contributions for some CCS priorities, approximately US\$ 1.5 million, particularly for priority disease interventions². However, it was not able to mobilize resources to implement other CCS priorities, such as those related to policy, systems and institutional development. Donor preference for a few priority programme areas seems to have resulted in funding gaps for strengthening health system capacity in Timor-Leste.

As the country is still going through a reconstruction and recovery phase, overall national capacity and infrastructure for effective service delivery is relatively limited. Due to the paucity of staff, government officials are, for instance, often designated as focal points for multiple programmes and provided with inadequate resources and support.

4.2 WHO's contribution to achieving the national health development agenda across the CCS priorities

The application of WHO's core functions as indicated in Box 1 for the implementation of CCS priorities is described below. WHO's focus in Timor-Leste continues to shift away from traditional support for direct implementation to supporting the MoH to build its own capacity to develop health policy and strengthen the health system.

Box 1: WHO's Core Functions

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.
2. Shaping the research agenda and stimulating the generation, dissemination, and application of valuable knowledge.
3. Setting norms and standards, and promoting and monitoring their implementation.
4. Articulating ethical and evidence-based policy options.
5. Establishing technical cooperation, catalyzing change, and building sustainable capacity.
6. Monitoring the health situation and assessing health trends.

² Examples of donor-preferred priority disease interventions include HIV, TB, malaria and immunization. The donors are GFATM for AIDS, TB and malaria, and GAVI for immunization.

4.2.1 Priority 1: Support for health policy and legislation development

WHO has been providing sustained and continuous support to health policy development with the appointment of a full-time senior adviser to the Ministry of Health. This has proved to be a good mechanism in providing policy advice, and assisting the government in strengthening health systems, partnership and many other health sector issues.

WHO and the EC supported the preparation of the National Health Sector Strategic Plan - HSSP (2008-2012), which is guiding the government in the sector development and informing strategies and plans being developed with other partners, such as AusAID and the World Bank. In addition, WHO contributed to the elaboration of the Medium Term Expenditure Framework (MTEF), which has enabled the MoH to develop a comprehensive national health plan and budget to implement the HSSP.

4.2.2 Priority 2: Donor coordination, partnership for health development and aid effectiveness

WHO has a privileged rapport with the government, and is thus well-positioned to facilitate partnership processes and provide support to donor and external resource coordination among the development community in Timor-Leste.

The Country Office has been able to collaborate successfully with the Ministry of Health, other national institutions, NGOs, and donor agencies to prioritize health on the development agenda. In addition to generating resources for itself (USD 1.5 million), WHO has been assisting the government in generating external resources for the health sector (i.e. US\$ 2.4 million from GFATM for TB, US\$ 9.4 million for HIV/AIDS).

WHO has supported the Ministry of Health in establishing donor coordination and partnership mechanisms. These forums resulted in a Combined Annual Plan and Budget, reflecting both government and externally funded activities. Despite limited capacity, the MoH has prepared the necessary conditions for moving towards a SWAp in the health sector. The preparation and approval processes of the HSSP 2008-2012 and the MTEF are being used as tools to achieve stakeholder agreement on spending priorities that close gaps and limit duplication.

WHO's proactive participation in the development of UNDAF 2009-2013 was specifically appreciated. There is a constant interaction among the UN agencies which emphasizes the need for the next CCS to consider UNDAF priorities to ensure their work is harmonized with that of other UN agencies.

UNICEF and UNFPA have been working closely with WHO and complementing the work across a number of areas. For example, in the area of immunization, UNICEF and WHO work together. In the area of essential obstetric care and midwifery training, UNFPA and WHO have collaborated effectively.

WHO has been requested to facilitate the coordination of multiple partners involved in specific programmes, such as TB and malaria, to ensure a harmonized response to the challenges in these areas. Further, WHO would provide specific support to build the capacity of the recently established Department of Partnership Management in the Ministry of Health to effectively manage partnership and coordinate resources and programmes of the development partners.

4.2.3 Priority 3: Health System Development

WHO has been working directly with the health authority in developing “initial steps in rebuilding the health sector in Timor-Leste” which have been the basis for the development of the national health system.

Given the enormous need for capacity building, particularly to implement the Basic Health Services Package and SISCa (integrated community health services) – both of which are based on primary health care values – there is more scope in this area, as identified below.

WHO’s advocacy role is evident in the extent to which the values and principles of primary healthcare have been articulated in the National Development Plan and HSSP. With support from WHO, Timor-Leste recently developed a paper, “Revitalizing Primary Healthcare: Timor-Leste’s Experiences”, to further strengthen the country’s community-based health system. The national health priorities related to the MDGs and Basic Health Services Package have been formulated with support from WHO.

WHO and other partners such as AusAID, the EC and the World Bank have been supporting the government to develop a Human Resources for Health (HRH) plan which is under review, and to develop a number of strategies and guidelines for addressing human workforce development. An example is the Guidelines for Fellowships and Scholarships Programme.

WHO supported the process of curriculum development for the School of Nursing and Midwifery. This included the development of a training plan and health workforce programme for different categories of the health workforce. This has contributed to the revitalization and expansion of primary health care services in Timor-Leste. WHO supported several other training programmes – e.g. two overseas training programmes on pre-hospital care and on public health in complex emergencies, and the development of a Management Training Programme for Community Health Centre Managers.

The HSSP-SP funded by the World Bank and AusAID, and the EC project have planned activities such as the HRH plan, in-service training assessment, and workforce performance analysis. The initiatives require better coordination as well as an agreement on division of labour for harmonized response to government requests. Support for better coordination should focus on health workforce *needs assessment* that includes the planning, production and management of medical doctors, nurses, midwives and other paramedical health workforce such as pharmacists, laboratory assistants and dentists.

WHO has provided information in health financing tools, practical guidelines, and training on key dimensions of financing and social protection mechanisms. The government is in the process of costing primary and hospital care to assess resources required to finance the health sector. WHO would assist the government to identify health sector needs and develop financing mechanisms to ensure universal coverage as provided for in the HSSP.

Quarterly and annual health reports were produced and disseminated in 2007 and 2008 with WHO support. The Health Management Information System unit needs continuous technical support as there are systemic issues and issues of data quality and reliability. This unit is now integrated with the surveillance unit in the MoH. The MoH conducts integrated disease surveillance with technical and financial support from WHO. In response to a request from the MoH, WHO has also supported the establishment of vital registration in three districts. With funding from HSSP-SP or through any other funding mechanism, WHO will coordinate all initiatives and support the government in setting up a comprehensive HMIS for evidence-based policy development and the monitoring and assessment of the health situation and trends.

There is a need to continue to provide management and leadership training for new managers as well as continuing education for the existing managers, taking into consideration the government's decentralization policy.

WHO's contribution to improving the quality and availability of essential medicines has been substantial; technical guidelines on the rational use of drugs have been distributed to health facilities for health workers to follow while dispensing medicines. The resources provided under this programme have been utilized for the emergency purchase of drugs.

Technical support provided by different partners needs more coordination and strategies should be implemented to minimize turnover and ensure sustained national capacity building in health systems development.

4.2.4 Priority 4: Interventions for priority health problems

WHO support was provided in the development of up-to-date standard operating procedures for laboratories and blood banks, as well as disease and programme-specific guidelines.

Support in *malaria control* included technical advice and development of the treatment protocol for prevention and management of malaria, orientation of all doctors, support in vector surveillance, mapping of malaria cases and vector control. The National Malaria Control Programme will receive US\$ 10.3 million from the GFATM (Round 7). WHO will facilitate implementation by supporting coordination and providing technical assistance.

In the National *TB control* programme, DOTS expansion has taken place in all community health centres. Technical assistance was provided to MoH in the preparation of a proposal for funding, submitted to the GFATM, during Rounds 4 and 7, both of which were successful. Technical assistance for capacity building of the programme was organized through a horizontal collaboration mechanism facilitated by WHO. The GFATM would provide US\$ 7 million for TB control. The procurement of first-line and second-line anti-TB drugs is being coordinated through WHO with the Global Drug Facility. Support was also secured from UNITAID for second-line drugs for the programme.

WHO provides support to the MoH in strengthening national capacity in programme management, implementation of HIV and STI prevention, care and treatment interventions, and monitoring and evaluation of the national AIDS programme. Under the HIV grant provided by GFATM to expand the scope of the national programme in controlling the spread of HIV and STI, including blood transfusion services, WHO provides assistance for the procurement of supplies, including pharmaceuticals, and equipment for the proposed new blood banks in four district hospitals.

WHO supported implementation of the National *Leprosy Elimination Programme*. The programme commenced in 2003 and the incidence has decreased. Support to other programmes, i.e. *elimination of lymphatic filariasis*, and control of *intestinal parasitic diseases* continued.

WHO's role in *maternal and child health* focused on capacity building and the provision of norms and guidelines. The Human Resources for Maternal and Newborn Health Strategy has been developed, along with a comprehensive intervention plan to ensure skilled care at every birth which has been endorsed by the Ministry of Health. Support was provided to the MoH to improve performance of the maternal and neonatal health programme at district level. The focus on adolescents is through the integrated programme on HIV/STI, family planning and health promotion. The WHO/UNFPA/UNICEF Adolescent Reproductive Health (ARH) Framework "Investing in youth" was translated and widely disseminated in collaboration with UNFPA. Support was provided to the expansion of IMCI in all 13 districts; supervisory capacity is now in place. Six districts have started implementation of community IMCI.

With support from WHO, UNICEF and other partners, *immunization* is a well-established programme in Timor-Leste. Immunization staff at district and subdistrict level have been trained, and all districts have one staff that is able to maintain the cold chain properly. Routine immunization coverage for infants has improved (DPT3 coverage increased from 57% in 2004 to 70% in 2008) and although it has not reached the regional target, there has been a rapid progress. Introduction of tetravalent (DPT and HepB) vaccine at the end of 2007 is a major achievement. The country has been polio free since 1995. However, during the last ten years the country has not achieved the required target for AFP surveillance. Measles supplementary immunization activities

were conducted in 2003 and 2006. However, reported measles incidence varied with high incidence in 2005 and no cases in 2007, indicative of weakness in general surveillance. In spite of several attempts to train laboratory staff in JE surveillance, the process is yet to be completed. SEARO has assigned a Temporary International Professional to assist in priority activities such as surveillance, conducting EPI and AFP surveillance review and preparations of the TT and measles immunization campaigns. The major constraints facing immunization services are inadequate human resources even though there are substantial financial resources, and the difficulty of access to about 30% of the population.

WHO provided technical support to the MoH and partners in implementing the National *Nutrition Strategy* to tackle the serious nutrition problem in the country. The support consisted of training workshops on infant and young child feeding across all districts, translation of the 3-in-1 training manuals on feeding for mothers with HIV/AIDS, and training of national staff trainers. Support was also provided to a national workshop to improve the quality of the nutrition programme across all districts. This resulted in an average increase in knowledge on nutrition services by more than 20%.

WHO support was also provided to address determinants of health and for the development of *health promotion* training materials for community health volunteers. The school campaign on World No Tobacco Day 2007 was supported and perceived to have improved school students' knowledge and awareness regarding the ill-effects of tobacco. There has been a concerted effort to strengthen the area of school health promotion. A National School Health Working Group has been established and is co-chaired by MoH and the Ministry of Education. Its membership includes nongovernmental organizations, WHO, UNICEF, UNFPA and development partners. Training of teachers on school health promotion was started in six districts with WHO technical support. The remaining districts will receive technical and financial support from WHO in 2009.

In the area of environmental health, WHO assisted the MoH in the development of sanitary norms, establishing an inspection unit, development of water quality standards, capacity building on water quality management and the provision of water testing kits. Support was also provided for a training workshop on clinical waste management for DPHOs in environmental health, as well as hospital staff and NGOs working in the environmental health programme. WHO, particularly the Regional Office, has provided continuous support to the MoH in building capacity in preparedness and response with regard to major natural and man-made disasters. WHO has developed guidelines and instructions for the management of emergency situations in IDP camps, and the mapping of the emergencies using Global Image Software (GIS). WHO assisted the MoH in establishing the National Task Force for avian influenza, conducted training for joint outbreak investigation, supervised the UN response to avian influenza at the country level, and assisted in the procurement of diagnostic reagents and personal protection kits.

In providing technical assistance to the Ministry of Health, WHO follows the key principles mentioned below:

- WHO priorities are adjusted according to national health objectives which include achieving the health-related Millennium Development Goals and universal access to primary health care services.
- Priority approaches are emphasized in the strategic agendas for which WHO's strong input (both technical and financial) are expected to bring substantial outcomes and their impact on country capacity.
- Well-defined and selected priorities will help to ensure a better match between the needs of the country and the globally agreed strategic objectives in which WHO has a clear advantage compared to other partners.
- Continued support from WHO will help the Ministry of Health to strengthen health policy and systems as well as public health services and management capacity at all levels; this, in turn, is expected to augment the government's commitment to decentralization.
- WHO's role has shifted from implementing specific health programmes to supporting the Ministry of Health to build its own capacity around the core functions and to strengthen the health systems for effective service delivery.
- Technical assistance will remain one of the most important core functions of the Country Office in the foreseeable future.
- Enhancing partnership with UN agencies and all partners in health and harmonization of programmes among development partners is crucial for aideffectiveness.

Strategic Priorities:

Based on the health issues and challenges in Timor-Leste, WHO's Eleventh General Programme of Work, WHO's core functions (see box 1) and recognizing WHO's role identified through consultations with national and international partners, six Strategic Priorities have been jointly agreed for WHO's cooperation with the government of Timor-Leste:

- (1) Health policy and systems
- (2) Disease prevention and control
- (3) Maternal and child health
- (4) Overall national capacity building
- (5) Partnership and coordination
- (6) Emergency preparedness and rapid response

Under each strategic priority, WHO will identify the main focus with areas for action and apply selected WHO core functions in formulating strategies to address these areas. The main focus indicates high priority in which WHO expects to be able to have an impact through its contributions of dedicated professionals and funds. The CCS main foci will also be linked to WHO’s Medium-Term Strategic Plan.

5.1 Strategic Priority 1: Health policy and systems

WHO will continue to provide support and advice in the areas of health policy and systems. Strengthening district health systems, quality of services and the Health Management Information System and support in the areas of health policy and systems are high priorities. The Organization’s support for human resource development needs to be scaled up, as well as improving national capacity in procurement, logistics and maintenance of a supply system.

Main Focus 1.1: Health systems strengthening

Areas for Action	WHO core functions	Strategies
District health systems (DHS) strengthening	3, 4, 5	Strengthen district health systems to deliver and manage the Basic Package of Health Services as defined in the HSSP and the SISCa, especially in view of the government’s commitment to decentralization of the health and other sectors.

Areas for Action	WHO core functions	Strategies
Health Management and Information System (HMIS) strengthening	2, 4, 6	Strengthen HMIS all levels, particularly in areas of data collection and reporting, national data management, managerial and epidemiological capacities of HMIS officers at national and district levels, utilization of data and development of user-friendly software for HMIS. Additional financial resources would be necessary.

Main Focus 1.2: Health policy strengthening

Areas for Action	WHO core functions	Strategies
Health policy advice	1, 4, 5, 6	Support the Ministry of Health by providing a full-time senior consultant located in the Ministry of Health.

Additional Focus Areas for Strategic Priority 1

Areas for Action	WHO core functions	Strategies
Human resources for health (HRH) master plan	3, 5	Facilitate harmonizing the multiple efforts of various partners in developing a comprehensive human resources for health master plan to address gaps in and improve the quality of the current health workforce.
Institutional capacity strengthening	5	Support for strengthening the Faculty of Health Sciences and the Institute of Health Science.

Areas for Action	WHO core functions	Strategies
Improvement of quality of services	3, 5	Support to improving the quality of services, by equipping diagnostic facilities, ensuring an adequate supply of essential medicines, and augmenting integrated disease surveillance for regular monitoring, and taking corrective measures for quality improvement. Operational research in this context will be supported.
Management of essential medicines procurement and supply	3, 5	Improve national capacity in procurement of essential medicines, logistics and maintenance of a supply system and its harmonization.

5.2 Strategic Priority 2: Disease prevention and control

Communicable diseases continue to be a major public health problem. There are resources provided by the GFATM and other partners. In addition to supporting the government’s coordination of multiple actors, WHO will support capacity building for effective implementation of these programmes, focusing also on elimination and eradication of some communicable diseases and on diseases of public health concern. Enhancing integrated disease surveillance would require continuous support.

Prevention of noncommunicable diseases would be addressed through health promotion. Addressing health determinants (water and sanitation, tobacco, environmental conditions), which are outside the health sector but have a direct impact on health, is also an area for support.

Main Focus 2.1: Disease Prevention and Control

Areas for Action	WHO Core Functions	Strategies
Public health workforce and programme intervention	3, 4, 5	Support capacity building of public health workforce and programme interventions for effectively addressing malaria, tuberculosis, STI/HIV/AIDS; for elimination and eradication of diseases (leprosy, lymphatic filariasis, yaws); and for control of communicable diseases of public health concern (dengue, intestinal parasitic infections, Japanese Encephalitis).

Main Focus 2.2: Disease Surveillance and Response

Areas for Action	WHO Core Functions	Strategies
Integrated disease surveillance	2, 3, 4, 6	<ul style="list-style-type: none">• Enhance integrated disease surveillance, particularly in the area of legislation/ regulation for epidemiological surveillance;• develop national and subnational data management;• strengthen technical capacities of data managers at all levels;• establish a laboratory network;• enhance surveillance capacity for risk factors of noncommunicable diseases.

Areas for Action	WHO Core Functions	Strategies
Strengthening implementation of International Health Regulations (IHR) 2005	2, 3, 4, 6	Support national core capacities for implementation of IHR (2005). Surveillance and response, laboratory diagnosis, public health legislation, disease prevention at point of entry (seaport, airport, ground crossings) and risk communication will be key areas for core capacity development in line with IHR (2005).

Additional Focus Areas for Strategic Priority 2

Areas for Action	WHO Core Functions	Strategies
Blood safety	5	<ul style="list-style-type: none"> • Enhance capacities of the National Laboratory, the National Blood Bank and peripheral level laboratories and blood banks to assist the public health programmes, quality diagnosis and to address blood needs, and to cope with the increasing demand for laboratory testing and blood donations.
Health Promotion	3, 5, 6	<ul style="list-style-type: none"> • Support for revision of the National Health Promotion Strategic Plan; • capacity building in health promotion at the national and district levels; • support the development of school health policy.

Areas for Action	WHO Core Functions	Strategies
Tobacco control	3, 5, 6	<ul style="list-style-type: none"> • Advocate existing tobacco control policy and support drafting of national tobacco control legislation.
Water and Sanitation	3, 5, 6	<ul style="list-style-type: none"> • Support for institutionalization of water safety plans, household water treatment and storage; • promotion of various low-cost and sustainable latrine options; • promotion of water, sanitation and hygiene in schools.

5.3 Strategic Priority 3: Maternal and child health

Efforts to reduce maternal and child mortality would focus on support for the immunization programme and related activities, and on effective interventions, focusing on the health workforce, facility-based deliveries, quality of care, contraceptive choice, health education, IMCI and nutrition.

Main Focus 3.1: Child Health

Areas for action	WHO Core Functions	Strategies
Immunization programmes	3, 4, 5	<ul style="list-style-type: none"> • Further support to improve routine immunization coverage; • strengthen polio eradication documentation; • improve disease burden knowledge for decision on introduction of new vaccines; • strengthen Ministry of Health and district level in planning and management capacity; • ensure injection safety including adverse effect following immunization surveillance.
Integrated Management of Childhood Illnesses (IMCI)	5	<ul style="list-style-type: none"> • Support for implementation of IMCI, particularly the expansion of the community IMCI.

Main Focus 3.2: Maternal Health

Areas for action	WHO Core Functions	Strategies
Making Pregnancy Safer (MPS)	3, 4, 5, 6	<ul style="list-style-type: none"> • Support for the proper training of staff in community health centres and district hospitals and the provision of adequate equipment and setting up safe delivery facilities in the community health centres; • pre- service training and in-service supervision of midwives; • advocate for expansion of contraceptive choice, delaying age of first pregnancy and attention for special care in adolescent pregnancies.

Additional Focus Areas for Strategic Priority 3

Areas for Action	WHO Core Functions	Strategies
Nutrition	3, 5, 6	<ul style="list-style-type: none"> • Strengthen the nutrition-related interventions and their coverage, with focus on mapping of key stakeholders' interventions and their impact; • establish quality control and assurance systems and laboratory for IDD monitoring; • assist in training on the new WHO growth standards; • assist in adaptation of WHO guidelines and protocols for the management of children with moderate malnutrition and those recovering from severe malnutrition.

5.4 Strategic Priority 4: Overall national capacity building

The work of WHO together with its development partners will focus on ensuring strengthening of national capacity based on the national health policy framework and national health sector strategic plan, as well as transfer of technical skills from international experts to national officials. This would help to ensure sustained national capacity in future. The priority strategic approaches include:

Main Focus 4.1: Strengthening institutional capacity of Ministry of Health

Areas for Action	WHO Core Functions	Strategies
Ministry of Health leadership and management capacity	1, 5	Support for further strengthening management, leadership and technical capacity of the Ministry of Health.
Organizational reform	3, 5	Support legislative, organizational and administrative reforms of management structures, systems and procedures in the Ministry of Health.
Technical quality assurance	5, 6	Promote capacity in technical supervision and control throughout the health sector, to promote quality and increase utilization.

5.5 Strategic Priority 5: Partnership and coordination

WHO will continue to support the Ministry of Health in the area of donors and partnership coordination, through strengthening the Department of Partnership Management.

As a privileged partner of the MoH and honest broker, WHO needs to increase its support to facilitate donor and partner coordination. WHO will build its support on existing mechanisms and facilitate the government's involvement in partnership and coordination of external resources for aid effectiveness.

Main Focus: 5.1. Coordination of Partners

Areas for Action	WHO Core Functions	Strategies
Department of Partnership Management, Ministry of Health	1, 6	Support for the Department of Partnership Management of the Ministry of Health to effectively manage partnerships and coordinate resources and programmes of the development partners.
Partners coordination	1, 3, 5	Facilitate the coordination of multiple partners involved in specific programmes (e.g. malaria, HRH, HIV), to ensure a harmonized response to the challenges in the specific health programmes; Support other partners in adhering to the principles of the Paris Declaration and the Accra Accord, especially the harmonization and alignment agenda.
Joint reviews	1, 6	Support for existing mechanisms of effective partnership and coordination, i.e. Joint Annual Review and Annual Planning Summit.
Resource Mobilization	1	Facilitate mobilization of additional financial resources for the health sector from the partners in health and the global partnership mechanisms.

5.6 Strategic Priority 6: Emergency preparedness and rapid response (EPR)

The country is prone to natural and complex emergencies, including emergencies such as floods and epidemics. Implementation of the International Health Regulations (2005) in the context of Timor-Leste will be emphasized. WHO will enhance its support to ensure adequate emergency preparedness and response.

Main Focus 6.1: Training, advocacy and coordination on EPR

Areas for Action	WHO Core Functions	Strategies
Building national capacity	3, 4, 5, 6	Support for the training of the health workforce in rapid response and emergency management including outbreak investigation and disease surveillance, and for providing emergency supplies.
Advocacy	1, 4	Advocate for adequate human resources in the area of health sector emergency preparedness, management and response.
Partnership and coordination	1, 4	Enhance partnerships for effective planning, coordination and response to emergencies.



6 Implementing the strategic agenda

6.1 Country level

The proposed agenda for WHO's Country Cooperation Strategy 2009–2013, Timor-Leste, is based on the situation analysis of the country's health and development challenges, on achievements and constraints in WHO's collaborative activities during the past three bienniums during the implementation of the WHO CCS 2004–2008, WHO's core functions and policy framework, and a discussions held during the WHO Country Cooperation Review mission, 22–26 September 2008. The review mission met Ministry of Health officials and key stakeholders and presented its findings to and received feedback from the senior MoH officials and the Regional Director, South-East Asia.

Compared to the period of the CCS 2004–2008, there are some major issues that may have implications for the WHO Secretariat, which include (i) shift in priorities; (ii) human resources in the WHO Country Office, funding allocation, logistics/infrastructure and connectivity; and the (iii) role of the WHO Regional Office and WHO headquarters.

6.1.1 Shift in priorities

The shift has begun in WHO's contribution from supporting the implementation of specific health programmes to supporting the MoH to build its own capacity around the core functions and to strengthen the health system for effective delivery of public health services. WHO will be enhancing its support for strengthening health policy and systems as well as public health services and management capacity at the national, district and community levels. This, in turn, is expected to augment the government's commitment to decentralization.

While implementation of all health-related programmes has been quite significant, it is somewhat hindered by the limited national capacity. WHO needs to identify where it can boost capacity, and prioritize and focus its work.

Maternal and child mortality in Timor-Leste are very high. The country is prone to natural and complex emergencies, including epidemics. WHO will enhance its support to ensure these crucial areas of health are adequately addressed. In addition, effective disease prevention and control interventions will continue to be supported including health promotion and health determinants, with special focus on adolescents and young people.

6.1.2 Human resources in the WHO Country Office

The current core capacity of essential technical and administrative competency in the WHO Country Office will need to be strengthened for the implementation of the strategic agenda.

Currently, WHO has deployed a full-time international senior policy adviser to support the MoH in health systems and policy development. The adviser is based in the MoH and, with adequate backup from the WHO Representative, has consistently proved a very good source of support in policy advice, health system strengthening, effective partnership and other health sector issues.

To address priority health interventions, two international epidemiologists (integrated disease surveillance and IHR), one international TB specialist, one international malaria officer, one national reproductive health programme officer, one national emergency preparedness and response programme officer, one national disease control programme officer, and one national health promotion programme officer are currently based in the Country Office.

Additional staff will be needed for:

- Health Management and Information System—a full-time international professional for two years to strengthen this critical area.
- HIV/AIDS/STI—a full-time international professional for two years to support the national programme in coordinating and harmonizing the assistance and technical support of other stakeholders.
- National Planning Officer—over the years, the size and budget of the Country Office has grown. A full-time National Professional Officer, Planning, is required to work closely with MoH in planning, implementing and monitoring WHO's collaborative programme.
- Administrative support—a full-time administrative officer is needed to support the professional and technical staff and to help develop the capacity of the local staff in the administrative unit of the WHO Country Office.

Training is needed in resource mobilization for all technical staff, in programme development and management for national technical staff, and in financial management and secretarial support for local administrative support staff.

6.1.3 Logistics, infrastructure and connectivity

Taking into consideration the country's transition, WHO must be responsive, flexible and aligned to the country needs while adhering to WHO's rules and regulations.

In spite of an improvement in connectivity, particularly a GPN and voice/video conference facility, there is a need to address the quality and quantity of the communication facilities for the WHO Country Office.

In support of an integrated United Nations in Timor-Leste, the WHO Country Office is already a proactive member of the UN Country Team (UNCT) and has actively participated in the development of the UNDAF and relevant coordination and other meetings. As the UNCT operates under the umbrella of the UN Resident Coordinator, UNCT members are expected to contribute to the operations costs of the Resident Coordinator. Therefore, the WHO Country Office has to budget adequately to cover this cost and the office running costs on the shared UN premises.

6.1.4 Financial resources

The cost of the additional human resource needs will add to the biennial budget. While the cost of the National Professional Officer Planning will be comfortably met by WHO, the funds required for the other planned positions will have to be raised from other sources. Significant costs will also be incurred from WHO funds for shared office space in the common UN premises and for contributions that will be made to the operations of the UN Resident Coordinator.

In addition to its own financial contributions, WHO will also mobilize additional funding for strategic priorities, in particular in the areas of strengthening national capacity and health systems which have a funding gap. WHO's advocacy role in the partnership and coordination activities could be an important tool to prioritize funding for the systemic activities and mobilize additional resources.

6.2 Support from the Regional Office and WHO Headquarters

Technical support from the Regional Office and headquarters (particularly in areas where country office expertise is not available) will be required, particularly in the priority areas identified in the CCS 2009–2013.

WHO's efforts to strengthen national capacity through training and workshops outside the country are quite prominent. However, given the limited number of staff at the MoH and their multiple responsibilities, the number of requests from the Regional Office and headquarters for nomination of MoH officials is considerably high. The Regional Office and headquarters should be aware of such constraints, and manage their requests accordingly, taking into consideration the country specific context.

The Regional Office and headquarters would also play a key role in mobilizing resources for priority areas where the assessed contribution is limited.

Conclusion 7

The SEARO/WHO Timor-Leste Country Office team will coordinate Organization-wide actions and collaborate with national counterparts and international development partners to implement, monitor, and evaluate the Country Cooperation Strategy. As with all strategic agendas, the new CCS provides a flexible framework for focused action that will meet the country's needs. It will be adjusted as needed to respond to changes in the country's health situation, national health development goals, and the organizational environment, through periodic, participatory assessment of its implementation.

Annex-1



Strategic Priority 1: Health Policy and Systems Main Focus 1.1: Health Systems Strengthening

Areas of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
District Health System (DHS) strengthening	<ul style="list-style-type: none"> Capacity of DHS managers needs to be strengthened. Capacity of community-based health workers needs further improvement. 	<ul style="list-style-type: none"> Health services decentralization has been identified as a priority. Government policy on strengthening health services through involvement of community at grass-roots level (through SISCa). 	<ul style="list-style-type: none"> Strengthen district health systems; based on the Basic Package of Health Services defined in the HSSP and the SISCa, especially in view of the Government's commitment to decentralization of the health and other sectors. Training DHS staff in management. Revitalizing PHC through strengthening community-based health workers and community volunteers (HMM/RC 2006, Regional Strategy). 	<ul style="list-style-type: none"> Improved health systems management, including planning, supervision, monitoring, recording/reporting at district level. Better management at SISCa level. 	Ministry of Health, World Bank, USAID, UNICEF, UNFPA.

Areas of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Health Management Information System (HMIS) strengthening</p>	<ul style="list-style-type: none"> Change in the national policy including reporting system of several programmes that required new forms and training for HMIS staff, and adjustment of the available software. Although training has been conducted several times to improve the capacity of the HMIS staff, many HMIS staff still unable to deliver. Inadequate compilation and reporting of the HMIS data at the Community Health Centre (CHC) level due to limited understanding of health workers on validating and analyzing the data. Capacity for data analysis at all levels still inadequate. Limited utilization of information from HMIS for policy and strategy formulation. 	<ul style="list-style-type: none"> HMIS is considered a priority in HSSP. Reporting system has been streamlined and avoids duplication. Various guidelines for HMIS have been developed, including guidelines for validating data and data analysis. Training of HMIS staff at district and national level. HMIS Unit of MoH was able to produce its annual Health Statistics Report in 2007 and 2008. Introduction of national family registration system by the MoH, through SISCa. Piloting of Vital Registration model in one district, in collaboration with the Ministry of Interior and the National Statistics Directorate. 	<ul style="list-style-type: none"> Strengthen HMIS at all levels, particularly in areas of data collection and reporting, national data management, managerial and epidemiological capacities of HMIS officers at national and district levels, utilization of data and development of user-friendly software for HMIS. Establishment of vital registration system. Development of operational and validated tools for collecting and updating information and facilitating routine analysis for the HMIS. Promote use of appropriate health informatics including GIS as a common tool for planning, implementation, monitoring of health services at all levels. 	<ul style="list-style-type: none"> HMIS unit in MoH strengthened and application of the system at all levels. HMIS unit in MoH able to provide timely and accurate data for planning, monitoring and improving the performance and quality of health services. Vital registration system established. 	<p>Ministry of Health, World Bank, AusAID, USAID.</p> <p>Good collaboration with UNFPA.</p>

Focus on Health Systems Issues

Areas of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Human Resources for Health (HRH) master plan	<ul style="list-style-type: none"> Development and implementation of HR database and plan. 	<ul style="list-style-type: none"> Government policy in place. 	<ul style="list-style-type: none"> Facilitate harmonizing the efforts of various partners in developing a comprehensive human resources for health master plan to address gaps in and improve the quality of the current health workforce. Assist the Member State in development of HR database and plan (WHA, HMM/RC 2006). 	<ul style="list-style-type: none"> HR database developed and updated HR plan implemented. 	<ul style="list-style-type: none"> Ministry of Health, EC, AusAID, World Bank, UNFPA.
Strengthening institutions for training of midwives	<ul style="list-style-type: none"> Inadequate qualified teachers and infrastructure in implementing a new midwifery curriculum (Diploma III) by the Institute of Health Sciences (IHS). 	<ul style="list-style-type: none"> MDG 4-5 relevant. Government policy in place. On the agenda of other UN agencies. 	<ul style="list-style-type: none"> Scale up skilled birth attendants to improve maternal and newborn health (WHA , HMM/RC 2005) Support for strengthening Faculty of Health Sciences and the Institute of Health Sciences and National Health Library. 	<ul style="list-style-type: none"> Quality of midwifery education improved. Qualified teachers in place. 	<ul style="list-style-type: none"> Ministry of Health, UNFPA. EC, AusAID.
Strengthening institutions for training of nurses	<ul style="list-style-type: none"> Inadequate qualified teachers and infrastructure in implementing a new Diploma in Nursing curriculum by IHS. 	<ul style="list-style-type: none"> Government policy in place. 	<ul style="list-style-type: none"> Scale up production and quality of health workforce (WHA , HMM/RC 2006). Support for strengthening Faculty of Health Sciences and the Institute of Health Sciences and National Health Library. 	<ul style="list-style-type: none"> Quality of nursing education improved. Qualified teachers in place. 	<ul style="list-style-type: none"> Ministry of Health, UNFPA. EC, AusAID.

Areas of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Essential Medicines and drug supply and management</p>	<ul style="list-style-type: none"> Incorporating the TLS National Essential Medicines List in the training of health-care professionals. Improving Drug Supply Management. 	<ul style="list-style-type: none"> Incorporating this in the training provides coherence from training to actual practice in the health-care system. Improved software providing better feedback on drug use and thereby improving drug supply management. 	<ul style="list-style-type: none"> Improve national capacity in procurement of essential medicines, logistics and maintenance of a supply system and its harmonization. Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported. Evidence-based policy guidance on promoting scientifically sound and cost-effective use of medical products and technologies by health workers and consumers developed and supported within the Secretariat and regional and national programmes. International norms, standards and guidelines for the quality, safety, efficacy and cost-effective use of medical products and technologies developed and their national and or regional implementation advocated and supported. 	<ul style="list-style-type: none"> Streamlined procurement and supply management systems. Increase in access to and rational use of Essential Medicines. 	<p>Ministry of Health, EC, UNICEF</p>

Areas of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Mental Health	<ul style="list-style-type: none"> Health system development to incorporate mental health. 	<ul style="list-style-type: none"> Mental health programme integrated with primary health care. 	<ul style="list-style-type: none"> Building community mental health system and prevention of harmful use of alcohol. 	<ul style="list-style-type: none"> Health system oriented to include mental health at the primary health care level. 	Ministry of Health, AusAID.

Strategic Priority 2: Disease Prevention and Control

Main Focus 2.1: Disease Surveillance

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Integrated Disease Surveillance System (IDSS)	<ul style="list-style-type: none"> Limited technical capacity. Retaining trained professional staff. Lack of understanding of district managers on the use of epidemiological data for decision-making. 	<ul style="list-style-type: none"> Epidemiology unit and system is in place. All districts have staff designated for disease surveillance. 	<ul style="list-style-type: none"> FETP for field level public health professionals. Short field epidemiology training course for paraprofessionals and district managers. Enhance integrated disease surveillance, particularly legislation for epidemiological surveillance. 	<ul style="list-style-type: none"> Public health professionals trained on outbreak investigation and disease surveillance. Improved quality of disease reporting and utilization of epidemiological data. 	Ministry of Health, USAID, AusAID.
	<ul style="list-style-type: none"> Need to generate evidence-based information. 	<ul style="list-style-type: none"> Multidisciplinary rapid response teams (RRT) at central level. 	<ul style="list-style-type: none"> Disease reporting based on laboratory confirmation. Train professionals on appropriate sample collection, preservation, storage and transportation. Develop capacity for field diagnosis using RDT and arrange confirmatory diagnosis in National Health Laboratory. 	<ul style="list-style-type: none"> Disease surveillance able to promptly detect and respond to any outbreak that might occur in the country, and provide timely epidemiological data on priority diseases. A functional multidisciplinary RRT at district level. Field-level professionals trained to collect and dispatch quality and appropriate samples. Establishment of laboratory confirmation for the surveillance system. 	Ministry of Health, AusAID, USAID.

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Data management	<ul style="list-style-type: none"> Improve data quality and validity. 	<ul style="list-style-type: none"> Computerized database with GIS facility. Data management system for disease surveillance data is in place. Strong data manager at the national surveillance unit. 	<ul style="list-style-type: none"> Development of national and subnational data management. Specialized training on database management and application of GIS for central level public health professionals. Support in strengthening technical capacities of data managers at all levels. 	<ul style="list-style-type: none"> GIS is used as a practical tool for disease surveillance and public health intervention planning. Improved quality of disease surveillance data. 	Ministry of Health
	<ul style="list-style-type: none"> Sustain IDSS programme. Integration and harmonization of the IDSS and HMIS is a sensitive issue and should not be a burden for quality, completeness and timeliness of reporting. 	<ul style="list-style-type: none"> IDSS has been implemented in all districts since July 2005. At national level, IDSS data have been used since then to monitor unusual events and performance of disease control programmes. 	<ul style="list-style-type: none"> Develop guidelines and SOP (general and disease-specific). Encourage government to fund IDSS in a phased manner and carry out external assessment of IDSS to identify gaps and develop action plan to those gaps. 	<ul style="list-style-type: none"> IDSS institutionalized and action taken to sustain the ongoing activities. 	
Implementation of IHR (2005)	<ul style="list-style-type: none"> Incomplete laws/decrees for public health particularly regarding control, sanitation, and quarantine at ports of entry. Limited technical capacity for the identification, diagnosis and control of outbreaks. Limited resources identified for the implementation of IHR 2005. 	<ul style="list-style-type: none"> IDSS is in place. Can serve as a nucleus to strengthen early warning and response system. 	<ul style="list-style-type: none"> Support to develop national core capacity for implementation of IHR (2005) by 2012. Surveillance and response, lab diagnosis, public health legislation, disease prevention at point of entry (seaport, airport, ground crossing) and risk communication will be key areas for core capacity development). 	<ul style="list-style-type: none"> Implementation plan for IHR (2005) designed and funded. Increased capacity at MoH for identification and control of outbreaks. Strengthened laboratory services. 	Ministry of Health, AusAID.
Noncommunicable disease (NCD) surveillance	<ul style="list-style-type: none"> The NCD area needs to be strengthened and risk factors identified. 	<ul style="list-style-type: none"> Government interest is evident. 	<ul style="list-style-type: none"> Support establishing risk factor and noncommunicable disease surveillance. 	<ul style="list-style-type: none"> Baseline prevalence established and risk factor identified. 	Ministry of Health.

Main Focus 2.2: Priority Communicable Diseases (HIV/AIDS, Tuberculosis, Malaria)

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
HIV-AIDS/STI	<ul style="list-style-type: none"> Inadequate technical capacity of health staff in the districts. Absence of any authenticated scientific and representative baseline study in components like prevalence, surveillance, sentinel surveillance. STI reporting system does not have systematic information on various components of the HIV programme. Low community awareness about HIV/AIDS. Level of awareness on HIV/AIDS and STI is much lower among adolescents and young people. Lack of proper data management system. 	<ul style="list-style-type: none"> All HIV Guidelines (PEP, PMTCT, ART, STI) drafted. STI: syndromic case management approach adapted in the government health system and trained staff available. Condom distribution system is operational. Funding support from the Global Fund (GFATM) received. Sentinel surveillance training and PMTCT training for midwives established. Ministry of Health has trained midwives and nurses in the syndromic management of STI. Behavioral and prevalence studies have been conducted and these data will help in the further implementation of preventive programmes for STIs and HIV/AIDS. Activities on community awareness on HIV/AIDS and STIs have started. 	<ul style="list-style-type: none"> Implement STI syndromic management in all health facilities. “Maintain” low endemicity of HIV in Timor-Leste. Support and assist development and implementation of national policies, strategies and action plans on prevention and control of STI/HIV. Support expansion of VCT in the country including development of systems for quality control of counseling and testing, and regular supervision. Support partnerships for coordinated multi-sectoral response to STI/HIV/AIDS within the national strategic framework. Support establishment of baseline strategic information on HIV prevalence including in the general community and in most affected risk group (MARGs), through integration of STI/HIV/AIDS epidemiological surveillance within the national integrated disease surveillance. Support evidence-based BCC initiatives with focus on HIV prevention including condom promotion and infection control measures in health care set up; stigma reduction and risk mitigation to prevent HIV infections. Support the national programme to improve implementation of GF funded project and in mobilizing additional funding in future rounds of call for proposal. Provide technical support to the NAC through the UN Theme Group. 	<ul style="list-style-type: none"> A quality assured network of Volunteer Counseling and Testing facilities expanded and operationalized. The national HIV/AIDS programme unit strengthened through appropriate training and other capacity building measures. Health staff trained in the syndromic approach in the management of STIs. STI and HIV/AIDS surveillance integrated into the disease surveillance system and monitored. Enhanced capacity of the National Laboratory in providing specialized laboratory support to the national Programme and in supporting the EQAS for HIV testing. Coordination among the partners including the National TB Control Programme established. 	<p>Ministry of Health, development partners, Global Fund and NGOs.</p>

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Tuberculosis control	<ul style="list-style-type: none"> • Low coverage of DOTS strategy in subdistricts and lack of monitoring system. • Low case detection and cure rates in TB control. • Inadequate technical capacity for TB control at the national and subnational levels. • Delay in implementing a structured national HIV programme is an obstacle for establishing TB/HIV surveillance system. 	<ul style="list-style-type: none"> • Expansion of coverage of DOTS strategy based NTP into all CHCs in all 13 districts. • NTP national unit established. • MoH took over the responsibility of NTP from the NGOs in 2006 while the NGOs continued to support NTP. • TB diagnostic facilities established in all district-level CHCs and selected subdistrict CHCs and NGO/private clinics. • Anti-TB drugs were obtained from the Global Drug Facility as grant up to 2009. • Storage and distribution of drugs integrated with the SAMES, the procurement supply management agency. • Anti-TB drugs stocks established in all districts. • TB programme recording and reporting system established at district and national levels. • DOTS Plus for the management of MDR-TB cases launched. • Discussions for TB/HIV collaboration initiated at national level. NTP strategy drafted and disseminated. 	<ul style="list-style-type: none"> • Support capacity building of public health workforce and programme interventions. • Strengthen DOTS delivery under proper case management conditions and as the primary TB control strategy. • Establish system to improve quality of sputum smear microscopy including external quality assessment protocol. • Establish an effective and sustainable model for funding, procurement and logistics management of anti-TB drugs, laboratory equipment and consumables. • Facilitate the establishment of a robust monitoring and evaluation system for the TB programme within the overall health information system. • Strengthen capacity for programme planning, implementation, evaluation and reporting through integrated training and refresher training. • Build capacity for improved supervision at all levels of health delivery network. • Improve general awareness about the treatable nature of the disease and the availability of quality and free diagnostic and treatment services at the public health facilities. • Support establishment of PAL models for subsequent countrywide implementation in a phased manner. • Coordinate and build capacity to address challenges including TB/HIV coinfection, MDR-TB and other emerging public health issues. 	<ul style="list-style-type: none"> • Accessible DOTS services for all citizens of the country. • Improved TB case detection rate to achieve global and national targets. • Quality assured sputum microscopy services available to all citizens. • Improvement in the outcome of TB treatment. • A robust programme for monitoring and surveillance system for TB established. • Health workforce trained to provide highest quality of TB care in facility and domiciliary setting. • Improved MDR-TB management established including infection control measures in service delivery points. • TB awareness improved among the general community and health care providers. • Coordination established between national TB and HIV control programmes. 	<p>Ministry of Health, Global Fund, development partners and NGOs</p>

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Malaria control</p>	<ul style="list-style-type: none"> Need further enhancement of technical capacity in control of malaria and other vector-borne diseases. 	<ul style="list-style-type: none"> Malaria Treatment Protocol launched in June 2007. More than 150 000 bednets distributed for children under 5 years and pregnant women. Full-time country programme manager for malaria in position. Funding support from Round 2 GFATM grants received and proposal for Round 7 approved. 477 health staff have been trained in the use of the National Standard for Malaria Treatment Protocol. Malaria Case Management training provided to 13 Timorese doctors and 140 Cuban doctors. Three-day entomology field training was conducted for 15 staff composed of all DPHO CDC and national staff. Three-day vector control training in 13 DPHO districts. Basic malariology and programme management training conducted for 13 DPHO. The biological method of vector control was not introduced. The entomological survey has been started in three districts: Manatuto, Covalima and Los Palos. 	<ul style="list-style-type: none"> Support capacity building of public health workforce and programme interventions. Training of medical staff on the national diagnostic and treatment protocol. Training laboratory staff in microscopic diagnosis and RDT use. Strengthening of quality control of malaria microscopy and RDT. Provision of Long-Lasting Insecticide Treated Bednets (LLIN), through public and private channels for at least 80% of population residing in high-risk regions. Strengthening of entomological surveillance for implementation of evidence-based integrated vector control programme. Introduction and implementation of biological methods of vector control (i.e., introduction of larvivoracious fish and use of bio-larvicides). Strengthening capacity of health volunteers for early diagnosis/ treatment and vector control activities in the high-risk remote villages. Building and supporting national capacity for epidemic response. Providing consistent and sustained technical assistance to support malaria control interventions planned under the Global Fund supported project/s. 	<ul style="list-style-type: none"> Health staff trained in use of national malaria diagnosis and treatment protocols for all malaria cases. Laboratory staff trained in laboratory diagnosis of malaria. Improved quality control of malaria diagnosis. Mosquito nets distributed to at least 80% of people in the high-risk regions. Reduced malaria vector density by implementation of evidence-based malaria vector control methods. Biological methods of vector control introduced in high malaria-endemic districts. Quality control of indoor residual spraying and LLIN. Strengthened cooperation with community health volunteers in the remote high-risk malarious areas for malaria control and prevention. 	<p>Ministry of Health, Global Fund, AusAID, UN agencies and NGOs.</p>

Main Focus 2.3: Elimination and Eradication of Diseases (Leprosy, Lymphatic Filariasis, Yaws)

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Leprosy</p> <ul style="list-style-type: none"> The security situation in the districts during 2007 has constrained the ability to intensify elimination activities. The enclave of Oecusse has the highest numbers and rates of leprosy and although it has decreased from 54.2 per 10 000 population in 2004 to 13.8 per 10 000 in 2006, it still remains unacceptably high. Inadequate number of focal staff for leprosy programme at the MoH. 	<ul style="list-style-type: none"> Since this programme's inception all districts and subdistricts throughout Timor-Leste have adopted the same approach and conduct the same activities for the elimination of leprosy. The Leprosy Elimination Programme has detected and registered 1303 leprosy cases of which 1001 have been cured. All districts have reduced the incidence and rate of leprosy since 2004. 	<ul style="list-style-type: none"> Support capacity building of public health workforce and programme interventions. Increase active case finding activities. Ensure continuous, uninterrupted supply of MDT. 	<ul style="list-style-type: none"> Elimination target (<1 case per 10 000 population) achieved by 2012. 	<p>Ministry of Health, LRM, Sasakawa Memorial Health Foundation.</p>	

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Filariasis	<ul style="list-style-type: none"> Financial constraints have hampered the programme's ability to continue in the remaining four districts where it is yet to be started. Securing commitment for programme (financial and policy) is needed. The programme's continued implementation will be affected by potential changes to the MoH strategy. Approximately 1 million DEC tablets destroyed in early 2008 as they had expired. Donor support has been obtained for provision of Ivermectin. A decision needs to be taken by MoH about future direction of the programme vis-à-vis the use of Ivermectin instead of DEC. 	<ul style="list-style-type: none"> Following successful pilot programme in the district of Oecusse, the programme was rolled out in other districts and has been ongoing in 9 of the country's 13 districts. The programme has been gradually implemented with more than 650 000 people with household coverage and medicine administration exceeding 90%. Monitoring and evaluation of sentinel sites, designed to monitor microfilaria density have been established. 	<ul style="list-style-type: none"> Support MoH for the continuation of the programme. 	<ul style="list-style-type: none"> Elimination of LF in the country after five years of continuous mass drug administration. 	Ministry of Health.
Yaws	<ul style="list-style-type: none"> Data on the prevalence of yaws remains limited. National programme for the elimination of yaws not yet commenced. No funds to implement the elimination plan. 	<ul style="list-style-type: none"> National plan to eliminate yaws by 2011 developed. 	<ul style="list-style-type: none"> Support Ministry of Health for the establishment and ongoing implementation of a national programme to eliminate yaws. 	<ul style="list-style-type: none"> Elimination of yaws. 	Ministry of Health.

Main Focus 2.4: Control of Communicable Diseases of Public Health Concern (Dengue and Japanese encephalitis)

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Dengue	<ul style="list-style-type: none"> Inadequate implementation of chemical vector control. National staff and district staff responsible for dengue need further training on integrated vector control. Need enhanced coordination between CDC and the department of Environmental Health. 	<ul style="list-style-type: none"> Dengue is monitored under IDSS, and able to provide epidemiological data. The National Task Force for dengue established since 2005. Integrated vector control implemented. Yearly epidemic preparedness plan in place. 	<ul style="list-style-type: none"> Support capacity building of public health workforce and programme interventions. Training of dengue case management for doctors and nurses, particularly those who are working in hospitals. 	<ul style="list-style-type: none"> Medical doctors and nurses in all hospitals able to properly diagnose and implement dengue case management. Reduce the mortality due to dengue infection. 	Ministry of Health, AusAID.
Japanese encephalitis (JE)	<ul style="list-style-type: none"> Limited human resources to focus on JE surveillance. Inadequate cold chain system (-20C) has also become one of the constraints to conduct JE surveillance. 	<ul style="list-style-type: none"> Establish a surveillance system for JE. Strengthen diagnostic skills of laboratory staff. Obtain burden of disease data for the potential introduction of vaccine programme. 	<ul style="list-style-type: none"> Support the MoH to establish a surveillance system. Enhance capacities of the national and hospital laboratories to assist the public health programmes. 	<ul style="list-style-type: none"> Increased burden of disease data. 	Ministry of Health.

Focus on other Disease Prevention and Control

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Blood safety</p>	<ul style="list-style-type: none"> • Absence of nationally coordinated services. • Nonavailability of adequate units of blood. • Weak testing facilities. • Inadequate clinical use of blood. 	<ul style="list-style-type: none"> • The drafting of national blood policy shall facilitate development of nationally coordinated blood transfusion services to assure access to safe blood and its rational use in the country. • The SOPs for blood bank are in place. • A series of training sessions have been conducted on blood safety for laboratory technicians specifically those working for blood transfusion bank in December 2004. • MoH has taken the initiative to establish a National Blood Bank. 	<ul style="list-style-type: none"> • Enhance capacities of the National Laboratory, the National Blood Bank and peripheral level laboratories and blood banks to assist the public health programmes, quality diagnosis and to address blood needs, and to cope with the increasing demand for laboratory testing and blood donations. • Implementation of WHO's Strategy for Safe Blood with the following components: • Nationally coordinated blood transfusion services; • collection of blood from voluntary, non-remunerated donors; • processing of donated blood using SOP; • rational use of blood and components; and • assuring quality at all steps. 	<ul style="list-style-type: none"> • Availability of safe blood and blood components to all those who need it through nationally coordinated blood transfusion services. 	<p>Ministry of Health.</p>

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Health laboratories	<ul style="list-style-type: none"> Limited laboratory support for the public and health-care delivery services. Inadequate teaching laboratories in the medical school. 	<ul style="list-style-type: none"> Growing awareness amongst policy-makers about the need for laboratories for public health, clinical diagnosis as well as teaching of students in medical and allied health sciences. 	<ul style="list-style-type: none"> Improving access to laboratory services for both public health and clinical services through a national network of laboratories. Assuring quality of laboratory services through improved quality systems. Promoting rational use of laboratory services. Improving safety in the laboratories. Using laboratories to teach and impart evidence-based training to students and health professionals. 	<ul style="list-style-type: none"> Availability of safe and reliable laboratory services at all levels of health care in the country to support both public health and clinical services. Establishment of national referral laboratories in the school of medicine. 	Ministry of Health.

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Health Promotion</p>	<ul style="list-style-type: none"> Human resource capacity to promote health is limited. Increasing demand for both communicable and noncommunicable disease interventions. Addressing health and social needs of young people in and out of school. 	<ul style="list-style-type: none"> Integration of health promotion activities into the existing district health system by providing training to health workers at these centres on basic health promotion approaches. Political will exists to address risk factors as well as the major determinants of health such as poverty. The Ministry of Education and Ministry of Health, jointly collaborate in school health promotion. 	<ul style="list-style-type: none"> Support for revision of the National Health Promotion Strategic Plan. Capacity building in health promotion at the national and district levels. Technical support to IHS to train health workers to implement and monitor health promotion activities. To address risk factors identifiable with both communicable and non-communicable diseases including the social determinants of health. Development of school health policy. To address knowledge and skills required to address the numerous concerns of young people. To avail appropriate and adequate health services for young people. 	<ul style="list-style-type: none"> Capability of IHS strengthened. District health centre staff exposed to health promotion concepts, content and skills. Specific health promotion action taken on HIV/AIDS, tobacco, alcohol, road safety and domestic violence among other factors. Preventive measures for diabetes, heart diseases and hypertension implemented. Development of school health promotion policy and strategies. Training of teachers to deliver and monitor structured school health promotion. 	<p>Ministry of Health, UNICEF, UNFPA.</p>

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Tobacco control</p> <ul style="list-style-type: none"> The country has a huge prevalence of tobacco use. The prevalence of current cigarette smoking among students aged 13-15 years is 50.6% among boys and 17.3% among girls in Timor- Leste. The prevalence of current use of tobacco products other than cigarettes in students aged 13-15 years is 29.0% among boys and 20.2% among girls. There is a lack of comprehensive tobacco control legislation. The people's awareness and knowledge on the dangers of tobacco is low. Timor-Leste is a new country and has no legislation on tobacco control. The country is therefore being targeted by the tobacco industry. There are no tobacco cessation activities at the community level. 	<ul style="list-style-type: none"> Timor-Leste is a Party to the WHO FCTC. Support for tobacco control is available from WHO and other international organizations and this should be made use of. Despite the constraints, the country has the willingness for tobacco control and the MoH has conducted a few health campaigns and seminars for public health students and health effects of tobacco use is included in the primary school curriculum. Timor-Leste is a new country. Hence, if adequate and effective tobacco control measures are taken right now, the nefarious efforts of the tobacco industry can be thwarted. Tobacco growing and employment in the tobacco sector is negligible. This provides an opportunity for more effective and more rapid implementation of the tobacco control measures. The tobacco control programme in Timor-Leste can be well extended up to the community level in the country at large. 	<ul style="list-style-type: none"> Advocate existing tobacco control policy and support drafting of national tobacco control legislation. Technical assistance in the development, adoption and implementation of the tobacco control legislation. Technical assistance to develop national policy, strategy and plan of action for tobacco control and its implementation. Support the implementation of relevant tobacco control activities for school students. Technical support in the development of IEC materials for the targeted population. Technical support in tobacco surveillance. Support in Behaviour Change Communication (BCC). 	<ul style="list-style-type: none"> A comprehensive tobacco control legislation in place. National tobacco control policy, strategy and plan of action developed and implemented. Development, translation, production and distribution of a guide on smoking cessation as well as relevant advocacy materials. Advocacy and awareness against tobacco use through WNTD (World No Tobacco Day) activities. Taxation of tobacco products. 	<p>Ministry of Health.</p>	

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Water and Sanitation	<ul style="list-style-type: none"> Achieving the water and sanitation MDG. Ensuring safety and sustainability of drinking water supplies. 	<ul style="list-style-type: none"> Financial support from donors like AusAid available. 	<ul style="list-style-type: none"> Support for institutionalization of water safety plans, household water treatment and storage. Promotion of various low-cost and sustainable latrine options. Promotion of water, sanitation and hygiene in schools. Provide technical support for developing strategies to achieve the MDGs. Provide technical and financial support in implementing water safety plans and its institutionalization. Promote household water treatment and safe storage. Promote water, sanitation and hygiene in schools Research on water and sanitation. 	<ul style="list-style-type: none"> Improved water and sanitation targets. Improved quality of drinking water. Various latrines options available for the communities. Improved quality of health of students. 	Ministry of Health, UNICEF, AusAid.

Strategic Priority 3: Maternal and Child Health

Main Focus 3.1: Immunization Programme

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<ul style="list-style-type: none"> Improving routine immunization Introduction of new vaccines Conducting integrated supplementary immunization activities Achieving VPD surveillance standards Injection safety and management of adverse events following immunization 	<ul style="list-style-type: none"> Necessity of WHO focal point to provide technical support for EPI. Limited number of trained health staff in both management and technical areas; this limits speed at which programme improvements can occur. High proportion of population lives in rural, dispersed communities; difficult to access for vaccinations and other services. Small proportion of births attended by trained health staff. Disease surveillance system requires strengthening. Integrated in-service training. 	<ul style="list-style-type: none"> MoH commitment for improving routine immunization services as part of primary health care package. Availability of financial resources from GAVI. Country polio free and few cases of measles, thus freeing time and resources for other activities. MOH interest to include TT immunization, measles supplemental immunization activities (SIA) and other child health interventions as part of the integrated community health package (SISCa). 	<ul style="list-style-type: none"> Further support to improve routine immunization coverage. Improve routine immunization coverage to reach Global Immunization Vision and Strategy (GIVS) goals. Improve disease burden knowledge for deciding on new vaccines. Introduction of new vaccines: hepatitis B, JE. Strengthen documentation of polio eradication efforts. Reaching certification standard AFP surveillance to prove absence of transmission/importation of wild poliovirus; carry out lab containment activities in line with WHO Global Action Plan on poliovirus containment; and subsequently to be certified as a polio-free country. Eliminate maternal and neonatal tetanus and sustainable measles mortality reduction. Ensure injection safety and AEFI surveillance system. Strengthen Ministry of Health / DHS planning and management capacity. Ensure injection safety including adverse effect following immunization surveillance. Establishing national regulatory authority for monitoring vaccine safety and AEFI. 	<ul style="list-style-type: none"> Reduction of morbidity and mortality due to vaccine preventable diseases. Safe injection practices are adhered to. 	<p>Ministry of Health, UNICEF, GAVI.</p>

Main Focus 3.2: Maternal and Newborn Health: Improving Quality and Access

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
MPS/RH	<ul style="list-style-type: none"> • Low level of CPR, while TFR is very high. • Low coverage of proportion of deliveries assisted by skilled birth attendant. • Increasing prevalence of adolescent pregnancy. 	<ul style="list-style-type: none"> • Commitment of Ministry of Health to advocate and improve FP services. • Commitment of MoH and UN agencies in increasing the proportion of deliveries assisted by skilled birth attendants. • Role of religious leaders to delay age of marriage. 	<ul style="list-style-type: none"> • Improve quality of care and expand contraceptive choice. • Planning and monitoring MNH programme. • Strengthen pre-service training and in-service supervision/monitoring performance of midwives. • Support for the proper training of staff in community health centres and district hospitals. • Provision of adequate equipment and setting-up safe delivery facilities in the community health centres. • Delay age of first pregnancy. • Advocate for expansion of contraceptive choice. • Special attention in caring adolescent pregnancy. • Focus on Adolescent Sexual and Reproductive Health (ASRH) strategy development. 	<ul style="list-style-type: none"> • Improved capacity of relevant health providers for provision of FP services. • Facilitation and capacity building of district MNH programme managers. • HIS supported in improving institutional capacity. • Capacity building of midwives in improving MNH care and monitoring MNH programme coverage. • Improved access to FP service for adolescent. • Addressing issues related to adolescent pregnancy. 	Ministry of Health, UNFPA, UNICEF.

Focus on other Maternal and Child Health activities

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Integrated Management of Childhood Illness (IMCI)</p>	<ul style="list-style-type: none"> There are different sources for indicators available in the country, so there is only an estimate child mortality rate. Lack of human resources trained in IMCI. A need to enhance the regular plan on supervision, monitoring, and evaluation. 	<ul style="list-style-type: none"> MoH with support of WHO had adapted and produced IMCI training modules, trained 365 nurses in IMCI. Supported expansion of IMCI at all districts. Adapted, printed, and implemented IMCI guidelines 2001. Updating of new IMCI guidelines and orientation for the facilitators, Cuban doctors, and Timorese. 	<ul style="list-style-type: none"> Support for implementation of IMCI, particularly the expansion of the community IMCI. 	<ul style="list-style-type: none"> IMCI programme implemented in all districts and community IMCI. 	<p>Ministry of Health, UNICEF, NGOs.</p>

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Nutrition</p> <ul style="list-style-type: none"> Nationally applicable information baseline on the nutrition profile of the population. Iodine deficiency disorders (IDD) are prevalent. Absence of national IDD control and prevention programme. Management of malnutrition in the community is needed. Absence of appropriate guidelines and protocol for the community-based management of children suffering from moderate malnutrition and those recovering from severe malnutrition. 	<ul style="list-style-type: none"> The “Landscape Analysis”: objective of assessing the existing gaps/constraints and identifying opportunities to strengthen the national nutrition programme. Promoting growth monitoring of infants, young children and adolescents as the best tool to measure the status of malnutrition in the community. 	<ul style="list-style-type: none"> Assist the national authorities in carrying out the “Landscape Analysis” mapping of key stakeholders/nutrition-related interventions/field assessments/coverage/impact of such interventions. WHO could assist in providing technical support in establishing quality control / assurance systems and laboratory for IDD monitoring. Assist in organizing training in the use and interpretation of the new WHO growth standards for infants, young children and adolescents. Provide technical assistance in the adaptation of existing WHO guidelines and protocols for the management of children with moderate malnutrition and those recovering from severe malnutrition. Assisting in adaptation of WHO guidelines and protocols for the management of children with moderate malnutrition and those recovering from severe malnutrition. 	<ul style="list-style-type: none"> Increased self/family and community care and awareness in women’s/maternal health. 	<ul style="list-style-type: none"> Ministry of Health, UNICEF, WFP, FAO. 	
<p>Gender</p> <ul style="list-style-type: none"> Multisectoral approach in consideration of socio-economic and cultural determinants. 	<ul style="list-style-type: none"> CAREID programme 2007-2010 for gender sensitive health care. 	<ul style="list-style-type: none"> Promote women’s empowerment related to gender equity and social determinants of health accompanied by advocacy to gender sensitive health care services and multisectoral approach. 	<ul style="list-style-type: none"> Increasing self/family and community care and awareness in women’s/maternal health. 	<ul style="list-style-type: none"> Ministry of Health. 	

Strategic Priority 4: Overall National Capacity Building

Main Focus 4.1: Management and Technical Capacity Strengthening

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Ministry of Health capacity on management and health policy development	<ul style="list-style-type: none"> Limited experience in policy development. Limited qualified national staff. Need to focus attention on development of regulatory policies for food and drug administration, health and medical education, health/medical research. Develop a capacity process within the MoH appropriate to the culture, language and political issues of the country. Address emerging issues in the health sector including incentives for health staff and private providers. 	<ul style="list-style-type: none"> One full-time policy adviser in place with WHO. Health Sector Strategic Plan (HSSP) prepared. Human Resources for Health Plan prepared. Medium Term Expenditure Framework prepared. WHO has an easily accessible wealth of expertise and information in health policy development and implementation. At this point in Timor-Leste's health system development, sound policy is essential. 	<ul style="list-style-type: none"> Continued provision of a full-time WHO international professional staff to work in Ministry of Health under the supervision of the WR. Develop training schemes that are specially designed for Ministry of Health staff and developed within the context of the culture, politics and health situation in Timor-Leste using a variety of learning and mentoring methods. 	<ul style="list-style-type: none"> Strengthened capacity in policy development and planning in the Ministry of Health. 	Ministry of Health, development partners in the health sector.

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
MoH organizational reforms	<ul style="list-style-type: none"> Appropriate deployment of adequately qualified and experienced officials at national and district levels. There is a need to further develop and enforce health sector laws and legislation. 	<ul style="list-style-type: none"> Ministerial Diploma of the Organic Statute for the Central Services: roles and responsibilities of the Ministry of Health and its organs legally defined. WHO can provide expertise in the further development of legislation for the health sector. 	<ul style="list-style-type: none"> Support legislative, organizational and administrative reforms of management structures, systems and procedures in the Ministry of Health. Support development of adequate and appropriate health legislation for Timor-Leste. 	<ul style="list-style-type: none"> Appropriate health legislation developed, reviewed and further modified. Systematic HR planning and deployment of qualified managers in place. 	Ministry of Health, Ministry of Justice, Council of Ministers, Parliament.
Technical quality assurance	<ul style="list-style-type: none"> Technical audit systems need to be developed. Limited organizational and managerial capacity and performance by health providers. Deficiencies in human resources, facilities, management and support services. 	<ul style="list-style-type: none"> HSSP has well-defined areas of focus and indicators. Proper monitoring and technical audit system will result in good quality technical programmes. Improvement of quality of the work and management of the health sector has been identified as a major priority by the government of Timor-Leste. 	<ul style="list-style-type: none"> Promote MoH capacity in enhancing a system of technical supervision and monitoring throughout the health sector. Support for improving the quality of services by equipping diagnostic facilities, ensuring an adequate supply of essential medicines, and augmenting integrated disease surveillance for regular monitoring and taking corrective measures for quality improvement. Operational research in this context will be supported. 	<ul style="list-style-type: none"> Technical audit system developed and periodic and joint supportive supervision provided to district and CHC managers. Quality assurance standards and criteria implemented and further enhanced. 	Ministry of Health, AusAID, UNICEF, UNFPA.

Strategic Priority 5: partnership and coordination

Main Focus 5.1: Strengthening partnership and coordination

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Strengthening Department of Partnership and Management, MoH	<ul style="list-style-type: none"> Government capacity to coordinate needs further enhancement in streamlining and harmonization of EDPs support. Various systems to manage EDPs' resources present a challenge to a newly developed MOH. 	<ul style="list-style-type: none"> WHO can provide assistance in donor coordination in two mandates: 1) its responsibility to assist the MoH in its activities and needs; and 2) its responsibility to lead in health issues in the donor community. With a full-time policy adviser in the MoH, WHO can provide adequate support in this area. Clearly defined roles and responsibilities for coordination in the MoH. Procedures for donor coordination defined. 	<ul style="list-style-type: none"> Support for the Department of Partnership Management of the MoH to effectively manage donors/partnerships and coordinate resources and programmes of the development partners. Serve as information and technical resource in discussions and coordination of assistance to the health sector. 	<ul style="list-style-type: none"> Donor coordination and allocation of resources facilitated. 	Ministry of Health, EC, Global Fund.

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
<p>Partners coordination, including NGOs and private sector</p>	<ul style="list-style-type: none"> Lack of information on actual and potential contribution of the private sector, NGOs and volunteers to the health system. Limited government initiative to involve the private sector, NGOs and volunteers in delivery/financing of health sector. 	<ul style="list-style-type: none"> Improving private sector; NGO/volunteer collaboration and partnership has been identified as a priority by the UN development partners and donor agencies involved in the health sector rehabilitation. Ministry of Health strategies and policies to involve the private sector, NGOs and volunteers in health sector reforms taking place in the country. Coordinating mechanisms exist for activities such as annual joint review and an annual planning summit. 	<ul style="list-style-type: none"> Facilitate the coordination of multiple partners involved in specific programmes (e.g. malaria, HRH, HIV), to ensure a harmonized response to the challenges in the specific health programmes. Support other partners in adhering to the principles of the Paris Declaration, especially the harmonization and alignment agenda. Development of transparent and effective framework for private, NGO and volunteer participation in the health sector. Support existing mechanisms of effective partnership and coordination, i.e. Joint Annual Review (JAR) and Sector Wide Approach (SWAp). 	<ul style="list-style-type: none"> Coherent work of all partners involved in health sector established. Mutual confidence and understanding between the government and the private sector, NGOs and volunteers working in health sector promoted. 	<p>Ministry of Health, UNICEF, UNFPA, World Bank, AusAID.</p>
<p>Resource mobilization</p>	<ul style="list-style-type: none"> Resource gap exists in the current biennial workplans 	<ul style="list-style-type: none"> Multiple partners interested to support the health sector. WHO is considered as a close partner of the Ministry of Health and a key player in EDP coordination. 	<ul style="list-style-type: none"> Facilitate generation of voluntary resources for the biennial workplans from the partners in health and the global partnership mechanisms. 	<ul style="list-style-type: none"> Resource mobilization plan developed and implemented. 	<p>Ministry of Health, development partners.</p>

Strategic Priority 6: Emergency Preparedness and Rapid Response

Main Focus 6.1: Strengthen EPR programme

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Training, advocacy and legislation on EPR	<ul style="list-style-type: none"> Due to resource limitations, the MoH has no unit nor full-time staff assigned for Disaster Management. Currently, it is under the Specialized Unit of the NCD Department in addition to its other responsibilities, including tobacco control. The focal point for Disaster Management and health staff at the district and subdistrict levels have little understanding of the National Disaster Risk Management Plan. Non-existence of Standard Operational Procedures (SOP) for the health sector at different level of health services, including hospitals. Technical guidelines for the health staff to prepare and respond to disaster do not exist. Emergency preparedness and response plans for hospitals are almost non-existent. The majority of hospitals are not trained in emergency preparedness and response. Lack of regular simulation and table-top exercises on disaster management and response in health sector. 	<ul style="list-style-type: none"> National Disaster Risk Management was finalized, distributed and used. Checklist for hospital preparedness and response is available. The Emergency Preparedness and Response manual for Timor-Leste has been developed. 	<ul style="list-style-type: none"> Support for the training of the health workforce (district and sub-district, hospitals) in emergency preparedness and response including outbreak investigation and disease surveillance, and for providing emergency supplies. Advocate for adequate human resources in the area of health sector emergency preparedness, management and response. Enhance partnerships for effective planning, coordination and response to emergencies. Strengthen legislation, policies and contingency plans that will support efficient work in EPR within health sector and across others. Develop Standard Operating Procedures (SOP) for the health sector. Support/strengthen MoH in setting up a unit/mechanism/programme that will address the need of EPR. Support to the MoH in conducting regular simulation exercises on disaster management and response. 	<ul style="list-style-type: none"> Health staff trained in emergency preparedness and response including outbreak investigation and response. Emergency coordination and partnership in health sector strengthened. Emergency preparedness plans and contingency plans for disasters prepared and updated. National strategy, legislation and technical guidelines for disaster management in health sector developed. Standard operating procedures (SOP) for health sector developed. Disaster Management unit at the Ministry of Health is supported. Regular simulation exercises are supported. 	Ministry of Health, National Directorate of Disaster Management (Ministry of Social Solidarity), UN agencies, NGOs.

Focus on other Emergency Related Issues

Area of action	Challenges	Opportunities	WHO priority	Expected results from WHO collaboration	Partners
Injury prevention	<ul style="list-style-type: none"> Lack of human resources in the field of chronic disease and injury. No nationwide injury prevention programme. 	<ul style="list-style-type: none"> Ministry of Health has established an NCD Unit and recognized road traffic injuries and animal bites as a major health problem. 	<ul style="list-style-type: none"> Train health staff. Develop and implement integrated injury prevention programme on a pilot basis. 	<ul style="list-style-type: none"> Human resource developed on epidemiology of NCD and injury prevention and safety promotion. Feasible and cost-effective injury prevention programme for the country developed. 	Ministry of Health.



Annex 2

Abbreviations

AI	Avian influenza
AEFI	Adverse events following immunization
AFP	Acute flaccid paralysis
ARI	Acute respiratory infections
ART	Antiretroviral treatment
ASRH	Adolescent sexual and reproductive health
AusAID	Australian Agency for International Development
BCC	Behavioural change communication
BCG	Bacille Calmette Guerin, an effective immunization against tuberculosis
CAREID	Canada-Asia Regional Emerging Infectious Diseases
CCS	Country Cooperation Strategy
CDC	Communicable Diseases Control
CHC	Community Health Centres
CPR	Contraceptive prevalence rate; the percentage of women between 15-49 years who are practising, or whose sexual partners are practising, any form of contraception.
DHS	District Health Systems
DOTS	Directly Observed Treatment, Short-course
DPHO	District Public Health Officer
DPT	Diphtheria, pertussis (whooping cough), tetanus
EC	European Commission
EDP	External development partners
EPI	Expanded Programme on Immunization
EPR	Emergency preparedness and response
EQAS	External quality assessment team
FAO	Food and Agriculture Organization of the United Nations
FCTC	Framework Convention on Tobacco Control
FETP	Field Epidemiology Training Programme
FHS	Faculty of Health Sciences

FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross domestic product ¹
GF	Global Fund
GFATM	Global Fund for AIDS, TB and Malaria
GIS	Global Image Software
GIVS	Global Immunization Vision and Strategy
HDI	Human Development Index
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HMIS	Health Management Information System
HMM	Health Minister's Meeting
HR	Human resources
HRH	Human resources for health
HSSP	Health Sector Strategic Plan
IDD	Iodine deficiency disorders
IDSS	Integrated diseases surveillance systems
IEC	Information education communication
IHR-2005	International Health Regulations (2005)
IHS	Institute of Health Science
IMCI	Integrated management of childhood illness
JE	Japanese encephalitis
LF	Lymphatic filariasis
LLIN	Long-lasting insecticide-treated bednets
MARG	Most-at-risk group
MDG	Millennium Development Goals
MDR	Multidrug resistance
MDT	Multidrug treatment
MNH	Maternal and neonatal health
MoE	Ministry of Education
MoH	Ministry of Health
MPS	Making Pregnancy Safer
MTEF	Medium Term Expenditure Framework
NAC	National AIDS Commission

¹ GDP is the total market value of all final goods and services produced in a country in a given year, equal to total consumer, investment and government spending, plus value of exports and minus value of imports

NCD	Noncommunicable diseases
NGO	Nongovernmental organization
NMH	Noncommunicable diseases and mental health
NTP	National Tuberculosis Programme
PAL	Practical approach to lung health
PEP	Post-exposure prevention
PMTCT	Preventing mother-to-child transmission of HIV
RC	Regional Committee
RDT	Rapid diagnostic test
RH	Reproductive health
RRT	Rapid-response team
SAMES	Servico Autonomo de Medicamentos e Equipamentos de Saude
SIA	Measles supplemental immunization activities
SISCa	Servisu Integrado Saude Comunitario (Integrated Community Health System)
SOP	Standard operating procedures
STIs	Sexually transmitted infection
SWAp	Sector-wide approach
TB	Tuberculosis
TFR	Total fertility rate; total number of children a woman would have by the end of her reproductive period.
TLSLS	Timor-Leste Survey of Living Standards
TT	Tetanus toxoid
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nation Population Fund
UNICEF	United Nation Children’s Fund
UNTL	National University of Timor-Leste
USAID	United States Agency for International Development
USD	US Dollar
VCT	Voluntary counseling and testing
VPD	Vaccines and preventable diseases
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WNTD	World No Tobacco Day
WR	WHO Representative

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