HEALTH SECTOR STRATEGIC PLAN

2008 – 2012

MINISTRY OF HEALTH
TIMOR-LESTE

SEPTEMBER 2007

This version is ready for publication, although, small changes can be incorporated up until the time that the Ministry of Health gives the instruction to publish

Ministry of Health
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September 2007

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FOREWORD

I am very pleased to present this Strategic Plan for the further development of our country's health sector. Improving the health of the nation is at the heart of the policies of our Government. Although considerable progress has been made – for example in the eradication of poliomyelitis and maternal and neonatal tetanus and in most encouraging increases in immunisation rates - too many women still die in childbirth and too many children go hungry and die from easily preventable diseases. Much more remains to be done in the years ahead.

This document provides the framework that will guide the efforts of the Ministry of Health and our partners over the next five years. It reflects the Ministry's fundamental belief that health services should be equally available to all people, without discrimination on the basis of gender, age, place of residence or socio-economic status. The strategies contained in the plan focus especially on the needs of mothers and children and the poor. For these vulnerable groups, ill health is not only a personal tragedy but also an economic burden that reinforces poverty nationally.

To meet our goals, this plan includes strategies that will strengthen health services and improve outcomes. As a priority, we will target infant and maternal mortality rates with the aim of achieving significant improvements. The needs of vulnerable people in rural and remote areas will receive special attention. We encourage the involvement of consumers and local communities in health affairs and intend to empower all people to take decisions based on informed choices. These proposals, together with many others in the plan, are designed to improve the health of our people and fulfil the Government's commitment to achieving the health-specific targets of the Millennium Development Goals.

To bring about all the enhancements in clinical care and public health services we must also change and develop our support services. In concert with the strategic plan, we have developed and are implementing a revised Basic Services Package for Primary Health Care and for Hospitals. New ways of working are being introduced and greater emphasis is being given to quality in all we do. More efficient and effective practices are essential and many of our systems and procedures need revision. Seeking constant improvement must become our normal way of working. For this the Ministry depends on the continued dedication of all our staff and those of our partner organisations. The Ministry's ambitious goals for system-wide improvements require the sustained budgetary support of our Government and financial and technical assistance from development partners. We are fortunate that both the Government and our partners share our commitment to priority goals and outcomes.

This strategic plan ushers in the beginning of what the Ministry hopes will result in a sector wide approach to the management and coordination of activities to improve health. To our development partners - both international and national – we welcome your support and are grateful for your contribution to the development of this initial strategic plan.

I commend this health sector strategic plan to you all. It embodies our ambitions for a better and healthier future for all people of Timor-Leste.

Dr Nelson Martins
Minister for Health
Timor-Leste
September 2007

ACKNOWLEDGEMENTS - LIST OF MAIN CONTRIBUTORS

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Many people contributed valuable input during the strategic planning process. MOH staff from central office, customised services, districts and sub-district facilities attended working group sessions and willingly gave of their time to review and/or expand on sections of the plan as they emerged. Service and programme heads were especially generous in critiquing draft position papers. External stakeholders provided useful comments both in consultative fora and in response to specific requests for information. The SPWG gratefully acknowledges all these contributions as strengthening the final document.

The Ministry acknowledges the technical assistance provided to facilitate the development of the HSSP by the European Commission funded Support to the Implementation of the Health Sector Investment Programme managed by Mott MacDonald in association with the Royal Tropical Institute (KIT).
While all SIHSIP team members contributed to this outcome, the Ministry wishes to express its particular appreciation to Mr Frank Terwindt for the preliminary research and to Dr Peter Lloyd for the review of material and compilation and finalisation of the HSSP.

LIST OF ABBREVIATIONS

ACT	Artemisinine Combined Treatment
ANC	Antenatal Care
AusAID	Australian Agency for International Development
BCC	Behaviour Change Communication
BCI	Behaviour Change Intervention
BEOC	Basic Emergency Obstetric Care
BOD	Board of Directors
BSP	Basic Services Package
CCT	Café Timor network (Clinica Café Timor)
CD	Communicable Diseases
CDP&C	Communicable Diseases Prevention and Control
CEOC	Comprehensive Emergency Obstetric Care
CFET	Consolidated Fund for East Timor (now General State Budget)
CIMCI	Community Based Integrated Management of Childhood Illnesses
CPD	Continuing Professional Development
CVD	Cardio-vascular Disease
DA	Department of Administration
DAFL	Directorate of Administration, Finance and Logistics
DF	Department of Finance
DHC	District Health Council
DHIME	Department of Health Information, Monitoring and Evaluation
DHM	District Health Manager
DHMT	District Health Management Teams
DHPP	Directorate of Health DHP Department of Health Promotion
DHS	Demographic and Health Survey
DHSD	Directorate of Health Services Delivery
DF	Department of Finance
DHRD	Department of Human Resource Development (future Directorate)
DMCH	Department of MCH
DOTS	Directly Observable Treatment Short Course
DP	Department of Planning
DPS	Department of Pharmacy Service
DPD	Department of Policy Development
DP	Development Partner
DSF	Decentralisation Strategic Framework
EC	European Commission
FA	Functional Analysis
FHPP	Family Health Promoter Programme
FMIS	Financial Management Information System
FP	Family Planning
FY	Fiscal Year (July-June)
GFATM	Global Fund for Aids, Tuberculosis and Malaria
GOTL	Government of Timor Leste
GDP	Gross Domestic Product
GSB	General State Budget (previously CFET)
GVNH	Guido Valadares National Hospital
HAST	HIV/AIDS/Tuberculosis
HDI	Human Development Index
HDR	Human Development Report
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HP	Health Post

HPFP	Health Policy Framework Paper
HRD	Human Resource Development
HSP	Hospital Services Package
HSRD	Health Sector Rehabilitation and Development Programme
HSSP	Health Sector Strategic Plan (2008-2012)
HWP	Health Workforce Plan
ICT	Information and Communication Technology
IDP	Internally Displaced Persons
IDS	Integrated Disease Surveillance
IEC	Information, Education, Communication
IGO	Inspector General's Office
IHR	International Health Regulations
IHS	Institute of Health Sciences
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ISAF	Intersectorial Action Framework (for Wellbeing and Health)
IST	In-service Training
IYCF	Infant and Young Child Feeding
JASR	Joint Annual Sector Review
JAPS	Joint Annual Planning Summit
LLITN	Long Lasting Insecticide Treated Net
LSMS	Living Standard Measurement Survey
MC	Mobile Clinics
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MOE	Ministry of Education
MOH	Ministry of Health
MOPF	Ministry of Planning and Finance
MOSA	Ministry of State Administration
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NCD	Non Communicable Disease
NDP	National Development Plan
NGO	Non Government Organisation
NHA	National Health Accounts
O&G	Obstetrics and Gynaecology
OH&S	Occupational Health and Safety
OOC	Out of Country
PER	Public Expenditure Review
PHC	Primary Health Care
PMIS	Personnel Management Information System (Government-wide)
PMU	Programme Implementation Unit
QA	Quality Assurance
RH	Reproductive Health
RMR	Repair, Maintenance and Renewal
SAMES	Autonomous Medical Supply System (Servico Autonomo de Medicamentos e Equipamentos de Saude)
SBA	Skilled Birth Attendant
SCM	Stakeholder Coordination Meeting
SDHC	Sub District Health Centre
SEM	Senior Executive Management (Minister, Vice Minister, Permanent Secretary)

SIHSIP	Technical Assistance for Support to the Implementation of the Health Sector Investment Programme
SIP	Sector Investment Programme
SPWG	Strategic Planning Working Group
SSU	Service Support Unit
STIs	Sexually Transmitted Illnesses
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TORs	Terms of Reference
TFET	Trust Fund for East Timor
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing (HIV/AIDS)
VHW	Village Health Worker
WHO	World Health Organisation

EXECUTIVE SUMMARY

The Timor-Leste Ministry of Health is committed to providing and regulating quality health services for all while promoting community and stakeholder participation. To achieve this mission, the MOH has developed a broad-based health sector strategic plan that outlines future directions for the national health system for the next five years within the framework of three overarching goals:

- Improved accessibility to, and demand for, quality health services
- Strengthened management and support systems
- Strengthened coordination, planning and monitoring

In essence, the HSSP is designed to guide the MOH and its partners in ensuring that all people in Timor-Leste, of whatever gender, age, place of residence or socio-economic status, will have:

- equitable access to good-quality, basic and essential health services provided in (and beyond) facilities that are well equipped and staffed by competent health professionals
- information that empowers them to make informed choices about matters affecting the health and well-being of themselves, their families and their communities

In Timor-Leste maternal and child mortality and morbidity indices remain unacceptably high despite sustained efforts from many quarters. Around half of all children are malnourished. The burden of communicable and vector-borne diseases, especially respiratory infections, tuberculosis, diarrhoeal diseases and malaria is heavy. At the same time, chronic conditions related to non-communicable diseases, and to injuries, are emerging increasingly as major public health priorities.

To address these significant problem areas and to better plan and build for the future, the MOH has identified a range of essential, prerequisite conditions or "success factors". These are:

- Sustained political and administrative will
- Highly visible and effective stewardship and leadership
- Timely provision of adequate resources
- Good planning, management, coordination, and monitoring and evaluation of systems and practices at all levels
- Appropriate integration of service and programme areas where commonalities exist
- Needs-based deployment of skilled staff with clinical competence and consumer-sensitivities
- Informed public participation in health decision making
- Collaboration and coordination between major stakeholders on planning, resourcing and implementing services and programmes

To promote progress towards achievement of its three overarching goals, the MOH has adopted 57 strategies overall. However, the sheer dimension of such a challenge given capacity limitations and the need to prioritise activities, has focused immediate attention on 32 cross-cutting strategies of which 17 form an essential core in ten priority areas of work. These priority areas and related core strategies are intended to be the major focus for action by the MOH and its partners over the next five years.

The 17 core cross-cutting strategies in the ten priority areas of work are:

Health services delivery

1. Further improve coverage and access to health services especially for the poor, the remote and other vulnerable groups through appropriate location of health facilities and the strengthening of outreach services
2. Strengthen delivery of basic health services by ensuring that the directives of the BSP are implemented at all mobile clinics, health posts, health centres and hospitals
3. Strengthen the quality of services delivered (especially in the mother and child field) in all facilities through capacity development in areas such as BEOC, IMCI, nutrition and Facility-based delivery and post-natal care

Behavioural change / health promotion

4. Change for the better the attitudes of health care providers sector-wide to effectively communicate with consumers especially in relation to the needs of the poor and other vulnerable groups through sensitisation and the building of good inter-personal skills
5. Strengthen BCC/BCI activities to promote better community appreciation of the value of effective evidence-based medicine and health care, and, as a consequence, promote more appropriate behaviour in this important area.

Quality improvement

6. Develop a culture of quality in public health service delivery and management through the use of MOH quality practice and professional standards

Human resource development

7. Strengthen human resource planning to reduce mal-distribution of workforce numbers and categories through improved needs-based deployment of staff
8. Introduce a broad-based incentive scheme to assist in appropriate deployment of qualified staff across the health care sector
9. Increase the number of skilled midwives through enhanced pre-service and articulated training opportunities and through improved supervision and control measures at work
10. Strengthen the capacity of nurses and allied health professionals in community-based work
11. Strengthen the skills, know-how and attitudes of managers at all tiers of the health system

Health financing

12. Further develop the evolved system of financial management and strengthen financial manage-ment capacity throughout the sector

Asset management	13. Develop a systematised approach to asset management that includes appropriate standards, technical guidelines, protocols and audit practices for asset procurement, maintenance and replacement, renewal and disposal
Institutional development	14. Reform administrative and management functions, structures, systems and protocols in the MOH (in line with the accepted recommendations of the functional analysis of the organisation) to promote responsiveness and capacity to effectively manage change
HMIS	15. Prepare an information master strategic plan that will guide appropriate phasing-in and implementtation of required information sub-systems
Gender equity	16. Promote gender mainstreaming in the MOH, improve awareness of gender issues throughout the health workforce and provide affirmative action opportunities for women and improve access to and services provided in a manner appropriate to both men and women
Research	17. Establish an operational research centre to assist in developing research capacity within the health sector of Timor-Leste to address health and system challenges and to inform clinical and public health practice

Outcomes

Overall outcomes to be achieved in the period 2008-2012 include reduced infant and child mortality rates, maternal mortality ratio, total fertility rate, and a more effective and efficient health system.

Implementing the strategic plan is recognised as a critical next step that will involve all stakeholders – the government, the MOH, partner organisations, and consumers at individual and community levels. Sustained technical assistance will be vital.

Primary responsibility for delivering the outcomes rests with the MOH. Strong human and financial resource planning and management will be required, as well as thorough monitoring and evaluation to measure results. A full complement of the M&E tools to accomplish the latter task has yet to be developed. Again the MOH will need significant technical assistance to:

- Develop a monitoring and evaluation outcomes matrix for use by central level departments, and districts and sub-district facilities
- Align the core 17 cross-cutting strategies with activities, planned outputs, targets, indicators and means of verification as capacity to do so develops
- Utilise existing information systems such as HMIS, disease surveillance and financial management with periodic surveys and additional studies on specific topics as necessary
- Encourage all partners to use the HMIS with confidence

Risks to successful implementation of the strategic plan have been recognised. They include political instability, reduced government allocation to health, reduced

support from development partners, inadequate attention to leadership and management capacity development, reluctance to support incentive schemes and widespread resistance to change.

To estimate expenditure required to achieve the goals of the strategic plan, the MOH has developed a rolling five year Mid Term Expenditure Framework. The MTEF outlines resources required and forecasts expenditures as presented in the current budgetary structure and broken down by different programme areas and population groups. It should be seen as a companion document to the HSSP.

Section 1 of the HSSP provides a rationale for strategic planning, describes the consultative approach used in preparing the plan and outlines the structure of the document.

Section 2 establishes the broad context within which the HSSP was developed.

Section 3 contains a detailed situational analysis of health issues and provides a portrait of the MOH currently and into the future.

Section 4 presents an overview of strategic direction and scope for Timor-Leste covering all service and support areas. The narrative is divided into service and support areas and comprises detail of relevant key documents, a situational analysis, objectives, strategies and indicators. Implementation activities are detailed in three areas (i) Programme and Service, (ii) Management and Support and (iii) Monitoring and Coordination. Additionally, Assumptions and Risks are detailed and a projected timeframe outlined. Micro-policy analysis is linked with a detailed assessment of current plans and directives for those programme areas yet to be addressed.

Section 5 focuses on cross-cutting issues within the health portfolio (identifying the 10 priority areas of work) and essential mechanisms for effective collaboration and coordination within and beyond the health sector.

Section 6 covers issues of collaboration and coordination in terms of community participation and engagement, intersectoral issues and collaborative partnerships with external agencies including NGOs. Finally, collaboration and harmonisation with donors, operational partners and the private sector are addressed.

Section 7 addresses implementation issues including funding, socialising, and monitoring and evaluating the HSSP.

Annexes are a series of tools for operationalising the HSSP in the support and coordination areas which are central to the implementation process. They provide: a comprehensive account, in log frame format, of goals, objectives, strategies, main activities, timeframes and responsibilities for support and coordination, which will mainly be used at central level in monitoring and coordination activities; the executive summary of the MOH functional analysis; a monitoring and evaluation target frame; a summary of technical assistance needs; and various diagrammatic presentations of relevance to the plan.

Finally, it needs to be documented that the HSSP was prepared in a context of unrest. The period during which the plan evolved has been characterised by social and political discontinuity. This has impacted on the final product and, inevitably, has contributed to a lack of certainty on several important fronts as noted in the document. In particular, the pressing need for reform, while acknowledged by key stakeholders both within and outside the MOH, is being approached with a level of caution that reflects not only an appreciation of the extent of capacity development needs within the Ministry but also a sense of what is achievable within the public sector arena of Timor-Leste.

Accordingly, the HSSP should be seen as a flexible planning instrument for the MOH and its partners. The document will require periodic (perhaps annual) review and sharpening as societal circumstances crystallise and as capacity to manage change develops.

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SECTION 1 INTRODUCTION

Rationale of the Health Sector Strategic Plan and structure of the document

Background

The Timor-Leste MOH has decided to develop a medium term Health Sector Strategic Plan to refine and consolidate existing micro-policy strategies, to prepare others in significant areas not yet addressed, and to prioritise and enhance operational practices. After approval by the Council of Ministers, the HSSP will provide guidance in the annual operational planning process for the next five years - 2008 to 2012.

What is strategic planning and how will it assist the MOH to achieve its goals?

Strategic planning is the process of developing a shared vision of an organisation's future and deciding on the major steps to be taken to move the organisation in that direction. The strategic planning process determines:

1. *what the organisation wants to achieve - usually expressed as strategic objectives*
2. *how the organisation will direct its resources towards achieving these objectives over the planning period - usually expressed as strategic actions*

The strategic planning process takes into account the environment in which the organisation functions, its aspirations, and its capacity (financial and otherwise) to achieve its vision. It entails the setting of over-arching goals, priority targets and milestones for a specified period of time. Objectives and targets are operationalised through strategic actions. Monitoring and evaluation of planning outcomes is assessed on the basis of agreed indicators.

Having a strategic plan helps to ensure not only that an organisation has longer term direction but also that its services, programmes, projects and day-to-day decisions contribute to its longer term interests. A strategic plan encourages people to work together towards common aims and to appreciate how their efforts will contribute to achievements at the highest level.

The strategic planning process used in preparing the HSSP

The following process was followed by the MOH in preparing the HSSP. A methodical step-by-step approach was adopted:

1. **Starting up:** The MOH decided in consultation with development partners and others that now was the time to prepare its initial strategic plan. A strategic planning working group was established and technical support obtained. Agreement was reached on the methods and approaches to be used to complete the task and on what the final product ("The Plan") would look like and what it would contain.

2. **Analysing the situation:** The MOH undertook an initial situational analysis (or organisational review) to identify its strengths, weaknesses, opportunities and threats and to consider its capacity to meet the vision and mission it had set itself in 2002. During this phase the Ministry also completed the protracted task of producing a statement of its core business – the Basic Services Package for Primary Health Care and Hospitals (BSP).

3. **Identifying critical issues for the future**: Following the organisational review, the MOH made critical decisions about what its fundamental goals should be within the context of persistent and significant national morbidity.

4. **Planning for the strategy:** The MOH re-assessed its priority roles and functions and reached general consensus on strengthening those services and programmes that will best assist in operationalising core values and principles into the medium term future.

5. **Preparing, reviewing and adopting the plan:** The MOH prepared several drafts of the HSSP before adopting a final version to be forwarded to the Council of Ministers for consideration and approval. The Plan was vigorously reviewed and modified in successive versions to increase the likelihood of successful implementation and to ensure broad-based commitment. The final version of the Plan is a comprehensive document. However, it is not – nor should it be – a complete document. Given the relative immaturity of the MOH, the enormity of the challenges facing it, and the societal instability within Timor-Leste, it is not surprising that there remain several areas of strategic uncertainty. Detailed attention to these areas will be required during the course of the planning period to flag options and to determine how best to develop and integrate new initiatives within the more developed strategic areas.

6. **Implementing the plan:** The MOH has committed to implementing the Plan through widespread and sustained socialisation strategies and through appropriate financial support as outlined in the Medium Term Expenditure Framework. The Plan will be monitored and evaluated regularly, and will be adjusted and updated as required – perhaps annually, but at least every three years. It is highly likely that even during the early implementation phase, modifications to the Plan (and its funding mechanism) will be needed. Suitable flexibility and sensitivity will be required to accomplish this ongoing task.

7. **Communicating proposed changes clearly:** The MOH appreciates that the HSSP will involve changes to the status quo. It has undertaken to support the Plan through appropriate communication and advocacy strategies that will be needed to facilitate a smooth process of change.

How will the HSSP be used?

In conjunction with the MTEF and the BSP, the HSSP will be the MOH's main reference document for sector development over the next five years. It will form the basis of annual operational planning and budgeting throughout the Ministry, and will be used to guide monitoring and evaluation of progress towards identified targets and indicators.

Responsibility for implementing the Plan will be shared across the Ministry and beyond. Institutionalisation across divisions, departments, facilities and their service and programme areas will need to be replicated at the level of the individual through a readiness to internalise the values inherent in the strategic directives and linked operational actions. Leadership in this process will come from many ministerial sources. External support will be available in the form of significant technical assistance as noted later in this document and through rigorous engagement with the private sector and with communities.

The HSSP is destined to be a useful tool for organisational growth. However, it will assist the MOH in reaching its potential only when:

- all key stakeholders (groups and individuals) understand it, feel ownership of it, are committed to it, and apply themselves to its implementation in a sustained and coordinated fashion
- adequate leadership and change management is entrenched and highly visible
- annual operational planning, budgeting and resource allocation systems use the strategic framework
- a system of comprehensive monitoring exists to ensure necessary and timely modifications

These various conditions are also characteristic of the Sector Wide Approach (SWAp) concept. The MOH has indicated its interest in working with partner agencies to move towards a more coordinated, comprehensive and harmonious sector development process. The HSSP provides the MOH with clear guidance on how to prioritise and how to promote capacity development - necessary first components of any successful SWAp arrangement.

Costs and funding of the HSSP

Complementing the HSSP is an MTEF. This is a comprehensive, rolling medium term estimate of capital and recurrent expenditure required to support all activities designed to achieve HSSP goals and objectives. The MTEF aims to link macro-financing plans (SIP) with resource allocation funding which the MOH intends to use in the future as its preferred mode of funding of services, programmes and facilities across the sector. The MTEF identifies sources of projected funding for the five year HSSP period. As such it is a financial management tool that provides the Ministry with data needed for annual budget planning and implementation decision-making. It also highlights gaps between revenue and expenditure. A comprehensive account of the MTEF is found in Section 6 of the HSSP.

It should be noted that the Government may decide to shift the annual budget cycle from fiscal years (July-June) to calendar years. If this were to occur, the transition would take place at the end of 2007. In that event, the last fiscal year of 7/2006-6/2007 will be extended by six months.

Due to incomplete and insufficiently reliable data, MTEF cost estimates and resource allocations for the first two years of the planning period are based primarily on historic budgetary practices. Progressively, as better and more comprehensive data become available, the model will be adjusted to reflect more precisely defined expenditure needs. The MOH appreciates the necessity to establish a more sophisticated funding allocation system. To do this successfully will entail the development of a corresponding capacity building programme for financial managers both centrally and at devolved levels. The aim of having an harmonious budget and accounting system is central to the effective implementation of the HSSP.

The structure of this document

Section 1 addresses the rationale of strategic planning and outlines the approach of the MOH in developing the HSSP for 2008-2012. It presents the vision and mission statements of the Ministry and the core operational values that underpin the day-to-day activities of its staff. It also flags the overall policy position of the Ministry.

Section 2 gives a brief snapshot of the broader context within which health strategies must evolve to reflect national circumstances, constitutional requirements, development goals, and the Ministry's obligations in terms of global and country-specific health matters. In doing so, the Plan provides a short profile of Timor-Leste and its Constitution, the Millennium Development Goals, the National Development Plan, the Health Policy Framework Paper, the Sector Investment Programme and the Basic Services Package.

Section 3 comprises a succinct situational analysis of current circumstances relating to:

- Health and demographic indicators
- Role and structure of the MOH
- Areas of positive activity
- Challenges ahead

Section 4 is the core of the HSSP. It begins by noting what is new in the strategic plan for the health sector. It provides a clear frame of the overarching goals that the MOH has set itself (and others) for the five year planning period (and beyond). It considers the range of potential barriers that could jeopardise goal attainment and explores possible ways of minimising these risks during the implementation phase. Then begins a detailed analysis of existent and yet-to-be addressed micro-policy strategies in the following domains:

- Primary health care
- Comprehensive hospital care
- Environmental health
- Referral
- Support areas

Section 5 provides details of the essential cross-cutting and coordination strategic issues that impact across the health sector and influence the activities of all services and programmes. It focuses, in particular, on the ten priority areas of work and related 17 core strategies.

Section 6 presents a comprehensive overview of the mechanisms by which the HSSP will be financed. The major components of the MTEF are noted and contextualised in relation to strategy development and implementation. Several annexed tables provide complementary details.

A set of **Annexes** complete the Plan. These annexes:

- Operationalise the strategic plan and provide central level implementation direction on goals, strategies, indicative activities and related indicators, a timeframe and responsibilities
- Highlight the major findings and recommendations of the functional analysis of the MOH
- Establish a monitoring and evaluation frame to assess progress towards goal attainment
- Overview technical assistance needs
- Present the MOH in diagrammatic form

Vision, mission, values, goals and working principles of the MOH

VISION

The Timor-Leste MOH recognises that health is influenced by a variety of determinants - education, income, housing, food, water and sanitation being among the more significant of these. With this broad understanding of health, the Ministry's vision is for a:

"Healthy East Timorese people in a healthy East Timor"

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

MISSION

Consistent with its vision statement, the MOH is committed to:

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

CORE VALUES

- Right to health
- Equity
- Pro-poor
- Cultural sensitivity
- Solidarity
- Friendliness

SERVICE VALUES

- Strong districts
- Good quality services - well managed, sensibly integrated, available, accessible, accountable, affordable and sustainable
- Visible and transparent support systems – health information, communications, human resources, administration and finance
- Strategic planning and priority setting based on achieving agreed Millennium Development Goals (MDGs)
- Quality improvement and clinical audit

GOALS

Overarching goal

Arising from the three components of its mission statement (ensuring availability, regulating and promoting participation) the MOH expects to contribute to the overall goal of improving the health status of the Timor-Leste people.

Operational goal

The MOH aims to provide quality health care for Timor-Leste by establishing and developing a cost-effective and needs-based health system which specifically addresses the health issues and problems of women, children and other vulnerable groups, particularly the poor, in a participatory way.

WORKING PRINCIPLES

- Provision of accountable central governance and effective and efficient local delivery of a comprehensive and integrated range of primary and secondary health care services across the nation (with a corresponding reduction in vertical, centrally-driven individual programmes)
- Active promotion of healthy lifestyles and health-seeking behaviour among the population
- Priority emphasis on prevention and control of communicable and selected chronic and non-communicable diseases, on trauma and related injury, adolescent health, and the wellbeing and health of vulnerable groups
- Priority emphasis on the provision of essential services for mothers and children
- Affirmative action on the heightened needs of all vulnerable groups– women, the poor, those from rural and remote areas
- Devolution of decision making and priority setting to districts (municipalities)
- De-concentration of financial and planning functions to districts (municipalities)
- Capacity building including human resource development
- Appropriate deployment and distribution of the health workforce
- Appropriate acknowledgment of the contributions of individuals to organisational objectives
- A genuine desire to listen to what communities say and to encourage their contribution
- Increased and more diverse public-private sector collaboration
- Evidence-based, quality interventions founded on considered use of reliable health information
- Implementation of health financing systems that promote equitable access to priority services

The values, goals and working principles noted above provide the basis for this health sector strategic plan. The strategies in the plan flow from these core elements.

SECTION 2 CONTEXT

General information on Timor-Leste

Background

Timor-Leste is a small country covering half the island of Timor. It has a land mass of approximately 14,610 square kilometres with a population in 2006 of 1,015,187. From the 16th century until 1975, Timor-Leste was a Portuguese colony. In December 1975, after a brief period of independence, Indonesia invaded and occupied East Timor. Nearly one quarter of the population is believed to have died during the occupation as a consequence of conflict, forced migration, malnutrition and unattended public health needs. In August 1999, after a referendum that endorsed progress to independence, widespread violence led by the militia resulted in the mass destruction of infrastructure and displacement of a large portion of the population. On 20 May 2002 Timor-Leste became an independent nation.

The country is divided into 13 districts, each with four to six sub-districts. The Oecusse District is an enclave located inside West Timor and accessible primarily by sea or air. Dili district is divided into four regions - Eastern, Central, Western and the island of Arturo. Almost 55% of the population reside in the Central region (Alieu, Ainaro, Dili, Emera, Liquica, Manufahi and Manatuto). Approximately 20% of the population is located in the Western region, (Bobonaro, Covalima and Oecusse) and slightly less than 25% is in the Eastern region (Baucau, Lautem, Viqueque). The two largest urban centres, Dili and Baucau, are home to 29% of the population. Seventy percent of the population is rural with most people living in small, scattered villages often isolated by mountainous terrain and poor roads. Public transport is limited. Buses operate between larger towns. In more remote districts travel is restricted to walking or the use of ponies. During the wet season many communities are isolated by landslide or lack of functional bridges.

There are sixteen distinct language groups in Timor-Leste reflecting the diversity of cultural traditions. The economy remains underdeveloped with primary activity in subsistence agriculture. The main commercial crops are rice and coffee.

Timor-Leste faces enormous development challenges relating to historic, cultural, demographic, economic and social factors. The turmoil prior to independence and the subsequent challenges of building a new nation have resulted in significant social dislocation. Much of the infrastructure of the nation, including the health and education system, is being rebuilt. This is occurring in the context of widespread poverty, extensive population movement (urbanisation), high levels of illness and disease and relatively low levels of literacy. Poverty in Timor-Leste affects two in five persons. It is predominantly rural, and higher in the West than the East.

Socio-economic profile

The 2006 Human Development Report scores Timor-Leste at 0.512 on the Human Development Index, ranking it 142 out of 177 countries. The Report highlights the following development indicators for Timor-Leste:

Table 1: Selected HDI indicators for Timor-Leste

Adult literacy rate (for ages 15 and older)	58.6%
GDP ($US) 2004	$0.3 billion
GDP per capita ($US) 2004	$367
Households under the national poverty line, predominantly in rural area (WB 2003)	40%
Percentage of the population without sustainable access to an improved water source	42%
Seats in parliament held by women (% of total)	25.3%

Source: UNDP 2006

In 2006, social and political instability and discontent led to demonstrations with bouts of extreme violence. Lingering tensions remain and many people continue to live in Internally Displaced Persons (IDP) camps in Dili. There is a degree of uncertainty about what the immediate future holds for Timor-Leste.

Despite widespread social unrest, there is evidence that Timor-Leste's economy is growing and that it will continue to do so into the future. There has been an economic turnaround following the contraction period subsequent to the departure of large numbers of UN and other personnel in 2002. Non-oil Gross Domestic Product is currently growing by about 5% annually in real terms. There has been some increase in food production since the drought in 2002/2003 contributing to a reasonably stable period of domestic inflation. Nevertheless, food imports continue to be necessary. Prospects are good for substantially larger financial resources from oil and gas revenues. It is predicted that over the next several years, the Government will increase public spending which, in combination with rising levels of private investment, will lift economic growth to around 7-8% annually from 2010.

MDGs, National Constitution, Legislation, NDP, HPFP, SIP and BSP

Millennium Development Goals

The Timor-Leste Government is committed at the highest level to achieving the Millennium Development Goals. The 2004 Timor-Leste MDG Report sets out what it portrays as realistic and achievable goals. At the same time it provides clear indication of the scale of the challenge facing the country. Table 2 shows selected MDG indicators for Timor-Leste:

Table 2: Global and local MDG targets for 2015 compared to the actual situation in 2001

Indicator	2001	2015	Global
Proportion of the population living on <$1 /day	20%	14%	½ of 1990
Underweight children	45%	31%	½ of 1990
Net enrolment in primary education	73%	100%	100%
Literacy rate 15-24 year olds	50%	100%	100%
Ratio of girls to boys in senior secondary school	58%	100%	100%
% land under forest	35%	35%	
Access to water (rural)	51%	75%	Double 1990
Access to sanitation (rural)	10%	40%	Double 1990
Unemployment	43%		

Source: Timor-Leste MDG Report 2004

Continuing civil unrest has characterised Timor-Leste society since early 2006. This instability seriously jeopardises the national MDG programme. What were ambitious targets have become even more challenging. Nevertheless, the MOH remains committed to its schedule of interventions and performance indicators as outlined in its recently released Basic Services Package. As the BSP notes there is evidence to suggest that using a small number of targeted and appropriate interventions can stimulate progress towards MDG achievement within existing resource bases. However, the Ministry is conscious of the shortened lead time now available to achieve targets.

The primary focus of the MOH is on MDG 4 (infant mortality), MDG 5 (maternal mortality) and MDG 6 (HIV/AIDS, TB and malaria). Tables 3, 4 and 5 below present the health targets for Timor-Leste based on these three MDGs for 2007, 2010 and 2015. The focus during the current planning period will be on progress towards the 2010 MDG targets.

Table 3: National Millennium Goal 4: Reduce Infant Mortality
(from Table 11.2 in National Development Plan)

Indicators	*Baseline 2001-2002*	*Targets*
Infant Mortality Rate	88 per 1000 live births	2005: Reduced by 20% 2007: Reduced by 25% 2010: Reduced by 30% 2015: Reduced by 50%
% of children under 1 year vaccinated with DPT3 and Measles	DPT 3 : 56% Measles: 47%	2005: Achieve 70% 2007: Achieve 80% 2010: Achieve 90% 2015: Achieve more than 90%

(International MDG target: reduce under-five mortality rates by two-thirds between 1990 and 2015)

Table 4: National Millennium Development Goal 5: Reduce Maternal Mortality
(Table 11.2 in National Development Plan)

Indicators	*Baseline 2001-2002*	*Targets*
Maternal Mortality Ratio	~800 per 100,000 live births	2005: Reduce by 30% 2007: Reduce by 40% 2010: Reduce by 50% 2015: Reduce by 70%
% of births attended by skilled health personnel	24%	2005: 50% 2007: 60% 2010: 70% 2015: 90%

(International MDG target: reduce maternal mortality ratio by three-quarters between 1990 and 2015)

Table 5: National Millennium Development Goal 6: Reduce the incidence of illness and death due to preventable communicable diseases
(from Table 11.2 in National Development Plan)

Indicators	*Baseline 2001-2002*	*Targets*
% of population treated and prevented from malaria and Tb	~ 200 deaths and 70,000 cases of malaria	2005: 30% Reduction of morbidity and mortality 2007: 40% 2010: 70% 2015: 80%
	30% taking effective malaria prevention and treatment	2005: 50% taking effective prevention and treatment 2007: 60% 2010: 80% 2015: 90%
	8,000 active Tb cases	2005: 40% reduction of Tb cases mortality 2007: 50% 2010: 60% 2015: 90%
% of Tb cases treated successfully	80% of detected cases cured under DOTS	2005-2015: Treatment of Tb under DOTS 90%
Number of persons infected with HIV	The prevalence of HIV estimated to 0,01-0,35%	2005-2015: Maintain the low prevalence rate of HIV at the same level

(International MDG targets: have halted by 2015 and begun to reverse the spread of HIV/AIDS and have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.)

Table 6 below is taken from the BSP and shows the interventions for the three health-specific MDGs with corresponding HMIS indicators collected as part of the routine operation of the Ministry's Department of Health Management Information System.

Table 6: MDG interventions and key performance indicators for Timor-Leste

MDG Goal	Intervention	*ROUTINE* HMIS INDICATOR
MDG 4. **Reduce Child Mortality**	1. Accessible, affordable health care	1. <5 years PHC facility Utilisation Rate
	2. Antenatal Care	2. 4 visit ANC coverage
	3. Care of the newborn	3. Neonatal Mortality Rate (Institutional)
	4. Improved nutrition of children: micronutrient supplementation	4. % children receiving Vitamin A supplementation
	5. Growth Monitoring	5. % children weighed
	6. Immunisation of children	6. % Children immunised against measles <1 year
		7. % facilities with functioning cold chain
	7. Integrated management of childhood illnesses	8. % children treated according to IMCI Protocols
MDG 5. **Reduce Maternal Mortality**	8. Skilled attendance during pregnancy, delivery and post natal	9. % Births assisted by skilled health personnel at the health facility
	9. Basic Emergency Obstetric Care	10. % facilities reporting all 6 BEOC functions in past 6/12
	10. Comprehensive emergency obstetric care	11. Caesarean section rate
	11. Family Planning	12. Couple year protection rate
	12. Reduce MMR	13. (Institutional) Maternal Mortality Ratio
MDG 6. **Reduce the spread of HIV/AIDS, STIs, Tuberculosis and Malaria**	13. TB Case detection	14. % TB Case detection rate
	14. TB Treatment with DOTS	15. TB cure rate (using DOTS)
	15. Malaria treatment	16. % malaria cases confirmed
	16. Malaria Treatment	17. Malaria case fatality rate < 5 years
	17. Malaria prevention by house spraying	18. % planned houses sprayed with IRS
	18. Malaria prevention in Pregnancy	19. % ANC clients receiving IPT
	19. STI treatment	20. Male Urethral Syndrome treatment rate
	20. STI Prevention	21. Number of condoms issued annually per male 15-49 years
	21. Voluntary counselling and treatment	22. % pregnant women tested for HIV/AIDS
	22. Reduce HIV prevalence	23. HIV prevalence 15-24 year old pregnant women
NON MDG activities	23. Ensured supply of essential drugs	24. % facilities out of stock of tracer drugs & vaccines

Source: MOH BSP 2007

National Constitution

The Constitution of the Democratic Republic of Timor-Leste affirms the recognition and respect for human rights as stipulated in the Universal Declaration of Human Rights (Part II "Fundamental Rights, Duties, Liberties and Guarantees", Section 23).

The Constitution addresses health specifically in several of its sections. Most significantly, it embeds health and medical/health care as fundamental rights for all citizens (Part II, Section 57). In the same section, the State is charged with the duty to promote and establish a national health system that is universal, general, free of charge and, as possible, managed through a decentralised participatory structure.

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

National health legislation

Legislation pertaining to the health sector in Timor-Leste is presented below in Box 1:

Box 1: Legislative enactments, resolutions, regulations and decrees relevant to the Timor-Leste health sector

Current Normative Diplomas	Nature
Government Decree No. 5/2003 of 31 December	Establish the Organic Structure of the Ministry of Health, its objectives and competencies under the coordination of the Central Services.
Government Decree No. 2/2004 of 21 April	Regulates Health Autonomous Medical Store (SAMES).
Decree-Law No. 12/2004 of 26 May	Regulates Pharmaceutical Activities in the areas of import, storage, export, and sale of medicines for human use.
Decree-Law No. 14/2004 of 01 September	Regulates Practice of Health Professions in the national territory.
Decree-Law No. 10/2004 of 17 November	Regulates Medical Certificate for Absence Justification due to ill health.
Government Decree No. 10/2004 of 24 November	Establish the National Health Systems, including the components, structure, vision, principles and objectives of the overall health systems, as well as the structure and roles of the National Health Services.
Decree-Law No. 18/2004 of 01 December	Regulates the licensing, operating and monitoring conditions of Private health Units.
Government Decree No. 1/2005 of 31 March	Regulates Disciplinary Code of Health Professions.
Decree-Law No. 1/2005 of 31 May	Establish the legal framework of Hospitals of National Health Services.
Decree-Law No. 2/2005 of 31 May	Establish the legal framework of the Institute of Health Science.
Decree-Law No. 9/2005 of 16 November	Regulates Epidemiological Surveillance Systems.
Decree-Law No. 14/2005 of 16 November	Regulates the Sanitary Surveillance Authority.
Government Resolution No. 2/2005 of 21 November	Establish the Medical Faculty at the Timor Lorosa'e National University.
Ministerial Orders	• Technical rules for the functioning & good practice of pharmacies; • Conditions of hygiene and technical adequacy of installations and means of transport of medicines; • Applicable rules to donations of medicines, medical consumption goods, medical equipment and others, to health institutions; • Licensing fees on pharmaceutical activities.

National Development Plan

National planning and policy development in Timor-Leste is guided by fundamental principles specified in the 2002 National Development Plan. The NDP proposes:

- An emphasis on preventive and promotive health care provided at local level
- A limitation on expenditure on hospital and specialist care (<40% of overall recurrent expenditure)
- Adoption of primary health care principles to optimise accessibility and coverage
- An approach to health care that embraces intersectoral collaboration
- A prioritisation of services and programmes that improve health status of vulnerable groups (children, women, rural populations, etc.)
- A recognition of the importance of effective management and regulatory systems and processes, qualified, experienced and motivated personnel, strong programmes of education and training, strategic policy directives, appropriate nation-wide health information systems and viable administrative support mechanisms

Specific reference is made in the NDP (page 158) to the need to:

- Prepare a comprehensive human resource development plan
- Train an adequate number of health personnel based on national needs
- Establish regulatory mechanisms for medical practice and professional ethics
- Develop incentive systems for motivating health personnel
- Optimise the use of available human resources through appropriate skills mix and productivity improvement

Health Policy Framework Paper

The 2002 Health Policy Framework Paper reaffirms the mission statement of the MOH with the tripartite focus on service availability, regulation, and community participation. Emphasis is given to primary and preventive health care. Multi-determinants of health are acknowledged and the corresponding need to adopt a multi-sectoral approach to health status enhancement.

The HPFP outlines the guiding principles for development and maintenance of government health services:

- *Priority setting*: A Basic Services Package is described that promotes priority setting of essential services in primary and secondary health care
- Decentralisation of services: A timely and appropriate movement towards de-concentration of the planning, management and delivery of public health care services is supported
- *Service delivery system*: The structure and functional details of the MOH is portrayed
- *Health financing*: Free public primary health care with potential for point-of-use charges for some curative care is described
- *Drug policy*: A system of classifying pharmaceuticals is noted including the development of an Essential Drug List developed and a list of importable non-scheduled drugs. The licensing of private pharmaceutical services and the establishment of an Autonomous Medical Supply System (SAMES) to administer drug importation, storage and distribution is foreshadowed.

Sector Investment Programme

Since 2004 the Government of Timor-Leste, through the Ministry of Planning and Finance and with international technical support, has coordinated all major public sector spending through a Sector Investment Programme. In essence, the SIP for the health sector has been an operational planning tool nestled within a less than comprehensive strategic framework. It has been largely input driven and has lacked genuine output and outcome definition. Although reflecting the MOH's tripartite mission (as described above), it was not designed to promote priority analysis. The SIP has been a means of assisting the Ministry in its efforts to progress towards its original targets without necessarily helping it to consider comparative advantages accruing in the different streams.

Herein lie the major differences between the SIP and the HSSP. Where the former has been largely operational and imposed, the latter is strategic in design, based on a consensual hierarchy of prioritised activities and focused on capacity development needs. This is not to suggest that the SIP has been ineffective – it has expedited some major advances. In particular it has been central to the widespread effective rehabilitation of fragile health infrastructure while at the same time limiting inappropriate building initiatives that could have threatened to derail plans to avoid over-production of facilities and corresponding staff increases.

How the HSSP builds on the SIP

Preparations for SIP Phase 2 (originally scheduled for June 2006 - June 2010) have largely been overtaken by the decision of the MOH to develop the HSSP and accompanying MTEF. The HSSP is an advance on the SIP in that it is both a medium term strategic plan and a medium term implementation plan. In addition it creates opportunity for eventual movement towards a Sector Wide Approach (SWAp) in planning and financing activities.

HSSP objectives have been inspired in part by the following six activity areas that had been identified for SIP2 attention:

- Rehabilitation of health infrastructure
- Implementation of the BSP
- Capacity development of human resources
- Development of the specialised ("customised") institutions
- Development and implementation of an incentive scheme for staff (for example, through the widespread provision of housing)
- Strengthening of policy, planning and management practices

SIP was designed to flag risks. In-built mechanisms have helped the MOH to anticipate and avoid risk situations. These mechanisms remain valid within the context of the on-going refinement and implementation of the HSSP. Many of the following issues persist as challenges to be resolved. As such they are pertinent to the risk reduction strategies articulated in the HSSP:

- Linking procurement of new equipment within an effective asset management system and processes
- Establishing building maintenance procedures and protocols, thereby capping building maintenance costs and promoting infrastructural longevity
- Enforcing rules and regulations that will ensure that SAMES is the sole supplier to the health sector of low-cost medicines and other soft technologies, thereby restraining costs and controlling supplies and distribution

- Strengthening information and monitoring systems centrally, and at district and facility levels to promote efficient data management
- Providing longer-term technical assistance to help develop and implement effective systems of practice and strengthen national capacity
- Strengthening central, district and sub-district monitoring, supervision and control capacity
- Strengthening MOH capacity at all tiers of the system to engage appropriately with communities
- Promoting collaboration and coordination between the MOH and NGOs and private sector health care providers

Basic Services Package

The concept of the Basic Services Package was introduced in 2002 as pat of the HPFP. Technical assistance was provided in 2006/2007 to consolidate previous work and to produce a definitive document combining primary health care and comprehensive hospital functions.

The BSP is based on the following principles:

- Evidence-based health interventions
- Client-centred services
- Integrated programme implementation
- Sound management - effectiveness, cost-efficiency, affordability
- Performance orientation

The BSP is the basis for planning, implementing, managing and monitoring progress towards achieving the MDGs within the health sector of Timor-Leste. The approved document comprises four components:

- Key service areas with descriptions of each service
- Levels of service in line with facility role and delineation
- Foundation of District Health Plan
- Policy development

The key service areas noted in the BSP are maternal health, child health, communicable diseases, non-communicable diseases, health promotion, and environmental health.

The minimum service components that public primary health care facilities will provide for their communities embody monitoring of public health, prevention and promotion interventions, diagnosis, treatment, referral, rehabilitation, and environmental health.

Deconcentration and decentralisation

The HPFP includes the significant objective of decentralising health services to promote more effective and influential strategising and decision-making by local level health staff and communities. District health development is a key component of this strategy with both the MOH and development partners agreeing that this is a much needed focus.

The term "district health" encompasses the whole of health concept – all facilities and activities conducted in a particular catchment area and serving a specific target population within that area. It includes the public sector as well as FBOs, NGOs and private sector actors, and systems for implementation, coordination, logistics, supervision, and monitoring and evaluation.

The movement towards decentralisation is likely to occur most effectively under the leadership of the District Health Office and the District Management Team.

The most important features of district health development that require attention are:

- A solid knowledge-base and situation analysis capacity (including the competence to undertake facility and population catchment area mapping)
- Expertise for annual and mid term consolidated development planning
- The development of district financing plans that include all partners and resources and encompass cost sharing
- Operationalisation of the BSP and related treatment and diagnostic protocols, quality assurance and referral system
- Human resource development priorities - staffing norms per type of facility, staff deployment, recruitment and retention criteria and procedures, capacity building, HR management, supervision and control, etc.
- Community participation and decentralisation
- Partnership arrangements/agreements with non-public sector actors and other service providers
- Stakeholder coordination/communication mechanisms
- Financial and administrative management activities - budgeting, accounting, budget monitoring and reporting
- HMIS, surveillance and research, monitoring and evaluation, and reporting systems
- Systems of logistics (resources procurement, distribution, storage, usage,) patient evacuation, radio, internet, etc.)
- Maintenance and asset management capacity

Proposed administrative devolution to municipalities

The Timor-Leste Government's proposal to move from 13 administrative districts to 31-35 municipalities has fundamental consequences for the health system. The most obvious concern is that the district health concept - internationally acknowledged as the most appropriate entity for health services planning and organisation – must be secured. The size of future municipalities and municipal populations may not justify a stand-alone system of primary health care and referral services (let alone aspects of other ministerial portfolios).

The MOH has prepared a detailed strategic proposal for the retention centrally or the transfer to municipalities of specific health responsibilities and functions. The strategy document – the first of its kind to emerge from a line ministry - has been well received by government. Core functions addressed in the strategy document focus on policies, regulations, external aid, technical support, human resources development, service and programme delivery, health information systems, health planning, budget and budget execution, revenues, procurement, asset management and audit. The Ministry's strategy outlines a modest and phased schedule for the devolution of many of these functions to the municipal level. Central to the proposal is an analysis of specific implications of decentralisation (notably required technical assistance, documentation, staff and budgets) and a weighing of advantages and disadvantages accruing to all parties. Regardless of the cautionary tone adopted in the strategy document, the MOH considers that the move to municipal structures remains an ambitious scheme given the level of current deconcentration across government.

In its role as steward of the health sector, the MOH recognises the importance of ensuring that future municipal authorities understand and apply public health considerations and values. Accordingly, the Ministry promotes the need for a municipal focus that supports optimal, equitable, efficient and sustainable health services coverage. The MOH will encourage municipalities to refrain from the creation of new and expanded health services in isolation of national imperatives. To achieve this, the Ministry will seek to have municipalities conform to the national health policy framework which defines criteria for the creation of new health structures. For this purpose, health service mapping and the hospital configuration plan are precious instruments that serve as pivotal references. Municipalities and the MOH will need to work together to ensure that unnecessary health facilities are not developed or that existing facilities are expanded only under specified circumstances.

While the concept of the "health district" is retained in the MOH's version of municipalisation, the majority of functions now performed by the District Health Management Team will be transferred to the new municipal authorities. This is feasible only if the majority of the DHMT staff with competence and capacity in public health and health services delivery is transferred to the municipalities. The current process of comprehensive health district development should be shifted progressively to the municipal authority but should involve to a large extent the same staff previously working under the auspices of the MOH. Should municipalities have the same or higher population size as do the current districts, the proposed changes will not have major implications. However, if public health competence (including the planning and management of service and programme delivery) shifts to the municipal level this may lead to similar initiatives being planned for other sectors. This could result in large municipal structures - a situation that would be neither efficient nor sustainable.

SECTION 3
SITUATIONAL ANALYSIS: WHERE ARE WE NOW?

Current health and demographic indicators

Box 2: Selected health and demographic indicators – 2006 unless otherwise stated

• Life expectancy at birth	60.5 (females) 58.6 (males)
• Total fertility rate	6.7
• Maternal mortality ratio	660 deaths per 100,000 live births*
• Infant mortality rate	88 deaths per 1,000 live births
• Under-five mortality rate (2004)	130 deaths per 1,000 live births
• Percentage of children ≤ five years with stunting	49%
• Percentage of children who are underweight	46%
• Tuberculosis incidence rate	556 per 100,000 population
• Malaria incidence rate	220 per 1,000 population
• HIV sero-prevalence rate	Low (only indicative figures available) but with high level risk behaviour

Various surveys and other sources provide data for the most recent estimates of Timor-Leste's priority health and demographic indicators. In aggregate these sources present a picture that is less optimistic than that obtained from the often cited 2003 Demographic and Health Survey alone. Nevertheless, improvement in some critical indicators is important to note and a reflection of the considerable effort of many people both within the MOH and its partner organisations.

Population

The population structure reflects the projections of the National Statistics Directorate based on the 2004 census. A medium scenario estimate of growth has the population increasing annually by 3.2%. Women of reproductive years (15-49) comprise 44% of the female population. Despite intermittent civil unrest following independence from Indonesia and internal displacement of a large number of people, the baby boom has continued unabated with people aged less than 15 years now making up 45% of the total population.

Timor-Leste has experienced a period of constant high fertility over the past several decades. This circumstance has been consistent across rural and urban areas. An overall decline in the rural and remote populations reflects a growing pattern of internal migration to the cities (notably Dili and Baucau) and to the larger district centres.

Maternal and child health

One Timor-Leste woman in sixteen dies during pregnancy. One in ten dies from pregnancy or pregnancy-related causes. The maternal mortality ratio for the period 2000-2006 is estimated at 660 deaths per 100,000 live births - an alarming figure.

Infant and under-five mortality rates signal a disturbing picture of child health in Timor-Leste. One in every eleven babies does not survive to his or her first birthday (88 infant deaths per 1,000 live births). Under-five mortality is 130 per 1,000 live births with diarrhoeal diseases, acute respiratory infections and neonatal causes accounting for over 75% of these deaths. Over the past decade there has been a less than desired lowering of these high levels of infant and child mortality. The causes of these phenomena need to be analysed more carefully. Post-neonatal

mortality - currently estimated at around 55 per 1,000 live births - has increased, constitutes the bulk (63%) of infant mortality and is a critical priority to be addressed.

Nutrition

Chronic malnutrition among Timor-Leste children is very high, with 49% moderately stunted and more than one in four children severely stunted. Acute malnutrition or wasting (thinness) is also very high, particularly in the second year of life. Eighteen percent of Timorese children between 12 and 23 months of age are wasted. The SPHERE standards consider that wasting of more than 10% constitutes an emergency situation. The prevalence of micronutrient deficiencies (notably iron, vitamin A and iodine) among children and pregnant and lactating women is also high. One third of children under the age of five years and one third of all women suffer from anaemia. Effectively combating malnutrition in Timor-Leste will require heightened attention to the nutritional needs of women during pregnancy and of children in the first two years of their lives.

The prevalence of intestinal parasitic infections among the Timorese population contributes significantly to malnutrition and anaemia. A study by the MOH and WHO in 2006 in selected districts found that 90% of children surveyed had a parasitic infection with over 25% having more than two infections.

Communicable diseases

The burden of infectious diseases is heavy. The incidence rate of all forms of tuberculosis is estimated at 556 per 100,000 population with a case fatality rate of 88 per 100,000. The number of new TB cases seen at public health facilities has remained relatively constant over the past four years. In 2006, the incidence of clinical malaria cases reached 220 per 1,000 persons, with a case fatality rate for falciparum malaria of more than 10% among the severely ill. Episodic outbreaks of dengue haemorrhagic fever are common with the most recent occurring in 2005 during which time the case fatality rate peaked at 14%. While malaria and dengue are endemic and impact on the entire population, the highest morbidity and mortality rates are in children.

Leprosy is endemic in several districts in Timor-Leste and cases of lymphatic filariasis are relatively common. The widespread incidence of diarrhoeal diseases is linked to lack of access to safe water with around 50% of households having to use groundwater susceptible to contamination by sewage and other waste.

Timor-Leste has yet to confront an HIV epidemic. However, conditions favourable to its spread are present as evident by the high level of risky sexual behaviour in urban areas in particular and poor understanding about symptoms and propagation of HIV in the general population. Sexually transmitted infections are prevalent. Sixty per cent of female commercial sex workers in Dili in 2003 had herpes.

Non-communicable diseases and related public health issues

The population of Timor-Leste aged 65 years or more is not expected to increase significantly over the next decade. Nevertheless, certain chronic diseases such as cardio-vascular and renal disorders, cancer, emphysema and other tobacco related diseases, and diabetes are likely to emerge.

A range of public health problems notably road traffic accidents are already assuming major proportions and are likely to become more challenging over time. Similarly as commercial and industrial sectors expand, an increasing number of work-related injuries will occur unless more attention is given to prevention and occupational health and safety in general.

BOX 3: Health and demographic priorities to be addressed in the next five years

- High rates of neonatal, infant and child mortality and morbidity from diarrhoeal diseases, acute respiratory infections, vaccine-preventable diseases, malaria and dengue fever and nutrition
- High maternal mortality ratio, and deaths from pregnancy, obstetric trauma and post delivery sepsis
- High rates of malnutrition in women and young children
- High case fatality from infectious diseases particularly TB, malaria and dengue fever
- The high total fertility rate
- Population growth
- Widespread unsafe sexual behaviour and lack of knowledge on HIV/AIDS and STIs
- High rate of road traffic accidents
- Likely rise in modern lifestyle disorders (chronic, non-communicable diseases) and other public health problems such as work-related accidents

The role and structure of the Ministry of Health

The MOH has two roles - stewardship and service/programme provision. Stewardship refers to the functions of (public and private) sector-wide policy direction, regulation, organisational monitoring and surveillance, intersectoral engagement, and the development, administration and financing of the public health care system. Provision refers to the delivery of health care diagnostic, treatment and rehabilitative services at primary and secondary levels, and the development and implementation of programmes of community engagement, disease prevention and control, and of health promotion.

The current organisational structure of the Ministry is shown in Annex E. The Central Offices of the MOH currently comprise three directorates:

- Health Services Delivery
- Finance, Administration and Logistics
- Policy and Planning

The senior civil servant in the Ministry is the Permanent Secretary. The Minister for Health and the Vice-Minister provide strategic direction to the organisation and assist in oversight on a day-to-day basis.

At the devolved operational level, the MOH provides primary health services through district arrangements with health centres, health posts and mobile clinics servicing geographically defined populations within the framework of the recently approved Basic Services Package. The BSP delineates specific roles and functions to be performed at the different facilities and direction on the minimum staffing levels and infrastructural support needed to ensure effective service delivery. The BSP also frames a complementary package of activities for the five referral hospitals and the larger national referral hospital.

District health teams under the Ministry's direction implement health policy and strategies through annual action plans and have a designated role in ensuring appropriate local service delivery and effective utilisation of resources. Historically, the annual planning process at district level has been separate from the budget cycle. However, steps have been taken in recent times to more appropriately couple these two activities. The recent introduction of the BSP has raised the integration of management planning to a higher level while at the same time promising to strengthen local strategic directions.

The activities of the "customised" services – the Institute of Health Sciences, SAMES, the National Laboratory and the hospitals are technically responsible to the Permanent Secretary but, under legislation, enjoy a (varying) degree of autonomy.

The structure, roles and functions of the MOH are being reviewed as part of institutional capacity development related to this strategic plan. The functional review underpinning the institutional strengthening has been completed and the implementation of supported recommendations will be ongoing over the next two to three years.

Since 2002, the MOH has engaged with donors and development partners on several levels. Informal bilateral meetings have been held as necessary to allow for frank exchange of views. Joint donor review missions to consider strategic and operational progress to date and to consider agendas for subsequent reporting periods have been scheduled biannually although societal disturbances have disrupted such meetings over the past 18 months. As well, a broadly constituted

Sector Working Group has been established to discuss coordination matters between the MOH, other ministries and its array of partners. This mechanism is in embryonic form without as yet a definitive statement of purpose. The goal of progressing towards a SWAp framework or some modified or intermediate form of donor harmonisation is currently under discussion.

A forum to promote intersectoral dialogue and clear understanding of MOH priorities and for debate and consultation between ministries on policy and strategy development has yet to emerge. Internally the MOH promotes consultation between central and district management and planning personnel through monthly gatherings at which specific needs, problems and priorities are addressed.

What is working well?

Some of the health sector initiatives begun following independence are now bearing fruit. In this section we look at critical success factors upon which to better plan and build for the future.

Micro-policy development

Strategic micro-policy development addressing topical health issues commenced in Timor-Leste even before the establishment of the MOH. Within five years almost twenty priority areas have been included in the Ministry's overall policy development programme. Many comprehensive strategic plans have emerged from fruitful cooperation between the MOH and development partners and other international agencies. The World Bank has complimented the Ministry on its efforts to use international standards as the benchmark of its policy documentation. The HSSP will build on this encouraging beginning by focusing attention on the efficiency and effectiveness of coupling strategies around common domain areas and using integration as a valuable utilisation tool.

District health management teams

Devolution of management authority and responsibility to district health teams has been a cornerstone of the MOH during its formative years. The Ministry's overall planning and implementation strategies have been enhanced through local level input and coordinated through central administrative and communication systems. While far from perfect, the district structure has assisted in the development of an information collection and reporting mechanism that is beginning to offer promise of useful health and utilisation data. District financial management is in its infancy. Significant capacity development over the planning period will be needed in this area.

Capital investment in infrastructure rehabilitation and reconstruction

In 2002 the MOH, with the support of its development partners, entered into a major programme of capital works rehabilitation and development. Health infrastructure damaged during the struggle for independence has been progressively reconstructed or newly built such that today 66 health centres and 174 health posts are operational across the 13 districts. Within the next eighteen months the hospital reconstruction programme will conclude. Modern state-of-the-art facilities are soon to open in Dili, Maliana, Maubisse and Oecusse, and others will follow in 2008 in Baucau and Suai.

Basic Services Package

Many facilities are capable of providing a reasonable range of appropriate services and programmes for inpatients and to individuals and communities on an outreach basis via mobile clinics and, most recently, through a locally-generated and centrally-supported health promoter programme. Although the BSP is only now being rolled out (a process that is scheduled to conclude at the end of 2008), several of the larger facilities are already totally BSP-compliant with capacity to target the major priority areas of maternal and child health (through neonatal care, IMCI, immunisation, skilled birth attendance and Basic Emergency Obstetric Care,

or BEOC, and HIV/AIDS, STI and TB, or HAST (through surveillance, screening, case management, and BCC and other promotion campaigns). Many are partially compliant. The BSP sets a target date of 2010 by which time 100% of health care facilities will be designated as "BSP ready".

The primary thrust of the BSP is to sponsor enhanced maternal and child health and HAST services. As standards of care improve, it is expected that attendance rates will increase, especially in the areas of antenatal care, BEOC, deliveries, post natal care, and reproductive health and family planning. Currently, overall utilisation remains unsatisfactory.

Critical success factors for improving standards of care and utilisation of services and programmes include the availability of:

- a sufficient number of skilled doctors, midwives and nurses willing to work where needed
- on the job training and appropriate management and supervision
- adequate supplies of medicines, equipment and other resources
- appropriate physical infrastructure at all facilities with sufficient space for confidential and sensitive case management and consultation
- budget access and financial capacity at facility level for recurrent costs
- a systematic and comprehensive extension of services through outreach activities

A willingness to accommodate cultural change and to adopt bureaucratic and political flexibility underpins progress in several of these areas.

Disease control

Timor-Leste has not had a reported case of polio since 2003 and is on the verge of being declared polio-free. The WHO estimates that by the end of 2008 through the efforts of the MOH working in collaboration with UNICEF, maternal and neonatal tetanus will have been eliminated. National DP3 immunisation coverage has reached 67% of the population and is expected to rise to 85% by 2008 – an encouraging advance given the relative infancy of the immunisation programme. The directly observed treatment short course for tuberculosis (DOTS) has now reached many new health centres and the cure rate is being maintained at 80%.

Programmes to eradicate lymphatic filariasis, to control intestinal parasitic diseases, and to confront significant levels of dermatological disorders have been undertaken by the MOH in conjunction with the WHO. These three programmes have led to significant reductions in the incidence of what had been endemic disease states.

The reasons for the successes in eradicating polio and confronting other vaccine-preventable and communicable diseases relate to strong commitment, active political participation at the highest level, technical and financial support from partners, insightful strategic planning, effective mass media campaigns and sustained community participation. Increasingly active and integrated surveillance, careful planning, supervision and monitoring systems with timely and adequate provision of funds, vaccines and commodities also contributed to these achievements.

While mortality from malaria and dengue remains stubbornly high, outbreaks are being managed more effectively and prevention programmes are starting to "bite". Here the critical success factors common to these two diseases include political commitment, effective intervention strategies as well as good multisectoral

collaboration involving civil society, communities and other ministries. The MOH has more often than not taken the lead in such intersectoral engagement.

Referral processes

Referral arrangements between facilities are also being formalised and a network concept of "referral and response" is to be introduced. Medical retrieval services have been boosted recently with the receipt of a fleet of modern, well equipped road ambulances from Kuwait and the Democratic Republic of South Korea.

Human and administrative resource development

To advance its goal of offering an accessible and effective network of primary and secondary health care services for all Timor-Leste citizens and, thereby, improve utilisation to acceptable levels, the MOH recognises the need to complement its capital works programme and the implementation of the BSP with:

- a major programme of human resource development through training and enhanced management competence
- an injection of "ear-marked" funds to significantly boost BSP capacity across the public health care system (minor refurbishment, essential equipment and pharmaceuticals, etc.)
- sustained attention to strengthening logistical (supply and distribution) support to public health facilities to improve the availability of essential medical equipment and other stock
- a sensitive process (involving meaningful community consultation) of relocation and realignment of public sector health facilities (and the staff working within them) to better match facilities with population settlement patterns across all districts in order to meet the stated standard of physical accessibility (two hours by foot to the nearest facility)

Crisis management

None of the above initiatives comes without a cost. However, the Ministry has demonstrated in recent times its ability to focus on core business in the face of major challenges. Justifiably, it has been praised widely for its immediate efforts to control potentially devastating consequences of the internal displacement of large numbers of people as a consequence of the civil disturbances of April-May 2006. Working from temporary office accommodation, the senior management tier of the Ministry organised MOH personnel to ensure the viability of sanitation services in the IDP camps in Dili, to assist in the distribution of food throughout the country and to provide additional support for pregnant and lactating women and their families who had been displaced. In addition, the Ministry, working closely with UNICEF, opportunistically vaccinated, provided Long Lasting Insecticide Treated Nets (LLITNs) and Vitamin A supplementation, and de-wormed 30,000 people living in the IDP camps.

The Ministry's capacity to manage in crisis and emergency contexts may stem from the deep-rooted experiences of many of its senior management and clinical personnel who calmly confronted the demands of the post-conflict circumstances in the aftermath of the violent independence struggle in 1999. Of equal note is the capacity of the Ministry's large group of professional staff to maintain focus on important tasks while being immersed in a distracting and, at times, discontinuous, process of health sector reform. Reflection on lessons learned needs to be institutionalised to embed and share insights.

Decentralisation

Meanwhile as BSP-driven reforms are being addressed, and in keeping with its strategic objective of devolving decision-making to the decentralised settings, the MOH has over the past six months been at the forefront of planning for Timor-Leste's adoption of municipal-style local government administrative arrangements. A municipal system will have major implications for the health sector in terms of roles and responsibilities. The MOH is well placed to respond to, and manage, this organisational shift. Capacity in this area is due in part to the Ministry's awareness of the distinction between the stewardship and provider functions and in part because of its experience in establishing a district delivery system.

Financial management

As part of broad organisational reform, and as foreshadowed in the MTEF, modifications to financial management processes within the MOH have begun to help promote a more optimal use of the funds allocated to health. The MOH has commenced the process of moving away from a centrally-based budget determination mechanism to one which aims, over time, to provide districts (or municipalities) with a resource allocation framework to negotiate needs-based funding. Also under consideration is the plan to introduce national health accounts which will allow for useful comparative internal and international analysis of total health expenditures in Timor-Leste by source and health care function.

Drug management

The MOH continues to struggle in managing pharmaceutical supply systems. Legislation to enhance the commercial autonomy and administrative responsiveness of SAMES has yet to result in major advance and there are persistent problems in identifying sources of drugs among an array of donors. Nevertheless, expenditures on essential drugs and medical supplies have increased significantly during the past five years due in the main to the presence of more front-line doctors with diagnostic skills that support higher prescription rates. It is anticipated that longer term technical assistance will be required in logistics management to improve the purchase and supply system and to strengthen practical management capacity.

Public-private integration

An innovative strategy of contracting health services to an NGO in a poor district has recently been piloted with significant impact in increasing health service coverage. The critical success factors here include an increase in financial resources from government sources, the injection of external management culture through a non-governmental, non-profit organisation and the appropriate sharing of authority and responsibility between central and local management groups.
On a system-wide level, the partnership between the MOH and NGOs is strong and continues to be nurtured from both sides. The Ministry is proceeding in its goal of strengthening capacity to provide service standard guidelines that reflect the principles and concepts of the BSP. Private sector agencies, heavily involved in the development of the BSP, are now being encouraged to adopt the role and functional delineations (and related resource implications) as their practice norms.

Box 4: Critical success factors in the health sector

- Strong political commitment and good planning, supervision and monitoring systems at all levels of the health system for very specific cost-effective public health interventions
- Timely and adequate provision of funds and commodities
- Availability of essential drug supplies and effective management of SAMES
- Adequate income and other incentives for staff particularly for those working in more remote settings
- Active human resource management development
- Extension of community services through systematic and sustained outreach activities
- Effective BCC and other health promotion campaigns
- Community participation in health planning and implementation activities
- Flexible financing arrangements and appropriate communication between central and evolved levels in financial management issues
- Regulatory measures through performance based contracting
- Partnerships with NGOs and other private sector agencies based on a shared understanding of quality and performance standards
- Appropriate longer-term external technical, management and financial support

What are the key challenges?

Health and population issues

The BSP highlights the significance of maternal and child health as the two major challenges facing the MOH.

The coverage of effective maternal health services remains low, especially for essential obstetric care. As the BSP notes there are, effectively, only six facilities across the country capable of providing the full range of maternal health services and programmes. Unmet need is high in such areas as safe motherhood, general reproductive health, family planning (including birth spacing) and reproductive choice awareness. The role of doctors and midwives and their capacity to offer BEOC needs urgent attention throughout the country, but especially in rural and remote areas.

The high rates of infant and child mortality are linked to poor coverage of well resourced child health services especially those provided through the Integrated Management of Childhood Illnesses (IMCI) framework. The deployment of health care professionals able to manage the wide range of childhood illnesses (especially diarrhoeal and acute respiratory infections) has improved with the advent of the Cuban medical brigade. However, there is some evidence to suggest that what could be referred to as the "medicalisation" of primary health care services has introduced diagnostic, treatment and referral complexities previously unknown and unnecessary. Many of the generalist doctors have had limited, if any, exposure to IMCI modalities. As a consequence medical management of childhood illnesses and conditions tends to ignore or downplay IMCI principles. Some concerns also exist about the viability of present methods of maintaining and updating the IMCI skills level of community and hospital-based nurses. IMCI-trained nurses have been observed to practice outside IMCI guidelines and to be unable to account for such actions. Lack of skilled and sustained supervision and control is a contributing factor in this situation.

The issue of ensuring sustainable IMCI capacity and worker compliance needs to be examined as a matter of urgency because IMCI is a proven strategy to increase child survival. Similarly, the relatively low use of oral rehydration solution for children under five years of age with diarrhoea needs to be reversed. The benefits of exclusive breastfeeding for babies below six months of age are frequently disregarded while inappropriate complementary feeding practices are common. There is also a high prevalence of micronutrient deficiencies. All these circumstances contribute to limited growth and development and reduced resistance to infection.

The large proportion of the population aged 20 years or less draws attention to the important area of adolescent health. This field is an emerging public health challenge for the MOH and its partners. Of particular concern are issues surrounding sexuality and sexually-related risk behaviour practices, and smoking prevalence rates of young adults.

Timor-Leste has large geographic areas where close access is not available to cost-effective interventions that might limit the high burden of infectious diseases. Such interventions are particularly needed to prevent and provide appropriate care and treatment for tuberculosis, acute respiratory infections, malaria, and dengue. Further efforts are required to continue building a well-functioning health system and to develop health facilities that can deliver effective services for many serious

emergency conditions. Likewise, alternative strategies for targeting and extending access, for example through outreach and community development programmes, should be implemented as a priority to address the pressing needs of the poor, the socially disadvantaged and those from more remote settings.

There has been some success in the past in controlling and/or eradicating certain diseases. However, the vertical approach of many disease prevention and control programmes has failed to spread benefits throughout the system. Focusing on a single health problem has resulted in missed opportunities to address others of similar nature within the same target group. This circumstance is clearly evident in the call within the micro-policy analysis section of the health sector strategic plan for greater integration of services and programmes within common domains (such as the Communicable and Non-Communicable Disease fields).

Consumers and providers

The MOH already focuses attention on behavioural change to improve the individual and household health practices of consumers and carers with regards to nutrition, the use of preventive measures and healthy lifestyles. However, even greater efforts are needed. Promoting important behaviours such as immunisation, reproductive choice, breastfeeding, oral rehydration therapy, and the consultation and use of skilled birth attendants for delivery, and IMCI-proficient practitioners for the treatment of childhood infections and other diseases is a priority need. Similarly, enhancing awareness of proven preventive measures (condoms, bed nets, etc.) to protect against major infectious diseases needs to be given more notoriety.

As the BSP notes in describing the "three delay model", there are several reasons why Timorese people fail to attend public and (private) health care allopathic health care facilities to the extent desired. In essence, the reasons boil down to poor community-wide knowledge about health and healthy practices, persistent faith in traditional medicines and traditional healers, a widespread lack of confidence in the quality of care available, and geographic disincentives to attend.

A summary of priority health service interventions can be seen in Box 5 below:

Box 5: Priority health service interventions

Maternal, new born and child health
- Basic emergency obstetric care including institutionally-based delivery
- Essential newborn care
- IMCI
- Infant and young child feeding
- Reproductive choice

Prevention and control of epidemic prone disease

Health prevention, protection, and promotion
- National immunisation programme
- Bednet use
- Nutrition education and growth promotion and healthy diet
- Mental health
- Alcohol, drugs and tobacco
- Reproductive choice and family planning (including STIs, HIV/AIDS, etc.)
- Eye care
- Oral care
- Safe drinking water and food safety
- Vitamin A and iron/folate supplementation and iodine

Integrated Management of selected diseases
- Malaria
- Dengue fever
- HAST [STIs & HIV/AIDS & TB]
- Leprosy
- Respiratory tract infections
- Diarrhoeal diseases
- Parasitic diseases (especially intestinal parasites & lymphatic filariasis)
- Hypertension and diabetes
- Smoking related diseases

Emergency care for trauma and accidents
- Road traffic accidents
- Accidents in the home and at work

At all service delivery levels, poor communication between providers and consumers is a major obstacle in promoting health in Timor-Leste. Detailed and substantiated data based on rigorous research (such as that likely to emanate from the long awaited "Health Seeking Behaviour Study") remain illusive, nevertheless, there is widespread belief that instances of closed facilities, inadequate clinical performance, inconsistent and, at times, weak management and supervisory practices, and inappropriate attitudes among MOH staff, when taken together, have had a detrimental influence on utilisation rates within the public health sector. Limited resources, poorly disseminated clinical standards and limitations in technical as well as counselling skills have also affected patient and client trust in providers.

The BSP is now being rolled out and attention is being given to significant changes in the structure and function of the Ministry. It is timely, therefore, to sensitise health care providers on professional ethics and to build their skills in interpersonal communication and counselling. This will assist in generating greater trust thereby empowering consumers to make appropriate choices in adopting healthier lifestyles and practices including utilising primary (and where necessary secondary) health care services and programmes.

Costs and sector resourcing

Internationally, cost of health care is a major barrier to the regular use of health services whether preventive, promotive or curative. For Timor-Leste cost needs to be conceptualised broadly. It does not have a precise dollar figure. There is only limited usage of the "user pays" principle in the public health sector beyond certain pharmaceutical charges which are dependent on drug availability and related (and variable) prescription practices. Moreover, there is nothing in the medium term to suggest that this situation will change (see the MTEF for further details). Nevertheless, it is possible to determine at an individual level some sense of the actual costs incurred in attending a health post, health centre or hospital.

The concept of "opportunity cost", that is, cost foregone, is a more meaningful basis for determining the impact on an individual or family of seeking public or private health care services. Opportunity cost means the value of the next best purpose an asset (such as time or work or employment) could have been used for if it had not been used for the purpose chosen.

The obvious example in the Timor-Leste context is the time taken to reach a health facility, the time taken to engage in a consultation with a health care provider or providers and the time taken to return home. This could be, for example, a mother taking a young child to visit the community nurse at the local health post for an immunisation treatment and clinical follow-up. A typical journey in the rural sector might take an hour or more, the consultation itself might take 30 minutes and the return home another hour or more. Half a day away from home would not be unusual. If the child being immunised has several siblings (again likely) then they would either accompany the mother or be cared for by another family member or some other responsible person in the community. It is possible that the father might have to provide the child minding duties.

The overall cost for this typical rural-based family of utilising the local public health facility would need to be assessed according to the level of disruption from the regular routine of the various members. In our example, both parents have been prevented from performing their daily chores – in the home and in the small vegetable garden nearby. The opportunity to produce and sell home-grown commodities has been lost (or foregone). The family faces a difficult choice in deciding whether to use their time to take their child to the health post in preference to engaging in the various activities that help them earn revenue or produce items for exchange. If there are doubts about the quality of care that the child is likely to receive at the health post or if, indeed, there is some uncertainty as to whether the post will be open when they arrive, then the choice will be simplified – the family will stay at home and forgo the opportunity of completing the immunisation programme. Or, if concerns about the health of the child are significant, the family may decide to seek the advice of the local traditional healer.

From the MTEF we learn that, on average, households spend about US$2 per capita annually on health services (including indirect costs). To this relatively small amount must be added the more significant opportunity costs noted above in the example scenario.

Informal private sector providers such as commercial pharmacists are often the first source of care for many consumers. This raises the issue of service quality given the limited effectiveness to date of MOH regulation and licensing. Anecdotally it is suggested that people can pay anything up to $50 for a single course of the more highly regarded medications (for example, antibiotics) – with or without a prescription. The Ministry and its partners face challenges to limit the impoverishing effects of inappropriate private, out-of-pocket health expenditures of this type.

The health system suffers from a limited availability of appropriately educated and trained midwives, community nurses and allied health personnel. It also faces the dilemma of finding staff prepared to work in rural and remote areas. The difficulty in deploying and distributing adequate numbers of qualified staff has been due, in part, to less than appropriate, centrally-controlled recruitment procedures and, in part, to a lack of clarity in role definitions and minimum staffing establishments for various facilities and services. One consequence of this is a significant mal-distribution of the workforce. The introduction of the BSP provides much needed clarity in the roles of health personnel for recruitment and deployment (and management) purposes. However, the ongoing process of rectifying historically inequitable deployment arrangements will require sustained political commitment and strong organisational leadership.

One of the critical factors limiting effective delivery of health services in the country is the low level of salaries for civil servants who comprise the majority of MOH staff. Although there is promise of an increase in the civil service salary scale as part of a process of administrative reform, current monthly rates of pay for professional staff range from $123 for level 3 staff (at which rate many nurses are employed) to $361 for level 7 staff (the Permanent Secretary's rate of pay). Low salaries demotivate people and force some qualified personnel to devote energies to private practice. A key challenge for the MOH and the Government of Timor-Leste more broadly over the next several years is to develop strategies that improve the income of government health staff or that support the institutionalisation of contract employment for professional cadres.

Initiatives of this type – within a broad-based incentives framework - are needed to promote a viable health system – one which reaches out to the poor and to those in rural and remote areas.

There is also a pressing need to introduce standards of practice for, and to enforce regulation of, private practice. Such initiatives would apply to both individual practitioners and to the facilities and services in which they work. The effect would be to provide more assurance of quality and at the same time reduce opportunities for malpractice. The more receptive sections of the private sector are anxious for the MOH to demonstrate appropriate governance and stewardship by such actions.

The health sector is reasonably well funded at around 12% of total government expenditure in 2007. In a climate of increasing national prosperity (albeit shadowed by concerns of persistent civil unrest), the Government has committed to maintaining expenditure on the social sectors (health and education) at around 35% of the General State Budget while capping expenditure on security (police and the military) at 20%. With or without the move towards municipalities, the challenge for the MOH over the current planning period will be to ensure that its government funding is allocated equitably, is used effectively and provides value for money. The policy commitment of capping hospital/curative expenditure at no more than 40% of budget must be maintained.

Within the context of budgetary growth (as outlined in the MTEF) the Ministry must work towards a more sophisticated allocation of its funds. It must also strengthen its budget planning and implementation procedures and improve local access to funds.

Box 6: Summary of key challenges in the health sector

- Low utilisation of cost-effective public health interventions due in part to a persistent faith in traditional medicine and healing and in part to a lack of faith in the quality of western medicine
- Poor attitudes and practices among some service providers in communicating with consumers
- Mal-distribution of health service providers, especially skilled midwives and community nurses
- Inconsistent quality of care in both public and private sectors exacerbated by inconsistent application of approved policies and protocols
- The continuing high maternal and child mortality and morbidity rates coupled with the emerging public health issue of adolescent health
- High need for family planning/birth spacing advice and commodities
- Low salaries of health staff in the public sector and lack of incentives to work in rural and remote areas
- Limited access to essential services among the poor and those from more remote areas
- Inadequate management and leadership, especially in monitoring, evaluation, supervision and for evidence-based, delegated decision making
- Inadequate capacity in human resource development including education and training and personnel management practices
- Limited harmonisation of external funding of the health sector resulting in unnecessarily complicated budget development
- Limited integration of services and programmes to the detriment of effectiveness and efficiency

Institutional challenges

As indicated in the recommendations of the 2006 functional analysis of the MOH, the central component of the Ministry demonstrates a lack of precision about what the roles and functions of its divisions and departments should be. It also suffers from uncertainty in senior and middle level management and leadership tiers. Productive partnerships between central office and district (and sub-district) service agencies are not always evident. The challenge now is to build constructive linkages for managing, coordinating and monitoring the HSSP implementation process in order to facilitate goal attainment at service and programme levels. Achieving goals – in particular the three goals underlying the Strategic Plan – will depend on central divisions and departments and their various programmes interacting closely and working in collaboration with front line service personnel to produce common outcomes.

The MOH is committed to building collaboration and coordination processes with private providers to increase effective service delivery. The capacity of the private health care sector in Timor-Leste is well known. Its potential to contribute to overall health status gain within the country is still to be reached. At present, the Ministry is unable to effectively monitor and regulate private providers despite a legislated role to do so.

Effective coordination with development partners is a priority for the MOH. The mechanisms for consultation, collaboration and coordination are well established on technical matters, but less so for strategic resource usage. The opportunity for the Ministry to take the lead in consistently analysing health priorities in the sector, and deciding on resource allocation has often been subsumed by strategies and plans initiated by donors and development partners. The production of this health sector strategic plan is an important step in strengthening the Ministry's capacity to assume leadership in sector-wide management. The HSSP highlights the Ministry's desire to work with development partners and donors in developing policy and in planning and financing the health sector in the country.

On several occasions during its short history, the MOH has shown itself to be a capable crisis manager during emergency periods. However, the institutionalisation and formalisation of a template, step by step, strategic approach that could be applied under all circumstances has yet to be developed. Rectifying this omission would allow the Ministry to confront not only communicable disease outbreaks but also to contribute meaningfully to intersectoral responses to natural or man-made emergencies.

SECTION 4 STRATEGIC PLAN

Strategic Plan Direction and Scope

What is new in the strategic plan for the health sector?

For the first time we, in the MOH of Timor-Leste, have a sector-wide strategic plan for all stakeholders. Sector-wide and all stakeholders means the private sector and partners as well as MOH employees and others. We encourage all stakeholders to work within the framework of this strategic plan and its desired outputs and outcomes. Such an approach reflects our ultimate objective of sector-wide coordination in planning, implementation and management.

For the first time, we have articulated a strategic frame of action based on our well known and accepted mission statement, and the values and working principles that emerge from the Constitution and the National Development Plan. We encourage all stakeholders to use the strategic frame when developing and implementing specific activities.

For the first time, we have prioritised, through sustained consultation, three overarching goals that provide general strategic direction to all stakeholders in our combined efforts to achieve progress in the reduction of the major areas of national mortality and morbidity that are causing us most concern. We have identified objectives, essential activities and indicators relating to these goals that, together, provide what we consider a feasible implementation framework to shape our actions.

For the first time, we have proposed a comprehensive, integrated and strategic approach to the prevention and control of common disease domains and to the related promotion of healthy behaviour for specific disease modalities. For this we have provided a programme and service-based foundation around essential micro-policy areas (some of which are yet to be developed) that will provide specific strategic direction to all stakeholders.

For the first time, and without downplaying the priority infectious diseases domain, we have acknowledged the significance of chronic, non-communicable disease processes and other emerging public health issues in an attempt to reduce the burden of current and potential problems.

For the first time, health outcomes linked to the three key health-specific MDGs and based on the BSP directives are used in an integrated fashion across the whole sector rather than on an ad hoc programme-by-programme basis.

For the first time, we have developed a strategic plan that is linked to a medium term expenditure framework and that allows for alignment with the planning-budgeting cycle of the Ministry.

Targets, goals and strategies

In Section 2 Tables 3, 4 and 5 are the millennium-related development targets that the Government of Timor-Leste (through the MOH) has set for the period of the HSSP and beyond. In Table 7 below the three overarching strategic goals that provide direction for all health care planning and implementation activities are listed along with 22 priority indicators. These goals and indicators are linked to the national millennium targets.

A full presentation of the goals and related objectives, strategies, main activities, indicators, timeframe and responsibilities is provided in the logical framework found in Annex A.

All strategies listed are a guide for resource allocation and for work at each level of the health system. While broad activities are provided for all strategies, detailed actions will be determined at each level of the system according to local needs analyses. These specific actions will form the basis of annual operating plans at devolved levels.

Indicators are aligned to all strategies. The present state of resource development in the MOH has meant that many indicators are input- or output-based with only some indicators being outcome-based. It is anticipated that during the planning period many of the output indicators will be translated into outcome indicators as data improve and as human capacity strengthens.

The support and coordination logframe of Annex A should be considered in tandem with the catalogue of integrated micro-policy strategies presented in Section 4 and the key cross-cutting strategies presented in Section 5. Viewed in combination these three components of the strategic plan provide a comprehensive and prioritised way forward for the MOH and its partners through the current planning period and beyond.

Table 7: Core HSSP goals and related indicators

NR	INDICATOR	TYPE	YEAR(S)
Goal 1: improved accessibility, demand and quality of health services			
1	% of PHC facilities in which BSP is implemented by trained staff	output	08-12
2	% of districts with functional evacuation and referral system	output	08-12
3	% of hospitals with developed business plan being implemented	output	09-12
4	% of TL covered by a programme of community based health services	outcome	08-12
5	% of district depots that experienced stock outs of tracer drugs in the course of the year.	outcome	08-12
6	# of formal of private sector- MOH partnership contracts signed.	output	09-12
7	# of districts, where responsibilities for health care have been transferred to municipal authorities	outcome	09-12
Goal 2: Strengthened support services and management			
8	% of planned measures towards capacity building implemented	output	08-12
9	MOH revised organogram and institutional framework for HSSP coordination implemented	output	08-09
10	Redistribution of staff, according to norms and rational needs implemented	output	08-09
11	% of projected additional staff trained and recruited	output	07-09
12	# of planned trainings and clinical practica organised/ implemented by ICS	outcome	08-12
13	incentive system for executive performance management operational	output	09-12
14	# of tracer drugs (essential) for which there has been a central level stock out in a given year.	outcome	07-12
15	% of prescriptions by health facilities according to protocol	outcome	08-12
16	% of biomedical equipment in hospitals that is out of order (non-functional) at a given point in time.	outcome	08-12
Goal 3: Strengthened coordination, planning and monitoring			
17	# of practical & articulated guidelines for policy documents produced and disseminated in a given year	output	08-12
18	% of scheduled coordination meetings carried out in a given year.	output	07-12
19	% of annual intersectoral action plans that was carried out in a given year.	output	09-12
20	% of departments and district teams implementing new planning and budgeting system.	output	07-12
21	% of HMIS reports (revised) compliance in a given year.	outcome	08-12
22	% of JASR recommendations followed up with decisions and actions	output	07-12

Risks and Assumptions

In the real world things sometimes happen that can seriously hinder the successful achievement of the best written plans. Through asking 'what if…?' repeatedly the MOH has concluded that the risks in Box 7 below are the most likely risks that could jeopardise the HSSP. Therefore they are the ones that need to be flagged during the implement phase. While developing the various strategies the MOH also noted the range of assumptions that underlie successful implementation. Close monitoring and evaluation of these assumptions will help in monitoring progress towards achievement of the desired outcomes.

Box 7: Risks and assumptions

Risks
- Poor macroeconomic growth reducing government allocation to health sector
- Interruption of support from international agencies as a result of changes in their policies or because of political instability
- Forthcoming elections and potential for prolonged political instability
- Resistance to change within the MOH and overall government especially concerning legislative review and human and financial resource management
- Incentives (including salary increases for the health workforce) are not introduced
- Inadequate attention to health promotion, BCC and health seeking behaviour
- Inadequate integration of vertical services and programs
- Limited improvement in quality of care

Assumptions
- Continuing solid economic growth
- Improved stability of the political situation in the country
- Political and bureaucratic will and commitment to reform the MOH in response to functional analysis recommendations and as a consequence of HSSP directives
- Continuity of resource availability (governmental and international donor)
- Enhanced management and clinical service capacity
- Broadening and meaningful collaboration between the public and private sectors of the health system

Overall, the HSSP:

- Reflects the need to think creatively for successful outcomes
- Highlights pro-poor interventions
- Links strategies and outcomes with targets and indicators based on micro-policies, priority health and disease challenges and key areas of work
- Takes an incremental approach to change. There is no sudden, surprisingly big change to be faced without adequate lead time to digest its impact
- Is not prescriptive it encourages flexibility at different tiers of the health system
- Recognises that improving health status in Timor-Leste depends not only on health sector activities but also on initiatives within communities and other sectors

Introduction to micro-policy prioritisation and integration

Since 2002 the MOH has devoted significant attention to the drafting of "micro-policy" documents that build on the principles espoused in the National Development Plan and the Health Policy Framework Paper. With technical assistance, the Ministry has tackled this task energetically and has developed a raft of strategic documents that aim to address many of the major health challenges facing the nation.

The MOH has now entered the next phase in its strategic planning work. The Basic Services Package has been approved and the organisation has resolved to optimise effective service and programme integration. These two circumstances provide impetus for the development of strategic guidelines in areas yet to be addressed and for an overall prioritisation of strategic initiatives that will assist efforts to meet Millennium Development Goals and other key targets.

The World Bank has remarked on the essential quality of the micro-policy documents that the MOH has prepared to date. However, it has also warned of the risk that prolific policy development can outstrip implementation and monitoring and evaluation capacity. This is especially so in cases where policy documents provide only limited implementation guidelines.
The MOH accepts these assessments and is intent on ensuring that its strategic policy-making allows for:

- The prioritisation of services and programmes according to the major target areas identified in the BSP, namely: MDG4: neonatal care, infant and young child feeding, IMCI and immunisation; MDG 5: skilled birth attendance at facilities and BEOC; MDG 6: HAST
- The horizontal integration of strategic activities across services and programmes within a comprehensive and consistent prevention, control and promotion framework that acknowledges commonalities in approaches where appropriate, combined with disease-specific interventions and risk behaviour-specific actions
- Sufficient operational direction and guidance within its micro-policy catalogue to promote effective implementation within the context of increasing organisational capacity and sustained financial commitment within a SWAp framework

The presentation of entries in Section 4 of the HSSP flags the major areas of strategic integration and reduces potential for disjointed and wasteful implementation actions. Each entry provides guidance on needed revisions to existing strategies or direction on strategy development that is required to address currently un-drafted fields (for example, the Non-Communicable Disease domain). In the former case, the entries consider the adequacy of existing strategic statements and propose, where necessary, modifications or additions to reflect new local epidemiological circumstances or best practice knowledge. In the latter case, the entries provide details of internationally accepted principles and concepts that can be applied meaningfully in the Timor-Leste context.

Each entry ends with a brief summary of activities fundamental to the socialisation and implementation of strategic priorities at central and devolved levels. These activities are specified according to the three core HSSP goals:

- Service and programme activities
- Management and support activities
- Monitoring and coordination activities

Detailed Service and Programme Policies – Primary Health Care

Detailed Service and Programme Policies – Primary Health Care

Integrated Management of Childhood Illnesses

Major HSSP Emphasis: **Goal 1**

Key Documents: NDP, HPFP, Basic Services Package, National Integrated Management of Childhood Illnesses Strategy (including the Community Integrated Management of Childhood Illnesses Component), Standards of Midwifery Practice for Safe Motherhood in Timor-Leste, Basic Emergency Obstetrical and Neonatal Care Training for Health Providers at National and Referral Hospitals, National Immunisation Strategy, Family Health Promoter (FHPP) National Guideline, all communicable disease strategies, National Nutrition Strategy, National Reproductive Health Strategy, National Health Promotion Strategy, Intersectorial Action Framework for Wellbeing and Health, WHO (2006) Integrated Management of Pregnancy and Childbirth: Standards for Maternal and Neonatal Care, WHO (2005) Improving Maternal, Newborn and Child Health in the South East Asia Region, WHO, New Delhi, relevant child health legislation

Important Strategic Documents not yet drafted: MOH Referral Strategy and related policies and protocols, relevant hospital child health protocols and guidelines emerging from BSP directives

Situational Analysis: Because of its simplicity and cost-effectiveness, IMCI has been adopted by many developing countries as the preferred mode of primary health care delivery for priority childhood disease conditions. The methodologies underlying the strategy are based on the use of endorsed soft technologies (for example, appropriate low cost and efficacious drug therapies), avoidance of unnecessary laboratory testing, and the symptomatic management of episodes of care based on well established and evidence-based diagnostic, treatment and referral protocols.

Timor-Leste has used the IMCI approach to provide health care workers, many of whom have had only limited opportunity for training beyond basic levels, with a model of how to proceed in the clinical encounter. Development partners have provided significant initial and ongoing IMCI skilling and follow-up assessment.

Traditionally, Timor-Leste midwives and nurses have provided all IMCI services for children

between the ages of one week and five years. The services have been based on internationally developed standards and protocols adapted for local use and reproduced in the Standard Booklet known as the "Buku Bagan".

While the implementation in Timor-Leste of IMCI principles and systems has been regarded universally as a strong contributor to the goal of improving child health, national childhood health status indicators remain poor. Four issues of relevance arise from this brief situational analysis.

First is the issue of how well IMCI methods are applied locally. Recent assessment of IMCI capacity at district and sub-district levels suggests that initial orientation and skilling in IMCI needs to be followed by a sustained and systematic programme of in-service consolidation. IMCI-trained clinicians have been observed to practice outside IMCI guidelines and to be unable to account for such actions. The BSP highlights the need for maintenance of skills in approved policy areas – such as IMCI - through ongoing in-service training and local mentorship and coaching.

Second, the effectiveness of the requisite health system infra-structure to support local IMCI efforts is problematic. Supervisory and monitoring roles and related functional responsibilities at different tiers of the system are not uniformly appreciated nor applied. Nor is basic equipment for IMCI practice universally available. The difference between current and optimal support arrangements can be measured by considering the required standards outlined in the BSP.

Third, the extent to which community engagement has generated adequate and appropriate sharing of responsibilities for strengthening child health is limited. The current IMCI policy document, although including a community component, does not project a genuinely integrated and community-oriented approach to child health care.

Fourth, the advent of a large number of generalist doctors working at district and sub-district facilities throughout the Timor-Leste public health system has introduced diagnostic, treatment and referral complexities previously unknown. Many of the doctors have had limited, if any, exposure to IMCI modalities with evidence that medical management of childhood illnesses and conditions tends to ignore or downplay IMCI principles.

Recently, the MOH reaffirmed its commitment to IMCI as its preferred approach to child health care by approving the long-awaited BSP. A January 2007

	version of the Accord Agreement between Timor-Leste and Cuba stipulates the obligation of the Cuban medical brigade to follow approved MOH policies.
Objective:	**To improve the health and wellbeing of Timor-Leste children under five years of age through the introduction, maintenance and monitoring of an appropriately tailored and comprehensive IMCI package of child health care services available and delivered on the basis of the role and functional delineations outlined in the BSP**
Strategy 1:	**Revise and update the current IMCI Strategic Policy document to provide additional guidance on identified priority areas, to accommodate the service and programme directives of the BSP and to better integrate community engagement within the core strategic areas**
Indicator 1:	Revised IMCI policy document available and used
Strategy 2:	**Improve and consolidate child-specific case management knowledge and skills of all health practitioners**
Indicators 2:	Full range of approved IMCI services and programmes operational Relevant IMCI priorities translated into practical time-bound and achievable actions (log frame) for CPD and in-service education IMCI M&E institutionalised IMCI capacity development institutionalised and incorporated in HIS calendar
Strategy 3:	**Improve the capacity of the health system to support the delivery of C-/IMCI services according to the roles and functional delineations noted in the BSP**
Indicators 3:	Adequate IMCI support systems in place and being utilised Management and leadership training scheme institutionalised and supported financially TA assistance in IMCI recording and data collection and analysis Approved referral system in place and being utilised appropriately for IMCI patients
Strategy 4:	**Improve family engagement and community practices to ensure an integrated approach to IMCI throughout Timor-Leste**

Indicators 4:

Effective IMCI monitoring, evaluation and coordination systems in place

MOH policy and financial support for community consultation

District and sub-district forums established and conducted

Family health promoter programme operational and functioning well and contributing to IMCI effectiveness

IMCI BCC/BCI materials available and used

Implementation Summary:

Programme and Service Activities

Confirm IMCI priority areas according to BSP and relevant MDG targets

Translate the relevant IMCI priorities from the BSP into practical, time-bound and achievable actions (log frame)

Ensure optimal integration of IMCI within all health facilities at both community and referral levels according to the distinctive roles and service directives of the BSP

Develop and strengthen family and community participation and engagement systems to support appropriate IMCI concepts and practices

Management and Support Activities

Manage, supervise and champion IMCI priorities across all tiers of the health system

Consolidate and systematically extend IMCI capacity development across the health workforce

Establish and apply appropriate on the job assessment and training to improve the quality and coverage of IMCI services to approved standards

Ensure effective financial, procurement and distribution systems to guarantee the availability of adequate supplies of essential equipment, assets and other resources for effective IMCI practice

Develop and implement universal referral procedures to ensure appropriate articulation of IMCI practices

Monitoring and Coordination Activities

Establish and apply appropriate monitoring and assessment systems to promote IMCI quality, consistency and conformity to approved standards

Engage inter-sectorally across government and the private sector to promote and institutionalise the benefits of IMCI

Establish and promote partnership arrangements with NGOs, community-based agencies and health service consumers locally to embed IMCI strategies

Collaborate with all major stakeholders in operationalising IMCI strategic priorities

Assumptions and Risks: Many of the strategies noted are dependent on the availability of significant financial, human and other resources. Equally important, however, is the need for clear and energetic political and policy commitment to follow through and sustain strategies that will often require extended lead time to demonstrate positive benefits. It is assumed that the necessary resources will be made available to support the strategies listed and that political and administrative commitment will remain strong. Lack of any of these fundamental inputs jeopardises the viability of the IMCI programme.

Time Frame: The five year timeframe of the HSSP (2008-2012) will be insufficient to see the resolution of many of the IMCI challenges facing Timor-Leste. Progress will be incremental in many cases. It is important, therefore, that an early start begin in:

- human resource capacity building
- developing scientifically sound and culturally sensitive legislation, protocols and guidelines
- consolidating a promising beginning to inter-sectoral teamwork, and
- engaging with local communities and population sub-groups

Accordingly, it is recommended that the first two years of the current HSSP cycle, in particular, should be devoted to these four critical foundation areas. Rolling revisions to the HSSP should be responsive to continuing need in these areas.

Detailed Service and Programme Policies – Primary Health Care

Nutrition for children and adults

Major HSSP Emphasis: **Goal 1**

Key Documents: NDP, HPFP, Basic Services Package, National Nutrition Strategy, Guidelines for the Inpatient Management of Children with Malnutrition in Timor-Leste, National Immunisation Strategy, National Reproductive Health Strategy, Maternal Food Supplementation Strategy, National School Health Programme (Draft), Inter-Sectorial Action Framework for Wellbeing and Health, National Integrated Management of Childhood Illness Strategy, National Environmental Health (umbrella) Strategy, National Iodised Salt Strategy, National Health Promotion Strategy, National Food Security Policy, relevant public health legislation on food safety

Important Strategic Documents not yet drafted: Guidelines for infant and young child feeding (IYCF), guidelines for supplementary feeding programmes, food safety policy, regulations, guidelines and protocols relating to major features of food processing and handling (currently under development by the Food Working Group)

Situational Analysis: The nutritional status of both children and adults in Timor-Leste remains significantly below acceptable world standards. As the National Nutritional Strategy notes, under-nutrition is brought about by a combination of broad economic, political, educational and cultural features of a society. In the case of Timor-Leste a combination of poverty, low employment, limited education, poor infant deeding practices, high levels of food insecurity and poor hygiene and sanitation has led to under-nutrition rates for young children that are among the highest in the world. So serious is the situation, that malnutrition is estimated to contribute to over half of all under five deaths in neonatal, under one and under five year age groups. Findings of the Timor-Leste DHS and more recent surveys highlight the enormity of the problem of malnutrition in young children and women in particular. For children:

- Almost 50% are underweight-for-age
- 15% are severely underweight-for-age
- Almost 50% of children under five years are stunted
- Almost 30% are severely stunted

Adequate nutrition in the first years of life is essential for children's physical and mental growth. Children

who were malnourished as infants do not do well at school.

Overall adult nutritional status is also a concern, especially for women. More than a third of non-pregnant women aged 15-49 and a quarter of men aged 15-49 are reported to be chronically underweight with Body Mass Indexes below 18.5. Fourteen percent of women are shorter than 145 cm, at which level pregnancy and delivery complication risks increase significantly. Other than children and women of reproductive age, the population sub-groups most vulnerable to the ravages of under-nutrition are, of course, the poor, people with disabilities, the elderly and those from disadvantaged rural areas.

UNICEF's conceptual framework for the causality of under-nutrition draws attention in Timor-Leste to inadequacies in dietary intakes across the age spectrum, low levels of exclusive breast feeding, micronutrient deprivation, extremely poor household food security, inadequate family attention to childhood illnesses, poor maternal health, high fertility rates overall and for teenage women in particular, and sub-optimal environmental sanitation.

High rates of malnutrition across all groups, but young children and women in particular, contribute to poor health status, poor educational performance, and low productivity for the nation as a whole.

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

Objective: **To implement a range of appropriate interventions that will improve the nutritional status of all citizens in Timor-Leste, in particular vulnerable population sub-groups**

Strategy 1: **Raise awareness of the gravity of the nation's major nutritional health problems and consequences and flag potential solutions at international and national levels, across government instrumentalities, NGO, UN agencies, other development partners, the media and most importantly with communities and families**

Indicators 1: Intersectoral/inter-agency agreements signed, publicised and supported

	Adequate nutrition resources available and used Nutrition-centred agreements and collaboration functioning well)
Strategy 2:	**Ensure BSP-appropriate nutritional health interventions (services and programmes) for the protection of foetal and infant growth (including Infant and Young Children Feeding protocols)**
Indicators 2:	Enhanced nutrition status according to MDG key performance indicators (see relevant entries in BSP Annex 4: MDG 4) Facilities providing nutrition services and programmes according to prescribed role
Strategy 3:	**Engage with communities in the development of locally appropriate and integrated processes and caring behaviours that contribute to the protection of foetal and infant growth**
Indicators 3:	Local compliance to BSP process and outcome indicators relevant to nutrition (see appropriate indicators in BSP Annexes 1 and 4) Nutrition outreach services operational and effective
Strategy 4:	**Improve the nutritional status of pregnant and lactating women (including the reduction of iron deficiency anaemia, Vitamin A deficiency) and of women of reproductive age generally**
Indicators 4:	National programme of nutrient supplementation operational and functioning well Nutrient supplementation statistics utilised in decision-making locally and centrally
Strategy 5:	**Improve food security**
Indicators 5:	Food security system operational and regulated and functioning well Inter-government cooperation on nutrition issues working effectively Local home food gardens being monitored
Implementation Summary:	**Programme and Service Activities**
	Confirm and socialise nutrition priority areas according to BSP and relevant MDG targets Ensure optimal integration of nutrition activities within all health facilities at both community and referral levels according to the distinctive roles and service directives of the BSP Develop and strengthen family and community participation and engagement in the full range of nutrition services

Management and Support Activities

Manage, supervise and champion nutrition priorities across all tiers of the health system
Consolidate and systematically extend nutrition capacity development across the health workforce
Establish and apply appropriate on the job assessment and training to improve the quality and coverage of nutrition services to approved standards
Ensure effective financial, procurement and distribution systems to guarantee the availability of adequate supplies of essential equipment, assets and other resources for effective nutrition services
Develop and implement universal referral procedures for moderately and severely malnourished children

Monitoring and Coordination Activities

Establish and apply appropriate monitoring and assessment systems to promote nutrition quality, consistency and conformity to approved standards
Establish and promote partnership arrangements with NGOs, community-based agencies and health service consumers locally to embed quality nutrition services
Collaborate with all major stakeholders in operationalising nutrition strategic priorities
Engage inter-sectorally across government and the private sector to advocate for legislation on iodised salt and a national code of marketing of breast-milk substitutes, and for improvements in national and household food security

Assumptions and Risks:

Many of the strategies noted are dependent on the availability of significant financial, human and other resources. Equally important, however, is the need for clear and energetic political and policy commitment to follow through and sustain strategies that will often require extended lead time to demonstrate positive benefits. It is assumed that the necessary resources will be made available to support the strategies listed and that political and administrative commitment will remain strong. Lack of any of these fundamental inputs jeopardises the viability of the nutrition health programme.

Time Frame:

The five year timeframe of the HSSP (2008-2012) will be insufficient to see the resolution of many of the nutritional challenges facing Timor-Leste. Progress will be incremental in many cases. It is important, therefore, that an early start begin in:

- human resource capacity building
- developing scientifically sound and culturally sensitive legislation, protocols and guidelines

- consolidating a promising beginning to inter-sectoral teamwork, and
- engaging with local communities and population sub-groups

Accordingly, it is recommended that the first two years of the current HSSP cycle, in particular, should be devoted to these four critical foundation areas. Rolling revisions to the HSSP should be responsive to continuing need in these areas.

Detailed Service and Programme Policies – Primary Health Care

Immunisation for children and adults

Major HSSP Emphasis: **Goal 1**

Key Documents: Key Documents: NDP, HPFP, Basic Services Package, National Immunisation Strategy (Revised Version February 2007), National Reproductive Health Strategy, Inter-Sectorial Action Framework for Wellbeing and Health, National Integrated Management of Childhood Illness Strategy, Family Health Promoter (FHPP) National Guideline, relevant legislation on maternal and child health,

Key Resources: WHO and UNICEF Global Immunisation Vision and Strategy 2006-2015 and other WHO policy and guideline documents on immunisation and related child and maternal health strategies

Key Websites: http://www.who.int/immunization/givs/en/index.html

Important Strategic Documents not yet drafted: Nil

Situational Analysis: The systematic implementation and monitoring of "best practice" national programmes of immunisation (linked with other acknowledged health care interventions such as Vitamin A supplementation and the use of insecticide-treated nets for malaria prevention) has led to remarkable global health status improvements – in particular for mothers and children. However, not all countries have experienced the same level of positive health enhancement. Nor have health gains been uniform within countries, with local differences in immunisation coverage leading to inconsistent health status advance.

In Timor-Leste, there is evidence to suggest that since independence from Indonesia the level of immunisation coverage for all conditions has decreased although there are regional exceptions and some recent improvements overall. Unreliable, incomplete and conflicting data make strong assertions on this issue problematic. Yet it is likely that, despite a relatively well organised immunisation system, patchy coverage has contributed to continuing high morbidity especially in young children and mothers.

Immunisation can prevent a range of illnesses – polio, diphtheria, tuberculosis, pertussis, measles, Hepatitis B and tetanus. However a system is only effective if structures are matched by adequate implementation

initiatives. It is here that Timor-Leste's problems are greatest. Sustainable local community activities involving appropriate human and other resources, supported by devolved and central monitoring and control mechanisms and championed by good leadership are essential components of an effective programme. Furthermore, as noted in the WHO/ UNICEF "Global Immunisation Vision and Strategy" document (p. 13), "integrating immunisation [and] other linked health interventions and surveillance … emphasises the role of immunisation in … building human resource capacity, improving logistics and securing financial resources". Currently, Timor-Leste is missing out on these compounding and cross-cutting advantages.

The limited evidence available suggests that from a demand/ consumerist perspective, immunisation rates in Timor-Leste vary according to socio-economic and education status, time taken to reach a health facility and, perhaps, regionality (urban versus rural). Mothers and children from poorer families, with limited education and living in rural settings are more likely not to have completed a full immunisation course (for example, the three dose DPT regime) than their wealthier, better educated and urban dwelling counterparts.

Moreover, compared to other South East Asian countries with similar levels of per capita GDP, Timor-Leste shows relatively lower immunisation rates overall (see Table 8 below).

Table 8: Immunisation Coverage in Timor Leste 2001-2006

	OPV3	BCG	DPT3	MCV
2002	43%	66%	44%	39%
2003	57%	72%	57%	55%
2004	57%	72%	57%	55%
2005	55%	70%	55%	48%
2006	65%	74%	67%	64%

Source: MOH EPI 2006

There is one important finding emerging from a meta-analysis of the various studies conducted in Timor-Leste on utilisation of health services that warrants further attention in terms of childhood immunisation rates in particular. This is the association between wealth and immunisation. Given that vaccines are provided free of charge, the significance of indirect costs (travel and opportunity costs for the family from a mother taking a child to a health facility, etc.) need to be assessed in terms of the value of providing mass immunisation campaigns locally for children with poor health facility access.

Timor-Leste has progressed far in the area of immunisation but the journey is a long way from over. The successes of the past must be recalled to encourage health providers, their managers and service communities to work together to sustain the momentum in order to reach the following objective (and related goals and targets).

Objective:

To prevent morbidity and mortality in Timor-Leste by pursuing the following immunisation goals and targets:

- **Increased and sustained improvements in access and equity to improve immunisation coverage overall (GLOBAL TARGETS: 90% COVERAGE NATIONALLY BY 2010; 80% SUB-NATIONAL MINIMUM TARGETS BY 2010)**
- **Reduction of morbidity and mortality in vaccine-preventable diseases (GLOBAL TARGET: REDUCE MEASLES MORTALITY BY 90% COMPARED TO 2000 LEVEL BY 2009)**
- **Increased availability of vaccines of assured quality**
- **Introduction and widespread use of new vaccines**
- **Increased capacity for surveillance and monitoring**
- **Consistently reliant systems of immunisation nationally**

Strategy 1:

Increase access in Timor-Leste to immunisation services to all especially those from vulnerable population sub-groups - the poor, the uneducated and the "hard to reach"

Indicators 1:

New immunisation policy implemented and functional

MOH executive focus on immunisation services and programmes

New immunisation policy socialised nationally

BSP—compliant integrated and comprehensive immunisation programme operational and functional

uality immunisation services provided – regular services, well publicised, safe and locally appropriate to match need and promote demand

Immunisation strategies applied locally on the basis of appropriate district and sub-district plans

Immunisation HRD needs determined and HRD plan developed and implemented

Strategy 2:

Strengthen national capacity in Timor-Leste to determine and set policies and priorities for new vaccines and technologies

Indicators 2:

Immunisation rates approach target levels for vulnerable population sub-groups

New vaccines and technologies adopted appro-priately

	Appropriate in-service and CPD immunisation programmes scheduled and course participants graduating
	Appropriate in-service and CPD immunisation programmes scheduled and course participants graduating
	Situational analysis of barriers to use of vaccines conducted and findings acted upon
Strategy 3:	**Integrate immunisation, other linked health interventions and surveillance in the Timor-Leste health system**
Indicators 3:	Analysis of immunisation statistics used in decision-making locally and centrally
	Strategic use of immunisation situational analysis across the health sector. "Success stories" replicated and institutionalised
	Audit conducted, results disseminated and considered actions taken
	Incentive scheme supported and operationalised
Implementation Summary:	**Programme and Service Activities**
	Confirm and socialise immunisation priority areas according to BSP and relevant MDG targets Ensure optimal integration of immunisation activities within all health facilities at both community and referral levels according to the distinctive roles and service directives of the BSP Develop and strengthen family and community participation and engagement systems to support appropriate immunisation practices
	Management and Support Activities
	Manage, supervise and champion immunisation priorities across all tiers of the health system Consolidate and systematically extend immunisation capacity development across the health workforce Establish and apply appropriate on the job assessment and training to improve the quality and coverage of immunisation services to approved standards Ensure effective financial, procurement and distribution systems to guarantee the availability of adequate supplies of essential equipment, assets and other resources for effective immunisation services Develop and implement universal referral procedures to ensure appropriate articulation of immunisation services

Monitoring and Coordination Activities

Establish and apply appropriate monitoring and assessment systems to promote immunisation quality, consistency and conformity to approved standards
Engage inter-sectorally across government and the private sector to promote and institutionalise the benefits of immunisation
Establish and promote partnership arrangements with NGOs, community-based agencies and health service consumers locally to embed immunisation strategies
Collaborate with all major stakeholders in operationalising immunisation strategic priorities

Assumptions and Risks:

Many of the strategies noted are dependent on the availability of significant financial, human and other resources. Equally important, however, is the need for clear and energetic political and policy commitment to follow through and sustain strategies that will often require extended lead time to demonstrate positive benefits. It is assumed that the necessary resources will be made available to support the strategies listed and that political and administrative commitment will remain strong. Lack of any of these fundamental inputs jeopardises the viability of the immunisation programme.

Time Frame:

The five year timeframe of the HSSP (2008-2012) will be insufficient to see the resolution of many of the immunisation challenges facing Timor-Leste and the attainment of the global targets noted in the previously cited WHO/UNICEF document. The relevant immunisation-related MDG targets specified in the BSP are more modest. They provide a benchmark for the MOH to assess progress towards global targets. Progress will be incremental in many cases. It is important, therefore, that an early start begin in:

- human resource capacity building
- developing scientifically sound and culturally sensitive
- legislation, protocols and guidelines
- consolidating a promising beginning to inter-sectoral teamwork, and
- engaging with local communities and population sub-groups

Rolling revisions to the HSSP should be responsive to continuing need in the various areas noted above.

Detailed Service and Programme Policies – Primary Health Care

Reproductive Health and Family Planning

Major HSSP Emphasis: **Goal 1**

Key Documents: NDP, HPFP, Basic Services Package, National Reproductive Health Strategy 2004-2015, National HIV/AIDS Strategy, Intersectorial Action Framework for Wellbeing and Health, National Integrated Management of Childhood Illness Strategy, National Family Planning Policy, Family Health Promoter (FHPP) National Strategy and Implementation Guidelines, National Health Promotion Strategy and relevant WHO/UNFPA strategic documents on reproductive health

Important Strategic Documents not yet drafted: Relevant policies and guidelines on adolescent health and men's health

Situational Analysis: In Timor-Leste more is known about reproductive health and family planning than about almost any other feature of the epidemiological and cultural profiles of the nation. This is because the major source for much of the country's health-specific data, the 2003 Demographic Health Survey – like all such investigations - focuses largely on women of reproductive years and on infants and young children. Findings from other similar surveys together with strengthening HMIS data, confirm that Timor-Leste has:

- High maternal mortality and morbidity rates
- High perinatal and neonatal mortality rates
- Low rates of adequate antenatal care and professionally assisted deliveries
- A high fertility rate (6.7) with short birth intervals and limited fertility regulation
- An adolescent population at high risk of sexually transmitted infections including HIV/AIDS
- A population that is poorly informed overall on health matters and on sexual and reproductive health choices in particular

Utilisation of antenatal, birthing and postnatal services by women in Timor-Leste is extremely low. Less than 60% of pregnant women attend even one antenatal session (let alone the desired four) while 90% of all births occur in the home. Involvement of skilled attendants at births is less than 20& - a major factor in the high rate of neonatal mortality.

Rigorous information on health seeking behaviour in Timor-Leste remains illusory with the long awaited national study yet to be conducted. Nevertheless, anecdotal evidence suggests that there are several systems barriers that act to influence non-utilisation of government services by pregnant women. Lack of adequate space and basic facilities within health centres and health posts are major deterrents to use. Inadequate numbers and deployment of clinical staff skilled in reproductive health practice continue to have a detrimental effect on service quality. Compounding this situation are ineffective control and monitoring systems, poor application of management and supervision processes, and a fragile drugs and medical supplies procurement and distribution system. In combination, these factors provide some insight into why so many women select not to attend public health care facilities for reproductive health care.

Beyond the health system itself, there are other well described external barriers to health seeking behaviour among pregnant women in Timor-Leste. In the BSP the "three delay model" of utilisation is described at length. Readers are directed to the BSP documentation for further details.

The MOH has produced a comprehensive, sensitive, well integrated, life-cycle oriented and rights-based strategic policy document on reproductive health and family planning services and programmes. The Ministry's inter-sectoral engagement and collaboration with faith-based organisations, NGOs and UN agencies in the health arena has been consistent and considered. Nevertheless, only limited progress has been made in improving Timor-Leste's reproductive health status over the past five years. With the production of the BSP and more directive policy on delineated service and programme roles across the public health sector, the opportunity must be grasped to affirm reproductive health and family planning policy priorities, and to identify, implement and monitor appropriate service delivery and programme roles and functions.

Objective:

To ensure that the people of Timor-Leste can:

- Experience healthy sexual development
- Enter into responsible relationships and enjoy sexual fulfilment
- Make considered judgments about family planning matters
- Avoid illness and disease related to sexuality and reproduction
- Receive appropriate reproductive and family health care and/or counselling when needed
- Be free from violence and other harmful practices related to sexuality and reproduction

Strategy 1 (Safe Motherhood):	**Revise and update the current Reproductive Health and Family Planning Strategic Policy document to provide additional guidance on determined priority areas and to accommodate the service and programme directives of the BSP**
Indicator 1:	Revised policy document available and used
Strategy 2 (Safe Motherhood):	**Increase the level of awareness in the population about matters relating to pregnancy and childbirth**
Indicators 2:	BCC/BCI campaigns prepared and conducted BCC/BCI materials prepared and disseminated
Strategy 3 (Safe Motherhood):	**Improve utilisation rate and quality of institutionally-based comprehensive maternity and new born services (prenatal, delivery, postnatal and perinatal health care in keeping with the role delineation directives of the BSP)**
Indicators 3:	RH & FP capacity reflects BSP directives District-based delivery plans produced and operationalised Health facilities BSP-compliant in RH and FP services and programmes IHS Community Midwife Diploma developed, conducted and graduates emerge with exit competencies reflecting priority activities documented in the BSP RH & FP policies, protocols, practices and competencies socialised within medical cadre and MOH monitoring and regulation system in place to ensure compliance CPD and in-service education programmes conducted for RH & FP practitioners MOH monitoring system operational and applied Revisions of activities and indicators undertaken and necessary changes implemented
Strategy 4 (Young People):	**Strengthen the provision of information to, and capacity development of reproductive health and family planning skills for young people, families and communities to assist in achieving an optimal level of health and development in young people**
Indicator 4:	Appropriate inclusion of youth-sensitive material in school curricula Youth oriented BCC campaigns developed and conducted

Strategy 5 (Young People):	**Increase accessibility to a wide range of suitable young person-friendly reproductive health and reproductive choice services and programmes**
Indicators 5:	Suitable range of young-person-friendly RH & FP services and programmes available and utilised Facilities oriented to provide youth-friendly RH & FP services and programmes
Strategy 6 (Family Planning):	**Increase community knowledge and awareness about reproductive choice to assist in behaviour change**
Indicators 6:	RH & FP legislation enacted Appropriate BCC/BCI materials available and used Facility staff competent in, and supportive of, informed choice concepts and practices Health facilities BSP-compliant in FP services and resourced appropriately Facility staff competent in, and supportive of, informed choice concepts and practices Appropriate BCC/BCI materials available and used
Strategy 7 (General Reproductive Health):	**Increase overall commitment across the MOH and partner organisations to sexual and reproductive health services for men and women**
Indicators 7:	Appropriate RH & FP services, programmes and commodities available, used and distributed appropriately Integration of STIs and HIV/AIDS services and programmes supported and sustained
Strategy 8:	**Legislate to assist in suppressing gender-related and sexual violence**
Indicators 8:	MOH and partners advocate for legislation to combat gender-related and sexual violence Programmes of community engagement on matters of gender-related and sexual violence developed and implemented
Strategy 9:	**Provide confidential, sensitive and culturally and religiously appropriate health care services and counselling responses to victims of gender-related and sexual violence**
Indicators 9:	Gender sensitive services are accessible for all from trained health professionals based on established protocols and systems All at-risk groups can access, and are provided with appropriate reproductive health services

Voluntary counselling and testing for HIV/AIDS is available and provided to all pregnant women
All women are informed about, and have access to service options for victims of gender-related and sexual violence

Implementation Summary:

Programme and Service Activities

Confirm and socialise reproductive health and family planning priority areas according to BSP and relevant MDG targets
Ensure optimal integration of reproductive health and family planning services within all health facilities at both community and referral levels according to the distinctive roles and service directives of the BSP
Develop and strengthen family and community participation and engagement in the full range of reproductive health and family planning programmes and services

Management and Support Activities

Manage, supervise and champion reproductive health and family planning priorities across all tiers of the health system
Consolidate and systematically extend reproductive health and family planning capacity development across the health workforce
Establish and apply appropriate on the job assessment and training to improve the quality and coverage of reproductive health and family planning services to approved standards
Ensure effective financial, procurement and distribution systems to guarantee the availability of adequate supplies of essential equipment, assets and other resources for effective reproductive health and family planning services
Develop and implement universal referral procedures to ensure appropriate articulation of reproductive health and family planning services

Monitoring and Coordination Activities

Establish and apply appropriate monitoring and assessment systems to promote reproductive health and family planning quality, consistency and conformity to approved standards
Establish and promote partnership arrangements with NGOs, community-based agencies and health service consumers locally to embed quality reproductive health and family planning services
Collaborate with all major stakeholders in operationalising reproductive health and family planning strategic priorities
Engage inter-sectorally across government and the private sector to advocate for legislation designed

to promote desired reproductive health and family planning principles and concepts

Assumptions and Risks: Many of the strategies noted are dependent on the availability of significant financial, human and other resources. Equally important, however, is the need for sustained political commitment to follow through with strategies that will often require extended lead time to demonstrate positive benefits. It is assumed that the necessary resources will be made available to support the strategies listed and that political and administrative commitment will remain strong. Lack of any of these fundamental inputs risks the viability of the reproductive health and family planning programme.

Time Frame: The five year timeframe of the HSSP (2008-2012) will be insufficient to see the resolution of many of the reproductive health and family planning challenges facing Timor-Leste. Progress will be incremental in many cases. It is important, therefore, that an early start begin in:

- human resource capacity building
- developing scientifically sound and culturally sensitive legislation, protocols and guidelines
- consolidating a promising beginning to inter-sectoral teamwork, and
- engaging with local communities and population sub-groups

Accordingly, it is recommended that the first two years of the current HSSP cycle, in particular, should be devoted to these four critical foundation areas. Rolling revisions to the HSSP should be responsive to continuing need in these areas.

Detailed Service and Programme Policies – Primary Health Care

Health Promotion and Education

Major HSSP Emphasis: **Goal 1**

Key Documents: NDP, HPFP, Basic Services Package, National Strategy for Health Promotion 2004-2010, Family Health Promoter (FHPP) National Guideline, Draft School Health Programme National Guideline, Intersectorial Action Framework for Wellbeing and Health, all communicable disease strategies, National Nutrition Strategy, National Reproductive Health Strategy, National HIV/AIDS Strategy, Inter-Sectorial Action Framework

Key Resources:

Hancock, T. (1999) "Creating Health and Health Promoting Hospitals: A Worthy Challenge for the Twenty-First Century", *International Journal of Health Care Quality*, Vol. 12, No. 2, pp. 8-19

Health Promotion Unit, NSW Health (1994) *Programme Management Guidelines for Health Promotion*, NSW Health, Sydney

Heenan, D. (1994) "A Partnership Approach to Health Promotion: A Case Study from Northern Ireland", *Health Promotion International*, Vol. 19, No. 1, pp. 105-113

Nutbeam, D. (1998) *Health Promotion Glossary*, WHO Collaborating Centre for Health Promotion, Department of Public Health and Community Medicine, University of Sydney, Sydney and WHO, Geneva

Western Pacific Regional Office (2002) *Regional Framework for Health Promotion: Building on the Successes of Healthy Settings*, WPRO, WHO, Manila

WHO (1996) "Healthy Cities", *World Health Forum*, Vol. 19, No. 1

WHO (1986) *Ottawa Charter for Health Promotion*, WHO, Geneva

WHO (1997) *The Jakarta Declaration on Leading Health Promotion into the 21st Century*, WHO, Geneva

Useful Websites:

www.healthycities.org
www.nt.gov.ah/health_promotion/bushbook
www.who.dk/tech/hs/hphbroc/htm
www.fhi.org/en/HIVAIDS/pub/guide/BCC+Handbooks/

Important Strategic Documents not yet drafted: Men's Health Strategy, Adolescent Health Strategy, National Health Promoting Schools Strategy, Health Promoting Facilities Strategy, National Workplace Health Promotion Strategy, National Umbrella NCD Strategy, National Remote Area Strategy, and a

Behaviour Change and Communication/Intervention (BCC/BCI) Communication/Mass Media Strategy

Situational Analysis:

Globally, health education as a strategy for achieving health status advance has been integrated into the broader concept of health promotion. Health education is about generating informed choices whereas health promotion is about making the healthier choice the easier choice or the *process of enabling people to increase control over and to improve their health*.

Health promotion initiatives may, and usually do, include health information and education - that is "Information, Education, Communication" (IEC) or as it is now more frequently labelled Behaviour Change Communication (BCC) and Behaviour Change Intervention (BCI). However, to be genuinely effective, health promotion initiatives must go further to include engagement with the legislature, policy arenas, health services and the wider environment. For it is in these contexts that most health-related choices are made.

Despite guidance in the form of a comprehensive and well structured umbrella strategic document that emphasises the five guiding principles espoused in the "Ottawa Charter", and several periods of international technical assistance, health promotion in Timor-Leste has tended to reflect the narrower confines of the health education paradigm. Opportunities to target the influential contexts of "policy, health services and the environment" have been limited to single, one-off forays. School health and family health promoter campaigns, for example, while sound in their conceptual foundations have floundered thus far because of limited local human and resource capacity, insufficient attention to intersectoral networking and public partnerships, and paucity of sustained commitment from political and ministry leadership and policy strategists.

As an overarching strategic imperative, health promotion must become one of the central planks of the mission of the MOH. Significantly greater attention - and resourcing - needs to be given to institutionalising health promotion as a core component of the role of all health care providers. The BSP highlights the centrality of health promotion as a major feature of primary (and referral) health care delivery in Timor-Leste. Ensuring the implementation of this directive will require a fundamental reorientation of the health care system to make it more responsive to health promoting opportunities and more capable of contributing to health promoting agendas.

Objective:	**To build on the strong health promotion foundations established in Timor-Leste through the production of the national strategy document by reaffirming MOH commitment to a health promotion policy framework that acknowledges the principles of the Ottawa Charter, emphasises an integrated three-pronged strategic approach (population groups, prioritised topics and settings) and utilises Behaviour and Communication Change/ Behaviour Change Intervention (BCC/ BCI) principles**
Strategy 1:	**Revise and update the current National Strategy for Health Promotion document in light of the role and functional delineations of the BSP by upgrading the strategic emphasis on capacity development of the entire MOH workforce to assist them in engaging inter-sectorally, and in promoting health across settings and among targeted population sub-groups**
Indicator 1:	Revised health promotion strategy approved and utilised
Strategy 2:	**Rationalise the current list of prioritised population sub-groups noted in the National Strategy for Health Promotion document and develop an indicative practical, time-bound and actionable log-frame in relation to each of the prioritised target groups**
Indicator 2:	Indicative, practical, time-bound and actionable log frame developed and followed
Strategy 3:	**Produce a "Health Settings Strategic Plan" and a BCC/BCI Strategic Plan that focuses on the significant contexts within which people in Timor-Leste live, work and play. The settings strategy should be integrated within the comprehensive and cross-cutting umbrella health promotion strategic framework and should allow for a blend of common and specific approaches relevant to each setting. Settings include but are not limited to the following: schools and other educational institutions, districts (or municipalities), local communities (for example, sucos or towns), workplaces and commercial premises, and health care facilities**
Indicators 3:	Prioritised health promotion plans based on significant contexts Facility-based BCC/BCI guidelines produced and implemented

Strategy 4:	**Reorient health posts, health centres and hospitals (through their design and construction, and by the ways in which they operate) to become health promoting facilities which strive to establish:** • **healing environments for patients/clients and their families** • **healthy workplaces for staff** • **leadership in environmentally sound practices**
Indicator 4:	Role analyses of all health workers undertaken and health promotion functions noted in all cases
Strategy 5:	**Confirm the strategic functionality of the Health Promotion Department within the Central Offices of the MOH**
Indicators 5:	HP leadership directed to team building and capacity development Focus of HPD activity on BCC/BCI programme and materials development
Strategy 6:	**Strengthen core health promoting competencies of all cadres of health workers practicing at different tiers of the health care system in Timor-Leste**
Indicators 6:	Job analyses undertaken and core health promotion competencies identified Pre-service curricula includes appropriate health promotion component In-service and CPD training programmes include appropriate health promotion component
Implementation Summary:	**Move from the Conceptual to the Practical** Translate the many conceptual strategies, indicating directions and priorities (such as those in the BSP) that are relevant to health promotion and reformulating them into practical, time-bound and achievable actions (displayed in log frame format). **Programme and Service Activities** Revise and produce BCC/BCI materials using the priorities and guiding principles of the Communication Strategy Ensure optimal integration and mainstreaming of BCC/BCI principles into all (non) communicable diseases interventions by the MOH and other stakeholders and support such integration within all health facilities at both community and referral levels according to the distinctive roles and service directives of the BSP

Develop and strengthen family and community participation and engagement to support BCC/BCI concepts and practices

Management and Support Activities

Manage, supervise and champion health promotion and education priorities across all tiers of the health system
As a priority bridge the health promotion activities centrally and at district level to enhance capacity building and to more effectively monitor the impact of BCC/BCI activities nationally
Ensure suitable financial, procurement and distribution systems to guarantee the availability of adequate supplies of essential equipment, assets and other resources for effective BCC/BCI practice

Monitoring and Coordination Activities

Integrate monitoring, supervision and assessment systems promoting BCC/BCI with IMCI and other (non) communicable diseases interventions focusing on quality, consistency and conformity to approved standards
Build structural links between schools and health facilities to enhance the above-mentioned management and support activities for school health education
Establish and promote partnership arrangements with NGOs, community-based agencies, schools and health service consumers locally to enhance a uniform use of key BCC/BCI messages
Engage inter-sectorally across government, especially for school health education, to promote and institutionalise BCC/BCI materials approved by the MOH

Assumptions and Risks: Many of the strategies noted are dependent on the availability of significant financial, human and other resources. Equally important, however, is the need for clear and energetic political and policy commitment to follow through and sustain strategies that will often require extended lead time to demonstrate positive benefits. It is assumed that the necessary resources will be made available to support the strategies listed and that political and administrative commitment will remain strong. Lack of any of these fundamental inputs jeopardises the viability of the health promotion programme.

Time Frame: The five year timeframe of the HSSP (2008-2012) will be insufficient to see the resolution of many of the health promotion/BCC challenges facing Timor-Leste. Progress will be incremental in many cases.

It is important, therefore, that an early start begin in:

- human resource capacity building
- developing scientifically sound and culturally sensitive legislation, protocols and guidelines
- consolidating a promising beginning to inter-sectoral teamwork,
- engaging with local communities and population sub-groups

Accordingly, it is recommended that the first two years of the current HSSP cycle, in particular, should be devoted to these four critical foundation areas. Rolling revisions to the HSSP should be responsive to continuing need in these areas.

Detailed Service and Programme Policies – Primary Health Care

Communicable Diseases

Major HSSP Emphasis: **Goal 1**

Key Documents:

NDP, HPFP, Basic Services Package, Intersectorial Action Framework for Wellbeing and Health, HIV/AIDS Strategic Plan, HIV, STIs and Risk Behaviour in East Timor, Draft Neglected Diseases Strategy, Draft National Strategy for the elimination of Lymphatic Filariasis and Control of Intestinal Parasitic Infections and Yaws, National Immunisation Strategy, National Mosquito-Borne Disease Control Strategy, National Leprosy Elimination Strategy, National Reproductive Health Strategy, National Strategy for Health Promotion 2004-2010, National Environmental Health Umbrella Strategy, Operational Plan and Protocols for a Dengue Disease Outbreak Control Programme in Dili, Draft Preparedness and Response Plan for Avian Influenza Pandemic RDTL, Caritas Dili (2001) 2nd ed National Tuberculosis Control Programme, relevant legislation on communicable diseases and population health

Key Resources:

WHO Eastern Mediterranean Regional Office (2002) "Integrated Approach in the Control of Communicable Diseases", Division of Communicable Disease Control Newsletter, Issue 1, p. 1 November

Pan American Health Organisation (2000) "An Integrated Approach to Communicable Disease Surveillance", Epidemiological Bulletin, Vol. 21, No. 1, pp. 1-4

Murgrditchian, D. and Khanum, S. (2006) "Placing Patient Safety at the Heart of Quality in Health Care in South-East Asia", International Hospital Federation Reference Book 2006/2007, pp. 21-24

WHO (2003) Regional Strategic Plan on HIV/TB, WHO, New Delhi

WHO (1999) Health Laboratory Services in Support of Primary Health Care in South-East Asia, WHO, New Delhi

WHO (2005) National Tuberculosis Programme for Timor-Leste, WHO, New Delhi

WHO (2003) Good Infection Control Practices with Emphasis on Prevention and Control of SARS: Report of a Regional Workshop Mumbai, India, June, WHO, New Delhi

UNICEF (2005) The State of the World's Children 2006: Excluded and Invisible, UNICEF, New York

Health Surveillance Working Group (2002) Strategy for the Coordination of Communicable Disease Surveillance in Canada, Health Canada

Useful Websites:

http://www.paho.org/english/dd/ais/EB_v21n1.pdf
http://www.cscw.ca/surveillance/projects/com_dis/sup_docs/CD%20Strategyfinal%2010-01-02.pdf
http://www.emro.who.int/pdf/dcdnewsletterissue1.pdf
http://www.who.int/hac/crises/tls/TimorLeste_May06.pdf
http://www.ihf-publications.org/html/images/pdfs_ref2/21-24.pdf
http://altair.undp.org/documents/7054-Preparedness_Response_for_Avian_Influenza_Pandemic.pdf
http://www.who.int/csr/ihr/en/

Important Strategic Documents not yet drafted:

Healthy public policy (across government), a synchronised, integrated and cross cutting "umbrella" Communicable Disease Prevention and Control (CDP&C) Strategy [as in the Environmental Health Strategy document and the proposed multiple component NCD Strategy document], specific mini-strategies for yet to be addressed major communicable diseases, National Health Sector Referral Strategy and related policies and protocols, Nosocomial Infections Strategy, relevant hospital adult and child health protocols and guidelines emerging from BSP directives, National Water and Sanitation Policy, Occupational Health and Safety Policy, Housing and Building Policy, Ambient Air Quality Policy, and regulations, guidelines and protocols relating to major features of population health

Situational Analysis Overall:

Since 2001 Timor-Leste has, like many other developing and developed countries (and regional authorities within countries) undertaken strategic planning for, and operational implementation of, communicable diseases prevention and control on an individual disease and vertical programme basis rather than through an integrated population-needs approach. As is evident from the persistently poor major health status indices in Timor-Leste, the traditional disease-specific, vertical management of endemic/entrenched communicable disease processes has proven less than effective despite the availability of internationally proven intervention measures. Global support for the vertical programme approach is waning as it becomes increasingly apparent that abundant human and financial resources are needed to substantiate such a model.

The HSSP provides for a reorientation of the way in which the Timor-Leste MOH addresses the nation's persistently grave communicable disease problems. The preferred approach is one where services and activities are integrated and coordinated wherever possible to promote enhanced efficiencies and effectiveness.

To embed integration, a Communicable Disease "Umbrella" Strategy – similar in structure and focus to the current Environmental Health Strategy and the proposed NCD Strategy – is required. The scope of such a strategy would be to incorporate all services provided to the Timor-Leste population with regard to surveillance, prevention, treatment and long term care of communicable diseases. Specifically, it would provide direction on how best to integrate services targeted to meet the needs of people at risk of, or suffering from vector-borne diseases, vaccine preventable diseases, tuberculosis, HIV/AIDS, other blood borne infections, sexually transmitted diseases and nosocomial infections.

The better examples of integrated strategic planning in communicable disease prevention and control share several characteristics. First, the approaches are comprehensive and require action at institutional, community and public policy levels. Second, they avoid small scale, disjointed programmes and projects that act to splinter actions. Wherever possible, communicable diseases are grouped so that they can be targeted through a set of harmonising and integrating actions that correspond to existing public health systems and incorporate contemporary evidence-based concepts. Third, they have a dual focus – addressing *common* and *specific* factors. *Common* factors involve IEC/BCC initiatives, re-orientation of health services to interdisciplinary preventive actions, and monitoring and evaluation strategies. *Specific* factors relate in the main to clinical treatment of, and legislative and regulatory matters on particular disease processes.

As noted in the BSP, the appropriateness of an integrated approach is readily apparent in relation to Timor-Leste's STIs and tuberculosis. The "HAST" acronym (HIV/AIDS, STIs and TB) is becoming increasingly familiar in developed and developing settings globally.

However, even in areas where disease processes are dissimilar an integrated strategic approach is applicable as it combines the cross-cutting aspects of disease control, such as surveillance, training, infection control and antimicrobial resistance containment, operational research and advocacy. Integration promotes a more equitable distribution and optimal use of health resources and contributes to building the health system on the basis of primary care.

Hence, the proposal in the BSP of integrating HAST and malaria in Timor-Leste as a viable means of strengthening both programmes at the service

planning and implementation level. Integration of this type establishes closer planning and evaluation links between services providing care to similar groups of people. It also provides opportunity for collaborative case management approaches between government and NGO services and other care providers.

To be successful, application of the integrated approach in CDP&C has to address several major issues – gaining essential support, identifying problems and barriers, developing solutions, setting priorities and ensuring that the integration process itself does not lead to delays in achieving targets of specific disease control programmes.

The Umbrella CDP&C strategy document will provide a framework for action in four key areas – generating political and bureaucratic commitment, integrating cross-cutting activities, scaling-up disease-specific control activities and developing synergy of management processes.

However, it needs to be appreciated that the overall strategic emphasis on complementarity and practice integration is not intended to detract from appropriate *specific* forms of action that have merit at the individual disease process level. The purpose and benefit of integration of, for example, HAST and malaria programmes, where this is appropriate, will be to strengthen each programme by drawing together and making use of overlapping and complementary parts.

Objective: **To address identified communicable disease priority areas through a synchronised, integrated and cross-cutting framework of strategies designed to promote health, prevent disease and public health-related morbidity, control risk factors and reduce illness, injury and death**

Strategy 1
CD Generally: **Prepare a Communicable Diseases Prevention and Control "Umbrella" Strategic Plan for Timor-Leste centred on the BSP and a comprehensive, cross-cutting and evidenced-based framework for action with clearly established priority rankings of target issues and an effective, integrated communicable disease surveillance system**

Indicators 1: Comprehensive Umbrella CDP&C policy document prepared and used
CD surveillance system integrated with HMIS systems

	Prioritisation of CD prevention, control and treatment strategies determined following broad consultation and socialised
Strategy 2	
CD Generally:	**Use the Umbrella CDP&C Strategic Plan to establish a standard and uniform framework for all communicable disease strategic planning and operational documents with explicit reference to common factors (surveillance, planning, provision, evaluation) and disease-specific factors**
Indicator 2:	Periodic revisions of micro-policy CDC strategic documents
Strategy 3	
CD Generally:	**Use the Umbrella CDP&C Strategic Plan to establish and disseminate best practice standards of surveillance, health promotion, prevention, clinical care and treatment for all communicable diseases**
Indicator 3:	Standards for surveillance, health promotion, prevention, clinical care and treatment for all communicable diseases established
Strategy 4	
CD Generally:	**Use the Umbrella CDP&C Strategic Plan to assist in keeping health care providers and the community informed of the most effective available communicable disease treatment modalities and approaches**
Indicators 4:	Informed health workers Informed communities Consistent BCC/BCI activities based on approved policies
Situational Analysis	
Mosquito-borne Diseases:	The ecology of Timor-Leste provides ideal conditions for breeding mosquitoes including those carrying disease. Climatic conditions combined with stagnant water surfaces (in drains, swamps, cultivated rice fields, artificial water holding receptacles such as tires and rubbish, etc.) are conducive to endemic outbreaks. Not surprisingly, then, the country continues to endure an epidemiology of both endemic and episodic mosquito-borne diseases (notably malaria, dengue, filariasis and Japanese encephalitis) second only to respiratory illnesses in terms of national morbidity and mortality. Population growth, high levels of overall morbidity, widespread poverty and drug-resistance to recommended treatments exacerbate mosquito-borne disease risk in Timor-Leste. Cumulatively, mosquito-borne disease represents a massive

barrier to socio-economic development and poverty alleviation.

All sub-districts are affected by mosquito-borne diseases, with data suggesting that more than 20-25% of consultations in health facilities are directly related to mosquito-borne disease. Falciparum and Vivax malaria appear to be equally common while Dengue occurs in sporadic epidemics.

Table 9: Malaria cases 2000-2006

	2000	2001	2002	2003	2004	2005	2006
Clinical	134,534	83,049	93,639	NA	179,179	142,274	147,638
Confirmed	NA	NA	26,651	33,933	39,829	40,509	25,925

(Source: National Malaria Officer Jan 2007)

As is evident from the above table, the quality of mosquito-borne diagnosis (especially of malaria) at district and sub-district health facilities is inconsistent. The introduction of expensive combined malaria Treatment (ACT) will place more emphasis on rapid testing and on related quality assurance practices. The BSP provides explicit guidance on the range of laboratory tests to be performed at the different tiers of the system and on the quality monitoring methods to be employed.

Preventive measures such as the distribution of Long Lasting Insecticide Treated Bed Nets (LLITNs) and targeted treatments have achieved some positive results over the past six years but much remains to be done. Considerable opportunity exists to reverse worryingly stubborn national epidemiological trends if adequate resources and human skills can be mobilised to address vector control. There is a need for coordination with the Environmental Health vector control activities

Strategy 5
Mosquito-borne Diseases: **Build on the strategic foundations established through the production of the National Mosquito-Borne Disease Control Strategy for Timor-Leste and linked operational plans (such as the Operational Plan and Protocols for a Dengue Disease Outbreak Control Programme in Dili) while integrating ongoing strategic activities to the role and functional delineations of the BSP, and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives**

Indicators 5:
- Integration of ongoing mosquito-borne disease control activities within the BSP and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives
- Revised mosquito-borne strategy document prepared and used
- Appropriate vector control methods applied

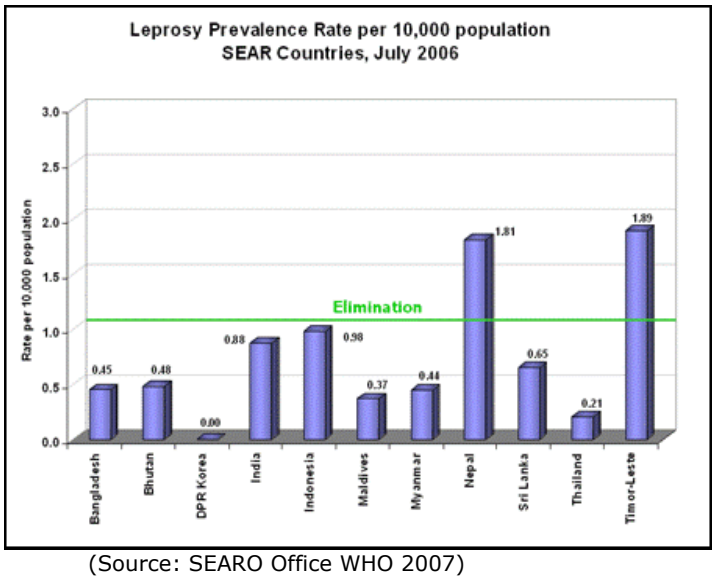
Other environmental control methods applied
Intersectoral action on environmental determinants
Increasing and diffuse use of LLITNs, spraying and chemicals
Epidemic plan prepared and ready for use
Accessible services functioning appropriately
Comprehensive BCC/BCI programmes involving inter-sectoral and community engagement conducted and evaluated
Research-driven control strategy developmen

Situation Analysis Leprosy:

Until recently the prevalence of leprosy in Timor Leste has been difficult to estimate precisely. However, national data from 1994-1997 and from district-based surveys in 2001 and 2002 indicate that leprosy has been endemic for many years.

The WHO through its South-East Asia Regional Office has collect data (see Table 10 below) that highlights a disparity between Timor-Leste and all but one of the other countries in the region in terms of leprosy elimination. As of July 2006 Timor-Leste with a prevalence rate of 1.89 per 10,000 people and Nepal with a prevalence rate of 1.81 per 10,000 people were the only countries in the WHO SEAR region unable to claim elimination of leprosy as a public health problem (that is, a prevalence rate of <1 case per 10,000 people). While the WHO notes that both Nepal and Timor-Leste are "making concerted efforts to achieve elimination", actions to date have had only limited impact on prevalence.

Table 10: SEAR Countries Leprosy Prevalence Rates



(Source: SEARO Office WHO 2007)

The cumulative human suffering and economic damage caused by leprosy is significant. It is estimated that more than 170 Timorese people contract the disease every year. Leprosy remains a leading cause of permanent disability in over half

the districts in the country, with Oecusse and Bobonaro having the highest numbers of reported cases.

Strategy 6 Leprosy:

Build on the strategic foundations established through the production of the National Leprosy Elimination Strategy while integrating ongoing strategic activities to the role and functional delineations of the BSP, and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives

Indicators 6:

Integration of ongoing leprosy elimination activities within the BSP and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives

Revised leprosy strategy document prepared and used

Intersectoral framework for leprosy determinants adopted

Action plans developed and implemented on the basis of the intersectoral framework

MOH logistics support for resources essential for management of leprosy cases

Situational Analysis Tuberculosis:

Tuberculosis is endemic in Timor-Leste. Based on the WHO's international classification system, Timor-Leste is considered a TB "high burden" nation with an estimated prevalence rate in 2005 of over 700 cases per 100,000 people. Findings from the DHS suggest an even higher rate if a purely symptomatic assessment of morbidity is applied. Regardless of the index used, however, the burden of the disease on the country is vast. Males and females with lowest body mass index status, from the poorest households, and from the rural eastern region are especially at high risk of contracting the disease.

New sputum positive cases identified and cured annually since the National Tuberculosis Programme started in 2000 are noted below in Table 11:

Table 11: TB Sputum +ve cases and cure rates 2000-2005

	2000	2001	2002	2003	2004	2005
#sputum +cases	1347	1288	1091	1026	1000	1035
Success Rate	65%	73%	81%	81%	80%	82%

(Source: Global Fund 2006)

The MOH and development partners currently provide an integrated package of tuberculosis clinical services and control interventions across the country. Since 2000 the coverage of tuberculosis control has increased and the number of cases tripled. However, coverage is still far from complete. BCG vaccinations are given to infants as part of the national

immunisation programme and as of 2006 had reached 67% coverage.

DOTS (Directly Observed Treatment Short Course) is regarded widely as the major weapon to halt and reverse the spread of Sputum +ve TB as each infected person may transmit the disease to between 12 and 20 others. Treatment is by standardised WHO regimens and the intensive phase is fully supervised. As noted in table 2, treatment results have improved with success rates increasing from 65% in 2000 to 82% in 2005. However there remains a need to improve the quality of sputum microscopy with many cases not confirmed at completion of treatment and many initial diagnoses not being controlled for accuracy (the initiation of treatment is often made without sputum diagnosis).

As noted above, the BSP highlights the well established clinical and health care relationships between TB and both HIV/AIDS and STIs. The BSP also proposes an integrated approach to the planning and delivery of HAST and malaria (and other vector-borne disease) services given the similarity of proven preventive and intervention strategies. Complementarity on common factors further enhances the desired process of integration and cross-cutting - fundamental to a system of efficient and effective health care planning and delivery.

Strategy 7 Tuberculosis:

Build on the strategic foundations established through the production of the National Tuberculosis Strategy while integrating ongoing strategic activities to the role and functional delineations of the BSP, and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives in particular the integration of HAST and malaria activities

Indicators 7:

Integration of ongoing TB activities within the BSP and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives

Revised TB strategy document prepared and used

BCC/BCI aligned to community-based HAST health promotion and HAST prevention programmes

HAST capacity developed within the health system and within communities

HAST public /private partnership enhanced

Intersectoral engagement in particular with the education sector

Integrated disease surveillance established

Prevention, control, diagnosis, treatment and rehabilitation established

Monitoring and evaluation conducted and acted on

Situational Analysis Blood-borne and Sexually Transmitted Diseases:

The first HIV/AIDS case in Timor-Leste was confirmed in 2001. As the BSP notes the current levels of HIV/AIDS in Timor-Leste are not known accurately. As of yet there is no routine sero-prevalence monitoring or notification, and no national-level sentinel surveillance. However, findings from research by Family Health International in 2003 suggested that the overall HIV prevalence rate was a low 0.6 percent with just three percent of female commercial sex workers in Dili being HIV-positive. Other sexually transmitted diseases (STIs) were common among these workers with a quarter having gonorrhoea and/or Chlamydia, and 60 percent having herpes.

Indicative figures support a commonly held contention that while prevalence of HIV/AIDS in Timor-Leste remains low at the moment, the level of risk behaviour is worryingly high. As a consequence the risk of an HIV/AIDS epidemic occurring in the future is real.

See the "Reproductive Health and Family Planning" entry for details on the low level of awareness in Timor-Leste of matters relating to STIs overall and the concept of safe sex practice.

Strategy 8 Blood-borne and Sexually Transmitted Diseases:

Build on the strategic foundations established through the production of the National Reproductive Health Strategy, and the National HIV/AIDS Strategy while integrating ongoing strategic activities to the role and functional delineations of the BSP, and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives in particular the integration of HAST activities

Indicators 8:

Integration of ongoing RH and HIV/AIDS activities within the BSP HAST framework and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives

Revised RH & FP and HIV/AIDS strategy documents prepared and used

Support for community based organisations

BCC/BCI aligned to community-based HAST health promotion and HAST prevention programmes

HAST capacity developed within the health system and within communities

HAST public/private partnership enhanced

Intersectoral engagement in particular with the education sector

Integrated disease surveillance established

Prevention, control, diagnosis, treatment and rehabilitation established

Monitoring and evaluation conducted and acted on

Uniform systems of syndromic management applied throughout the nation

Situational Analysis Diarrhoeal Diseases:

Diarrhoea ranks as one of the four major child health problems in Timor-Leste along with acute respiratory infections, malaria and malnutrition. One fifth of all deaths of Timorese children under five years are attributable directly to diarrhoea. It is not uncommon for Timorese children to present to health facilities with symptoms reflecting all four conditions.

As noted by UNICEF in its *2006 Report on the State of the World's Children*, diarrhoea is eminently preventable. Approximate percentage figures for Timorese children under five with diarrhoea receiving oral re-hydration and continued feeding is unknown. However, UNICEF estimates that for children from across the least developed country group (which includes Timor-Leste), only 36% receive the recommended anti-diarrhoeal regime as and when needed. The underlying theme of the UNICEF report - "children from the least developed countries risk missing out" – has stark application in Timor-Leste.

In keeping with its focus on integrated service provision, the BSP highlights the applicability of linking diarrhoea, malaria and pneumonia as part of comprehensive primary and secondary care consultations. It recommends a continuum of care approach where case management occurs in the community, at primary care health facilities and at the referral level.

Strategy 9 Diarrhoeal Diseases:

Build on the strategic foundations established through the production of the IMCI Strategy while integrating ongoing strategic activities to the role and functional delineations of the BSP as it pertains to diarrhoeal services, and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives - in particular the integration of malaria, pneumonia and diarrhoeal services

Indicators 9:

Integration of ongoing IMCI activities (with an emphasis on diarrhoeal diseases) within the BSP framework and the umbrella CDP&C policy framework that affirms comprehensive and cross-cutting initiatives

Revised IMCI strategy documents prepared and used

Supporting community based organisations

BCC/BCI alignment to community-based health promotion and diarrhoeal prevention programmes

Integrated pneumonia, malaria and diarrhoeal capacity development within the health system and within communities

Public/private partnership enhancements

Intersectoral engagement in particular with the education sector

Integrated disease surveillance

Prevention, control, diagnosis, treatment and rehabilitation

Monitoring and evaluation

Situational Analysis

Nosocomial Infections: Nosocomial (also known as iatrogenic) infections are those types of infections resulting from patient interaction with the health care system – in particular the hospital sector. Nosocomial infections are either health system-induced complications of illness (such as exposure to strains of bacteria that are drug resistant) or the consequence of sub-standard practices (for example in the area of infection control where failure to observe simple hand washing techniques, for example, is a major contributor). Internationally, a nosocomial rate of around 5-6% is the norm. While this appears high, it is suggested that the rate is likely to increase as predisposing factors such as increased age, co-morbidities, invasive procedures and imunosuppression treatments become more common.

In the South East Asia WHO region, nosocomial infections are a major patient safety issue. Many countries have established infection control programmes and have adopted best practice standards to minimise such infections. Several countries are field testing the WHO's advanced guidelines on hand hygiene. Timor-Leste is not among this group and lags the field in its infection control systems and applications. Challenges exist in terms of the practical skills level at the front line, adequacy of management supervision and support, and overall attitude to the issue of quality of care. The MOH recognises the need to strengthen its practices at both the system and implementation/ practice levels.

Strategy 10

Nosocomial infections: **Use the Umbrella CDP&C Strategic Plan to establish best practice standards of quality assurance and infection control throughout the Timor-Leste health care system to support patient and client safety**

Indicators 10: Quality assurance system established and applied centrally and locally

Infection control system established and applied centrally and locally

Situational Analysis

National Emergencies: Health authorities the world over are central to a country's preparation for, and response to, national emergencies whether they be man-made, natural or technological. In Timor-Leste the MOH has been involved with other agencies, both in-country and internationally, in preparing strategic management

plans for such occurrences in several communicable disease areas - Avian Flu epidemics, Dengue Disease outbreaks and the occurrence of Severe Acute Respiratory Syndrome (SARS) infections.

In preparing for major emergencies in these communicable disease areas and others, certain principles guide the planning and implementation process. These principles reflect the concept of "risk management" which is at the heart of all emergency/disaster planning approaches. Risk management is based on a series of well defined steps that aim to reduce inherent dangers and the likely impacts or consequences arising from the emergency situation. The steps are sequential and provide a progressively more detailed insight for decision-makers preparing for, and responding to, the extreme circumstance. Guidance on risk management is available from many sources. A useful website that provides a comprehensive template for national emergency strategic planning can be found at:

http://www.shrewsbury.gov.uk/public/Publications/riskmanagement/risk+management+guidelines.htm

A useful website that focuses in part on the preparedness of health care managers/leaders and health care facilities to respond quickly to significant emergencies can be found at:

http://www.bt.cdc.gov/planning/responseguide.asp

Both the Avian Flu Pandemic and the Dengue Fever Outbreak plans developed recently in Timor-Leste follow the accepted risk management sequential step by step approach. They also adopt an inter-agency and intersectoral framework of action.

In 2007 the WHO successfully advocated for the implementation of the International Health Regulations which are designed to provide a legal framework to protect all nations from acute public health risks that have the potential to spread internationally and impact negatively on health, trade and travel. Timor-Leste is bound by these regulations. Details of the IHR can be found at:

http://www.who.int/csr/ihr/en/

Strategy 11
National Emergencies (SARS, Avian Influenza):

Use the internationally acknowledged risk management approach to produce a template emergency management plan for the MOH to meet its obligations in working with other agencies in preparing for and implementing

appropriate responses to national, regional or local disaster and/or emergency situations

Indicator 11: Emergency management plan prepared and available for use

Strategy 12 International Health Regulations: Use the IHR as the accepted framework for managing the nation's collective defences against acute public health risks

Indicator 12: International Health Regulations adopted and functional

Situational Analysis Vaccine Preventable Diseases: See "Immunisation for Children and Adults" entry

Implementation Summary:

Programme and Service Activities

Confirm and socialise communicable diseases priority areas according to BSP and relevant MDG targets
Ensure optimal integration of communicable diseases programmes and services within all health facilities at both community and referral levels according to the distinctive roles and service directives of the BSP
Develop and strengthen family and community participation and engagement to support appropriate communicable diseases programmes and services

Management and Support Activities

Manage, supervise and champion communicable diseases priorities across all tiers of the health system
Consolidate and systematically extend communicable diseases capacity development across the health workforce
Ensure effective financial, procurement and distribution systems to guarantee the availability of adequate supplies of essential equipment, assets and other resources for effective communicable diseases practice
Develop and implement appropriate universal referral procedures for patients suffering from a communicable disease

Monitoring and Coordination Activities

Establish and apply appropriate monitoring and assessment systems to promote communicable diseases service quality, consistency and conformity to approved standards
Establish and promote partnership arrangements with NGOs, community-based agencies and health service consumers locally to embed communicable diseases strategies

Collaborate with all major stakeholders in operationalising communicable diseases control and prevention strategic priorities
Engage inter-sectorally across government and the private sector to promote and institutionalise the benefits of appropriate communicable diseases control and prevention strategies

Assumptions and Risks: Many of the CDP&C strategies noted are dependent on the availability of significant financial, human and other resources. Equally important, however, is the need for clear and energetic political and policy commitment to follow through and sustain CDP&C strategies that will often require extended lead time to demonstrate positive benefits. It is assumed that the necessary resources will be made available to support the strategies listed and that political and administrative commitment will remain strong. Lack of any of these fundamental inputs jeopardises the viability of the CDP&C programme.

Time Frame: The five year timeframe of the HSSP (2008-2012) will be insufficient to see the resolution of many of the CDP&C challenges facing Timor-Leste. Progress will be incremental in many cases. It is important, therefore, that an early start begin in:

- human resource capacity building
- developing scientifically sound and culturally sensitive legislation, protocols and guidelines
- consolidating a promising beginning to inter-sectoral teamwork,
- engaging with local communities and population sub-groups

Accordingly, it is recommended that the first two years of the current HSSP cycle, in particular, should be devoted to these four critical foundation steps in the prioritised CDP&C areas. Rolling revisions to the HSSP should be responsive to changing needs in these areas.

Detailed Service and Programme Policies – Primary Health Care

Non-Communicable Diseases

Major HSSP Emphasis: **Goal 1**

Key Documents: NDP, HPFP, Basic Services Package, Environmental Health Strategy (the "umbrella" micro-policy), Intersectorial Action Framework for Wellbeing and Health, National Health Promotion Strategy, Family Health Promoter (FHPP) National Strategy and Implementation Guidelines, National Nutrition Strategy, National Oral Health Strategy, National Mental Health Strategy, relevant public and environmental health legislation

Useful websites: www.cdc.gov/pcd/issues/2006/jan/05_006.htm
http://www.nida.nih.gov/PDF/HealthDispPlan.pdf

Important Strategic Documents not yet drafted: Healthy public policy (across government), micro-policy documents – an "umbrella" Non-Communicable Disease Control Strategy [as in the multiple component environmental health strategy], specific strategies and related "mini" action plans for cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, renal diseases and their risks factors, eye health, substance (including tobacco) use/abuse, injuries/trauma (self inflicted and otherwise), occupational health and safety policies, housing and building policies, and regulations, guidelines and protocols relating to major features of population health

Situational Analysis: The term "non-communicable" diseases is used conventionally to refer to major chronic disease processes - cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, renal diseases – that are linked by common risk factors. Sometimes, the NCDs concept is also applied to broad and entrenched public health areas such as mental health and injury/trauma that share behavioural and lifestyle features.

On pragmatic grounds (limited capacity and finite resources, etc.) a further extension to the NCDs concept is warranted in Timor-Leste. This extended focus is appropriate also because of the prevalence in the country of other significant public health risks that require similar integrated, sustained and multi-focused prevention and control approaches. Hence, this section of the HSSP addresses oral health, eye health and substance (notably tobacco) use and abuse in addition to the array of NCDs listed above.

Determining NCD morbidity and mortality in Timor-Leste is problematic given the paucity of available

population-based surveillance data and the non-existence of disease registries. Not surprisingly the few demographic and health surveys conducted in the country have targeted dominant preventable infectious diseases and maternal and infant morbidity and mortality.

The lengthy list of "to-do" strategic documents noted above gives an indication of the policy emphasis to date. Significantly there is no mention in the HPFP of – and hence no guiding direction on - any of the major chronic disease processes or of drug or other substance abuse. While trauma and mental health (the latter in the context of post-conflict related distress) are noted in this seminal strategic document, the sheer volume of infectious disease cases and the extreme level of maternal and child morbidity have been, justifiably, the overwhelming strategic and operational focus of the MOH and its partner organisations. Moreover, the relatively short life expectancy of the average Timorese has had the effect of deflecting local health policy development away from chronic diseases and life-style linked public health disorders that often require longer term exposure to causative agents.

In NCD areas where policy strategies have been developed (for example, in mental and oral health), discussions on "burden of illness" rely in the main on international incidence and prevalence norms with local circumstances estimated on these bases. Limited local workforce capacity and persistently frail infrastructure are presented in such policy documents as likely indices of unmeasured morbidity status.

The incidence of mature-age onset diabetes, chronic respiratory disease, heart disease and cancer are reported anecdotally as increasing. However, it is difficult to quantify such claims. The World Bank - in unpublished commentary – provides some support to such suggestions by noting that while data on NCDs are unavailable, these diseases are likely to be "significant causes" of morbidity and premature mortality in Timor-Leste.

Reliable hospital inpatient morbidity and mortality data are only now becoming available. Informative analysis of trends remains a tantalising prospect for the future. Nevertheless, it is useful to note that recently refined National Hospital inpatient mortality data show that the major causes of death at the facility in 2006 were linked to infectious diseases and acute episodes of malnutrition. Table 12 below provides a list of the 10 major causes of death of inpatients at the National Hospital during 2006. Among the NCDs cardiovascular diseases ranked sixth overall (4.4% of the total). It is possible that other NCDs made up some of the large "Other"

category that ranked first (19.8%) However, the overwhelming impact of infectious diseases and birth-related problems on inpatient mortality persists. Hospital morbidity data – causes of admission – reflect similar circumstances.

Table 12: Ten Leading Causes of Mortality of Patients Admitted to Hospital Nacional Guido Validares: 2006

Rank	Cause of Death	No. of Deaths	% of Total Hospital Deaths[1]
1	Other causes	77	19.8
2	Pulmonary Tuberculosis	50	12.9
3	Malaria	30	7.7
4	Malnutrition	27	6.9
5	Lower respiratory tract infections	18	4.6
6	Cardiovascular diseases	17	4.4
7	Gastro-intestinal diseases	10	2.6
8	Meningitis and encephalitis	10	2.6
9	Prematurity	9	2.3
10	Acute asphyxia	8	2.1

[1] There were 389 reported hospital deaths at HNGV in 2006

Source: Department of HMIS, MOH 2007

Despite the paucity of reliable and useful incidence and prevalence data on NCDs from both the inpatient and ambulatory care sector, it is clear that Timor-Leste needs to begin the process of strategically addressing NCDs as part of its core business. Guidance on how to proceed is available from the experience of a number of developing and transition countries.

The best examples of integrated strategic planning in non-communicable diseases control (NCDC) share several characteristics. First, the approaches are comprehensive and require action at institutional, community and public policy levels. Second, they avoid small scale, disjointed programmes and projects that act to splinter actions. Accordingly, NCDs are grouped so that they can be targeted through a set of harmonising and integrating actions that correspond to existing public health systems and incorporate contemporary evidence-based concepts. Third, they have a dual focus – addressing *common* and *specific* NCD factors. *Common* factors involve IEC/BCC initiatives, re-orientation of health services to interdisciplinary preventive actions, and monitoring and evaluation strategies. *Specific* factors relate in the main to legislative and regulatory matters on particular disease processes.

Objective:	**To address identified NCD priority areas through a synchronised, integrated and cross-cutting framework of strategies designed to promote health, prevent disease and public health-related morbidity, control risk factors and reduce illness, injury and death**
Strategy 1 **NCD Generally:**	**Raise and institutionalise the profile of Timor-Leste's major NCD issues at national level, across government instrumentalities, with public and private health sector agencies, and within communities and population sub-groups**
Indicators 1:	NCD legislation enacted and applied NCD MOUs signed and socialised Development partners financial commitment to NCD strategic plans obtained NCD MOUs with major stakeholders NCD operational plans socialised NCD operational decisions published and implementation steps determined
Strategy 2 **NCD Generally:**	**Prepare an NCD "Umbrella" Strategic Plan for Timor-Leste based on the BSP, a comprehensive, integrated and cross-cutting framework for action, a clearly established priority ranking of target issues and a solid evidence-base founded on an effective NCD surveillance system**
Indicators 2:	Comprehensive Umbrella NCD policy document prepared and used NCD surveillance system developed and used NCD priorities determined and socialised
Situational Analysis **Mental Health:**	In Timor-Leste the combination of poverty, unemployment, illiteracy, malnutrition, urbanisation, gender biases and continuing civil unrest following years of fierce militia resistance to Indonesian rule have placed enormous pressures on the health system to address escalating cases of mental illness. Comprehensive, systematic and integrated efforts to promote mental health and prevent and alleviate mental illnesses are constrained by human and resource capacity limitations, and a lack of widespread understanding of the potential that exists to prevent a range of mental illnesses.
Strategy 3 **Mental Health:**	**Build on the strategic foundations established through the production of the National Mental Health Strategic Plan for Timor-Leste while linking ongoing mental health strategic activities to the role and functional delineations of the BSP, and the umbrella NCD**

	policy framework that affirms integrated and cross-cutting initiatives
Indicators 3:	MOH support for mental health as priority area for integrated and collaborative action Revised mental health strategy document prepared and used Data collection and analysis system developed and implemented Integrated and coordinated approach to mental health illness management developed and implemented Priority focus on child and adolescent mental health, community care, reduction of stigma and discrimination, mental health as part of primary care and the availability of psychotropic drugs determined
Situational Analysis Oral Health:	Despite the early development of an oral health strategic policy document emphasising health promotion and prevention of diseases, there has been only limited systematic preventive and promotive attention to this NCD area. As a consequence dental caries and periodontal diseases now affect a large proportion of the population. Inadequate diet, poor oral hygiene and less than optimal exposure to fluoride are major causative factors. The problem spans the age continuum with preschool children commonly having tooth decay and the older population being subject to oral cancers due to the high prevalence of smoking and betel quid chewing.
Strategy 4 Oral Health:	**Build on the strategic foundations established through the production of the National Oral Health Strategic Plan for Timor-Leste while linking ongoing oral health strategic activities to the role and functional delineations of the BSP, and the umbrella NCD policy framework that affirms integrated and cross-cutting initiatives**
Indicators 4:	MOH support for oral health as priority area for integrated and coordinated action Oral health strategy document revised and socialised Data collection and analysis system developed and implemented Integrated and coordinated approach to oral health illness management developed and implemented Priority focus on child and adolescent oral health and oral health as part of primary care

Situational Analysis Eye Health:

The vision status of children and adults in Timor-Leste is well below acceptable international standards. The Timor-Leste Eye Health Survey of 2005 found that for people over the age of 40 years:

- One quarter had some form of significant vision impairment
- Around 8% (13,500 people) were blind (with cataracts the chief causative factor)
- One third of people who had had cataract surgery remained blind following the procedure
- The level of health seeking behaviour for eye or vision problems is low

Eye disease (especially blindness) decreases quality of life and poses a significant economic burden on individuals, families and society. The majority of eye conditions in Timor-Leste are either preventable or treatable with proven interventions being extremely cost-effective. Although the bulk of visual disability in Timor-Leste occurs in older adults, globally childhood blindness is second only to cataract in blind-person-years. The population sub-groups most vulnerable to vision impairment are the poor, the elderly and those from rural areas. While women do not have a higher prevalence of vision impairment, their utilisation of services tends to be lower than that of men.

Strategy 5 Eye Health:

Build on the strategic foundations established through the production of the National Eye Health Strategic Plan for Timor-Leste while linking ongoing eye health strategic activities to the role and functional delineations of the BSP, and the umbrella NCD policy framework that affirms integrated and cross-cutting initiatives

Indicators 5:

Raised awareness of blindness in Timor-Leste and priority strategies determined for eye health action across government instrumentalities, NGO, UN agencies, the media and the community

Integrated and coordinated approach to eye health management developed and implemented

Eye health diploma course developed and conducted

Technical assistance available and local resourcing confirmed to support major elements of eye health care

Improvement in the quality, quantity and equity of cataract services

Situational Analysis Diabetes:

Diabetes is a growing international health concern. It is estimated that 300 million people will be affected by 2025, 75% of whom will come from developing countries. In Timor-Leste anticipated increases in life expectancy, major changes in

traditional diet and lifestyles that reflect progressive urbanisation and social development will markedly increase the prevalence of diabetes. The overall impact on individuals, communities and the health care system of undiagnosed, untreated and poorly controlled diabetes will be significant.

Diabetes adds to the burden of preventable diseases and leads to major economic losses stemming from high costs of care and lost productivity. However, scientific evidence highlights the potential to prevent the disease and its complications through cost-effective measures at population level. Whether Timor-Leste needs to consider targeting high "at-risk" groups will need to be considered when prevalence data are available.

Strategy 6 Diabetes:

Produce a mid term diabetes prevention and control strategic plan for Timor-Leste that is integrated within the comprehensive and cross-cutting umbrella NCD framework

Indicators 6:

Diabetes strategy document prepared and used

Integrated and coordinated approach to diabetes management developed and implemented

Diabetes surveillance integrated within NCD surveillance system and used

Primary prevention of diabetes (and other NCD disorders) included as part of the role of all front line health workers

In-service and CPD training in diabetes prevention, management and control for all health workers developed and included in IHS calendar

Situational Analysis

Cardiovascular diseases:

Cardiovascular diseases (CVDs) include diseases of the heart and the blood vessels. In prevention terms, preventable CVDs refer to two groups of diseases: first, the atherosclerotic conditions that lead to coronary artery disease, stroke and peripheral vascular disease; and second, hypertension and its consequences. There is significant overlap between the two groups with hypertension being a major risk factor in the first set of conditions. As such preventive strategies are common across the entire preventable CVD range.

CVDs have reached epidemic proportions in both developed and developing countries. The limited attention to CVDs in Timor-Leste has been at the secondary curative level. Public health approaches – notably disease prevention, risk factor control and health promotion – have not featured prominently. The urgency of re-orientating strategies is acute with evidence showing that appropriate investments in prevention can reduce the incidence of CVDs.

Strategy 7
Cardiovascular diseases: **Produce a mid term CVD prevention and control strategic plan for Timor-Leste that is integrated within the comprehensive and cross-cutting umbrella NCD framework**

Indicators 7:
- CVD strategy document prepared and used
- Integrated and coordinated approach to CVD management developed and implemented
- CVD surveillance integrated within NCD surveillance system and used
- In-service and CPD training in CVD prevention, management and control for all health workers developed and included in IHS calendar
- Physical activity and healthy nutrition programmes developed and implemented nation-wide

Situational Analysis
Cancer:

Cancer is an increasingly significant contributor to global disease burden with an estimated 15 million new cases occurring annually by 2020. More than 60% of these new cases will occur in less developed countries.

Scientific evidence shows that at least one third of the annually occurring cancers can be prevented and another third diagnosed early or down-staged at diagnosis. The key, then, for all countries regardless of their state of development is to focus at population level on public health strategies that minimise exposures to cancer risk factors and on improved early detection initiatives.

Given the lack of any surveillance data on cancer in Timor-Leste and the completely undeveloped state of cancer control services, it is recommended that the proposed mid-term cancer strategic programme focus overwhelmingly on prevention and control approaches and minimise attention to other dimensions (pain relief, palliative care and treatment) until population-based prevention and control strategies are institutionalised.

Strategy 8
Cancer: **Produce a mid term cancer prevention and control strategic plan for Timor-Leste that, while integrated within the comprehensive and cross-cutting umbrella NCD framework, emphasises population-based activities at the expense of treatment services and programmes**

Indicators 8:
- Cancer strategy document prepared and used
- Integrated and coordinated approach to cancer management developed and implemented
- Cancer registries developed and used and integrated within NCD surveillance system and used

In-service and CPD training in cancer prevention, management and control for all health workers developed and included in IHS calendar

Emphasis on population-based activities at the expense of treatment services and programmes

Integration of primary prevention and early detection as part of a comprehensive cancer BCC/BCI strategy

Situational Analysis Injury/Trauma:

The case management and early treatment of trauma in Timor-Leste was noted in the 2002 HPFP. It has been listed as a component activity in the curative section of the BSP. However, the focus does not extend in either of these documents to the prevention and control of injuries (or accidents or trauma more generally). As such there has been a strategic policy hiatus in this important area.

Injuries result in major economic loss to countries while inflicting significant personal burden on victims and their families. It is estimated that motor vehicle accidents alone will be ranked second in developing countries in order of disease burden in 2020 compared with their 2004 ranking of ninth.

With an agrarian social-base, with minimally enforced public health regulations, with a poorly developed road system and subject to harsh climatic conditions, Timor-Leste exhibits all the classic characteristics of a country prone to endemic injury-trauma status. Anecdotally, treating injuries (or trauma) at primary and secondary health care facilities consumes a significant amount of medical and nursing time. Just how much time is hard to quantify at the moment with any degree of confidence.

Injuries have been regarded traditionally as random, unavoidable accidents. However, like all disease processes, injuries tend to affect identifiable high-risk groups and to follow predictable patterns. Interventions among these at-risk groups can, therefore, prevent injuries. It is on this basis that Timor-Leste's strategic injury prevention and control planning needs to commence.

Strategy 9 Injury/Trauma:

Produce a mid term injury/trauma prevention and control strategic plan for Timor-Leste that is integrated within the comprehensive and cross-cutting umbrella NCD framework

Indicators 9:

Injury/trauma prevention and control strategy document prepared and used

Integrated and coordinated approach to injury/ trauma management includes data collection and analysis

Integrated and coordinated approach to injury /trauma management includes data collection and analysis

MOH advocacy and leadership for intersectoral attention to injury/trauma

MOH advocacy and leadership for intersectoral focus on road safety

MOH advocacy and leadership for intersectoral focus on occupational health and safety

MOH advocacy and leadership for intersectoral focus on occupational health and safety

In-service and CPD training in injury prevention and control for all health workers developed and included in IHS calendar

MOH focus on front line and referral clinical management skills for trauma and injury

Situational Analysis

Substance Use / Abuse:

Little documentary evidence is available on the prevalence of substance use/abuse in Timor-Leste. Health-related surveys have not focused on drug and other substance usage, perhaps reflecting the perception of its secondary significance. Anecdotally, tobacco and alcohol are held to be the two most commonly used drugs and cannabis and meta-amphetamine the most commonly used illicit drugs. Licit and illicit drug use tends not to be intertwined.

As in all settings, young Timorese are prone to copy the drug use patterns of adults. Women appear less likely to use both licit and illicit drugs, although this phenomenon may be changing. Drug use patterns are probably associated with broader socioeconomic conditions such as level of education and employment opportunities and the distribution of health and community support services. The ready availability of notionally "prescription" medications at commercial pharmacy outlets, and limited MOH surveillance of this practice, compounds current substance abuse circumstances.

As in all countries, effective prevention and control of licit and illicit substance use and abuse can be facilitated through:

- initiating and sustaining a process of stakeholder consultation at all levels
- collaboratively addressing prevention issues
- devising and implementing an evidence-led plan of preventive action
- ensuring close monitoring and evaluation of priority implementation strategies

Strategy 10

Substance abuse:

Produce a mid term substance abuse prevention and control strategic plan for Timor-Leste that is integrated within the comprehensive and cross-cutting umbrella NCD framework

Indicators 10:

- Substance abuse prevention and control strategy document prepared and used
- Integrated and coordinated approach to substance abuse management developed and implemented
- Diabetes surveillance integrated within NCD surveillance system and used
- Legislation enacted and regulations on substance abuse
- MOUs on substance abuse prevention and control signed
- Development partners financial commitment to substance abuse strategies obtained
- Stakeholders commitment to substance strategies obtained
- Consultation strategies produced and socialised
- Substance abuse strategies produced and disseminated across the MOH and partnership sectors

Implementation Summary:

Programme and Service Activities

Confirm and socialise non-communicable diseases priority areas according to BSP and relevant MDG targets

Ensure optimal integration of non-communicable diseases programmes and services within all health facilities at both community and referral levels according to the distinctive roles and service directives of the BSP

Develop and strengthen family and community participation and engagement to support appropriate non-communicable diseases programmes and services

Management and Support Activities

Manage, supervise and champion non-communicable diseases priorities across all tiers of the health system

Consolidate and systematically extend non-communicable diseases capacity development across the health workforce

Ensure effective financial, procurement and distribution systems to guarantee the availability of adequate supplies of essential equipment, assets and other resources for effective non-communicable diseases practice

Develop and implement appropriate universal referral procedures for patients suffering from a non-communicable disease

Monitoring and Coordination Activities

Establish and apply appropriate monitoring and assessment systems to promote non-communicable diseases service quality, consistency and conformity to approved standards

Establish and promote partnership arrangements with NGOs, community-based agencies and health service

consumers locally to embed non-communicable diseases control and prevention strategies
Collaborate with all major stakeholders in operationalising non-communicable diseases strategic priorities
Engage inter-sectorally across government and the private sector to promote and institutionalise the benefits of appropriate non-communicable diseases control and prevention strategies

Assumptions and Risks: Many of the NCD strategies noted are dependent on the availability of significant financial, human and other resources. Equally important, however, is the need for clear and energetic political and policy commitment to follow through and sustain NCD strategies that will often require extended lead time to demonstrate positive benefits. It is assumed that the necessary resources will be made available to support the strategies listed and that political and administrative commitment will remain strong. Lack of any of these fundamental inputs jeopardises the viability of the NCD programme.

Time Frame: The five year timeframe of the HSSP (2008-2012) will be insufficient to see the resolution of many of the NCD challenges facing Timor-Leste. Progress will be incremental in many cases. It is important, therefore, that an early start begin in:

- human resource capacity building
- developing scientifically sound and culturally sensitive legislation, protocols and guidelines
- consolidating a promising beginning to inter-sectoral teamwork, and
- engaging with local communities and population sub-groups

Accordingly, it is recommended that the first two years of the current HSSP cycle, in particular, should be devoted to these four critical foundation steps in the prioritised NCD areas. Rolling revisions to the HSSP should be responsive to changing needs in these areas.

Detailed Service and Programme Policies – Comprehensive Hospital Care

Detailed Service and Programme Policies – Comprehensive Hospital Care

Comprehensive (Secondary and Tertiary Level) Hospital Care

Major HSSP Emphasis:	**Goal 1**
Key Documents:	NDP, *Decree-Law: 1/2005 Statutes of Hospitals*, HPFP, Basic Services Package, 2004 Standard Treatment Guidelines for Primary Health Care Facilities in Timor-Leste (including essential medicines protocols), Basic Emergency Obstetrical and Neonatal Care Training for Health Providers at National and Referral Hospitals
Key Resources:	Hospital Guidelines including WHO (2005) *Pocket Book of Hospital Care for Children*, WHO, Geneva (which includes topics such as neonatal care, surgical problems, injuries, poisoning and others – extending IMCI to the hospital setting), WHO (2000) *Management of the Child with a Serious Infection or Severe Malnutrition: Guidelines for Management at a District Hospital*, WHO, Geneva, WHO (various dates) Technical Review Papers, D. Jamison et al (eds) (2006) *Disease Control Priorities in Developing Countries*, 2nd ed, OUP and The World Bank, New York (which includes chapters on district hospitals, referral hospitals, surgery, emergency medical services, strategic management of clinical services among other topics of relevance), Duke, T. et al (2006) Editorial: Hospital Care for Children in Developing Countries: Clinical Guidelines and the Need for Evidence, *Journal of Tropical Pediatrics* Vol. 52, No. 1, pp. 1-2, Graham, W. et al (2000) Criteria for Clinical Audit of the Quality of Hospital-Based Obstetric Care in Developing Countries, *Bulletin of the World Health Organisation*, Vol. 78, No. 5, pp. 1-11
Useful Websites:	http://www.who.int/child-adolescent-health/publications/CHILD_HEALTH/PB.htm http://www.dcp2.org/pubs/DCP bulletin@who.int
Important Strategic Documents not yet drafted:	Treatment and referral guidelines (or clinical pathways) adopted for Timor-Leste for major hospital specialty and sub-specialty medical and surgical areas Lists of common presenting problems for adults with standard definitions, initial diagnoses and management, ongoing management and objectives, indications for specialty care referral and criteria for return to primary care

Situational Analysis:

Since 2001 the priority focus of policy development and implementation within the Timor-Leste MOH has been on strengthening the network of primary health care facilities and their various services and programmes. Meanwhile major rebuilding and rehabilitation of the fabric of the national and referral hospitals and of the larger district health centres has proceeded relatively slowly notwithstanding significant technical and financial input from government and development partners.

Within the next eighteen months the major hospital capital works reconstruction programme will conclude. Modern state-of-the-art facilities are soon to open in Dili, Maliana, Oecusse and Maubisse, and others will follow in 2008 in Baucau and Suai. The passage in 2005 of hospital "autonomy" legislation and the recent approval of the Basic Services Package for Primary Health Care and Hospitals together with the imminent release of the Health Sector Referral Policy and the Remote Area Policy formalises and consolidates the delineation of an integrated system of health care delivery across the nation.

These circumstances also set the scene for a sustained period of technically assisted, in-depth analysis and implementation of standards of hospital clinical, technical, management and administrative practice that will act to enhance quality of institutional services overall. In the clinical sphere, improvements will occur through enhanced systems and methods in standard and emergency triage, diagnosis, treatment guidelines ("clinical pathways"), supportive care, and monitoring and follow-up.

It is anticipated that steady progress will be made in reducing current hospital mortality and iatrogenic complications. Of course, improvements in these areas will require not only standards development, but also complementary and coinciding initiatives in human resource capacity development, financial and asset management systems and practices, and audit and quality improvement initiatives as well.

The BSP provides direction for the Ministry and for management boards and executive teams of each hospital on the minimum range of secondary (that is, more "complex") medical and nursing services to be offered at referral hospitals and tertiary services at the more narrowly delineated national hospital level. As the BSP notes:

The procedures to be done at referral hospitals depend to a large degree on the level of skill and equipment available. Where there are specialist surgeons, obstetricians or paediatricians [working in tandem with nurses and other professional and

technical staff with appropriate experience and skills]…more complex services can be provided.

Annexed to the BSP (Annex 2) is a template listing minimum referral and national hospital care and support functions designed to guide decisions about the appropriateness and priority ranking of specific clinical programmes to best meet the health needs of catchment populations. The template identifies the following specialty and sub-specialty areas:

- Outpatient services (diagnostics, referrals, accident and emergency, eye and dental services)
- Internal medicine services (communicable diseases, NCD and gerontology)
- Obstetrics and gynaecology services (antenatal, BEOC, comprehensive emergency obstetrics care, gynaecology, family planning, infertility and O&G surgery)
- Paediatric and neonatal services (nutrition, communicable diseases, NCD, psychiatry)
- Surgical services (general, ENT, neurosurgery, eye, orthopaedics, plastics, trauma, urology, vascular and OH&S)

This framework (together with complementary service and diagnostic delineations noted in Annex 1 of the BSP) should be seen also as a tool to assist hospital managers, and the MOH more broadly, in prioritising human resource, asset and infrastructure needs as part of each hospital's strategic, operational, business and budget planning activities.

Objective: **To ensure that Timor-Leste's referral hospitals and the national referral hospital contribute in a cost-effective and cost-efficient manner to national health status improvements through appropriate, internationally accepted quality of care standards and in accordance with the minimum set of delineated roles and functions specified in the BSP**

Strategy 1: **Mid term strategic plans prepared by all referral hospitals and the national referral hospital in consultation with the MOH and other stakeholders (including consumer representatives) and with external technical assistance. These plans should be based on international standards of practice and the BSP framework and should identify priority second (and third level) referral hospital services to be offered to catchment populations as part of an integrated, efficient, comprehensive and needs-based network of health care delivery**

Indicators 1: Mid-term strategic plans produced and socialised

Strategic plans identify priority speciality/sub-specialty areas in keeping with the BSP directives and protocols

	Strategic plans identify relevant referral criteria and these are used to guide practice
	Referral policies produced and socialised
	Operationalisation of human, financial and other resource needs through annual activity plans
	Operationalisation of information management needs through facility annual activity plans
Strategy 2:	**Clinical standards for all hospital-based specialty and sub-specialty areas as identified in the BSP established and used as the basis of monitoring quality of care**
Indicators 2:	Agreed systems of clinical triage, diagnosis, treatment and auditing implemented
	Clinical pathways model or similar suitable approach identified, adopted for local conditions and used in all prioritised specialty and sub-specialty clinical areas
	Clinical audit and peer review system adopted and implemented with regular publication of findings
Strategy 3:	A comprehensive programme of human resource development implemented by all referral hospitals (with the support of the MOH) to enhance the operationalisation of the mid term strategic plans
Indicators 3:	Management and support skills profile applied for use in determining capacity development needs
	Clinical skills profile applied for use in determining capacity development needs
Results of skills audits used in determining capacity deficits and guiding decisions about HRD focus	
Implementation Summary:	**Programme and Service Activities**
	Confirm and socialise comprehensive hospital care priority areas according to BSP and relevant MDG targets
	Ensure optimal integration of comprehensive hospital care services within the hospital referral network according to the distinctive roles and service directives of the BSP
	Develop and strengthen family and community participation and engagement in the range of comprehensive hospital services
	Management and Support Activities
	Manage, supervise and champion comprehensive hospital care across the health system
	Consolidate and systematically extend comprehensive hospital care capacity development across the institutional health workforce
	Ensure effective financial, procurement and distribution systems to guarantee the availability of adequate supplies of essential equipment, assets and

other resources for effective comprehensive hospital care practice
Develop and implement appropriate universal referral procedures to support an articulated health system

Monitoring and Coordination Activities

Establish and apply appropriate monitoring and assessment systems to promote comprehensive hospital care service quality, consistency and conformity to approved standards
Establish and promote partnership arrangements with NGOs, community-based agencies and health service consumers locally to embed comprehensive hospital care strategies
Collaborate with all major stakeholders in operationalising comprehensive hospital care strategic priorities
Engage inter-sectorally across government and the private sector to promote and institutionalise the benefits of appropriate comprehensive hospital care strategies

Assumptions and Risks: Many of the strategies noted are dependent on the availability of significant financial, human and other resources. Equally important, however, is the need for clear and energetic political and policy commitment to follow through and sustain strategies that will often require extended lead time to demonstrate positive benefits. It is assumed that the necessary resources will be made available to support the strategies listed and that political and administrative commitment will remain strong. Lack of any of these fundamental inputs jeopardises the viability of the comprehensive hospital care programme.

Time Frame: The five year timeframe of the HSSP (2008-2012) will be insufficient to see the resolution of many of the challenges facing the Timor-Leste hospital network. Progress will be incremental in many cases. It is important, therefore, that an early start begin in:

- human resource capacity building
- developing scientifically sound and culturally sensitive legislation, protocols and guidelines
- consolidating a promising beginning to inter-sectoral teamwork, and
- engaging with local communities and population sub-groups

Accordingly, it is recommended that the first two years of the current HSSP cycle, in particular, should be devoted to these four critical foundation steps in the hospital services sector. Rolling revisions to the HSSP should be responsive to changing needs in the sector.

Detailed Service and Programme Policies – Environmental Health

Detailed Service and Programme Policies – Environmental Health

Environmental Health

Major HSSP Emphasis: **Goal 1**

Key Documents: NDP, HPFP, Basic Services Package, Environmental Health Strategy (the "umbrella" micro-policy), Intersectoral Action Framework for Wellbeing and Health, National Mosquito Borne Disease Control Strategy, National Avian Influenza Strategy, National Food Security Policy, Operational Plan and Protocols for A Dengue Outbreak Control Programme in Dili, and relevant public health legislation

Important Strategic Documents not yet drafted: National Water and Sanitation Policy, Occupational Health and Safety Policy, Housing and Building Policy, Ambient Air Quality Policy, regulations, guidelines and protocols relating to major features of population health

Situational Analysis: A healthy environment is a pre-requisite to good health and a sound economy. The major pre-conditions for a healthy environment are: safe water supply, sensible sanitation and hygiene practice, safe systems of food processing and storage, an absence of vermin and disease transmitting vectors, appropriate means of waste management, safe work places, sound housing and clean air. Currently, in Timor-Leste these pre-conditions are met only sporadically, often with dire consequences for national health status. The Government - through the promotion of cooperative inter-ministerial and development partner activity and through community engagement at central and local levels - is committed to improving these environmental determinants of health and wellbeing. However, the paucity of public health infrastructure (for example, adequate water and waste disposal systems, extensive electricity grids, assured communication and transportation systems, sealed roads, solid housing stock, etc.) combined with a systemic lack of knowledge and understanding of public health risks and appropriate personal hygiene practices, signals the enormity of the challenges ahead.

The health profile of Timor-Leste features endemic states of acute respiratory infections, diarrhoeal diseases and malaria. High rates of dengue fever, tuberculosis, leprosy and internal parasites are prevalent also. All of these conditions are linked closely with environmental factors. Similarly, many

people suffer from both acute and chronic illnesses relating to poor hygiene, inadequate sanitation and/or unsafe water supply, sub-standard housing and harsh workplace conditions.

The brief overview that follows on the main components of the environmental health challenges facing Timor-Leste should not be construed as suggesting that that the various issues presented are discrete from one another. In essence, environmental health is about interactivities, inter-relationships and causes and effects. Similarly, effective management of environmental health concerns involves inter-sectoral, cross cutting approaches to attitude and behaviour change on the part of government, the private sector and the community, all committed to a common goal.

Objective: **To improve the quality of the environment of Timor-Leste to assist in enhancing the health and wellbeing of the population and to reduce rates of illness, injury and death**

Strategy 1 Environmental Health Generally: **Raise the profile of Timor-Leste's major environmental health issues at international and national levels, across government instrumentalities and other agencies, and within population sub-groups**

Indicators 1:

Documentary evidence (policies, strategies, training ventures, etc.) supporting/mentoring Timor Leste's environmental health agenda and specific strategic directions

Relevant legislation enacted and regulations approved

MOUs signed and implemented

Development partners support policy development with resource augmentation

Schedule of environmental health interactivities publicised

Other stakeholders commit to approved environmental agenda

Output of environmental health consultative activities produced

New/changed environmental health arrangements implemented

Strategy 2 Environmental Health Generally: **Establish a shared platform for environmental health practice across government and within population sub-groups in Timor-Leste**

Indicator 2: Intersectoral environmental health guidelines and protocols prepared and publicised

Situational analysis Water:	The majority of the Timor-Leste population – in both urban and rural areas - does not have access to consistently safe, protected water sources. Catchment areas for urban water supply in particular are unprotected from microbial and chemical contamination of human settlement, free roaming livestock and agricultural activity.
Strategy 3:	**Improve access to safe water in Timor-Leste in order to reduce waterborne disease**
Indicators 3:	MOH draft regulatory arrangements produced and presented to government MOH water quality standards publicised MOH water quality monitoring activities scheduled and implemented (for both production and supply points) Shared monitoring responsibilities agreed and operationalised Compliance monitored (% of district and sub-district centres adopting regular monitoring of water quality at production points and undertaking follow up actions for improvement) Implementation of recommendations monitored (% of community water schemes adopting community based approaches for water quality improvement through source protection and possible disinfection) MOH guidelines prepared for water quality improvement strategies MOH follow-up actions such as sanitary inspection, source protection, disinfection at production points and disinfection at the point of use (household level) implemented
Situational analysis Sanitation:	The close connection between water supply and man-made contamination is highlighted in survey findings that suggest that persistently higher rates of childhood mortality and morbidity in rural areas of Timor-Leste are due in part to the close proximity of primitive toilet facilities to household water supplies.
Strategy 4:	**Improve sanitation and hygiene practices in Timor-Leste in order to reduce the incidence of faeco-oral transmitted diseases**
Indicators 4	Sanitation and hygiene legislation approved MOH guidelines on public sanitation and hand washing produced and implemented Strategy document produced and socialised MOH sanitation and hygiene education campaigns developed, scheduled and implemented Attitudinal changes to sanitation and hygiene achieved (% of communities adopting MOH comprehensive hygiene promotion approach to sanitation services and protocols; % schools adopting MOH hygiene promotion approach to sanitation services and protocols)

Situational Analysis Food:

Food-borne diseases have a significant impact on health in Timor-Leste. Consumption of locally produced food (purchased in villages or central markets) is the norm across the country with only limited availability of processed and packaged foods. Typically, food eaten outside the home is prepared by either stationary or mobile street vendors. Environmental health concerns relate to poor preparation, handling and storage of food products, lack of infrastructure such as potable water and refrigeration and lack of awareness about food safety and hygiene.

Strategy 5:

Reduce the risk of food-borne disease in Timor-Leste by ensuring adequate safeguards in food preparation, processing, transportation and storage

Indicators 5:

National Food Safety Working Group established and meeting regularly (at least twice yearly)

Food safety legislation approved

Guidelines and procedures implemented and monitored

food poisoning outbreaks investigated

Food safety compliance monitored inter-sectorally

Food handlers have completed the basic food safety training course

Situational Analysis Vector Control:

Mosquito-borne diseases such as malaria, dengue, Japanese encephalitis and filariasis are second only to respiratory diseases as the leading cause of illness and death in Timor-Leste. Across the country, dwellings and their surrounds, agricultural and industrial sites, and road-building and other development programmes have created significant breeding habitats for mosquitoes. There is a need for coordination with communicable disease vector control activities.

Strategy 6:

Reduce illness and death in Timor-Leste from vector-borne diseases, especially mosquito-borne disease

Indicators 6:

MOH-led vector control working group established and meeting regularly (twice yearly)

MOH current status bulletins of vector borne disease control methods produced for all arms of government (agriculture, education, etc.)

MOH intersectoral programmes (vector control working groups) developed to reduce the vectors

MOH vision of a vector-free Timor-Leste produced

National and local BCC/BCI campaigns scheduled and conducted

Districts with local contingency plans in place

	Districts with vector density monitoring mechanisms in place Appropriate and responsive surveillance and tracking systems in place Integrated vector control management systems in place
Situational Analysis Waste Management:	Refuse management practices are less than ideal in East Timor. In urban areas waste products are placed in open street-level bins through which animals scavenge. The waste then accumulates on footpaths and in the streets. The portion of the waste that is burnt includes highly contaminant plastics and other substances that produce air pollutants, fine particulate matter and volatile organic compounds.
Strategy 7:	**Minimise the impact in Timor-Leste of human generated waste on the environment and on health**
Indicators 7:	Intersectoral working party on waste management established National guidelines to support legislation on waste management developed and approved Districts have access to behaviour change material on waste management and have operationalised strategies supporting waste management principles Strategies supporting waste management principles implemented
Situational Analysis (Occupational Health and Safety):	Safe working conditions have yet to be considered as an integral part of environmental health in Timor-Leste because of the significant and immediate challenges of communicable diseases and maternal and child morbidity. This situation will change as the economy strengthens, as agricultural and other industries proliferate and mechanise, and as more people are exposed to occupational dangers. The principles of a safe society will then ensure greater attention to legislation, regulation and guidelines to promote workplace safety and related occupational health and safety training.
Strategy 8:	**Minimise occupational health risks and promote a healthy workforce in Timor-Leste**
Indicators 8:	OH&S intersectoral for a established to address the issue broadly WHO healthy workplace model adopted intersectorally Comprehensive set of workplace standards and guidelines developed and disseminated with related training across workplaces

Situational Analysis Housing:

The agrarian basis of Timor-Leste society has influenced housing design and preferred disposable construction materials even in the urban centres. With large families living in cramped and non-purpose built dwellings, communicable diseases proliferate.

The list of unhealthy housing conditions is lengthy. The following is a sample only: poor (or no) flooring materials, inadequate floor space, limited barriers to vermin and livestock, unhealthy waste disposal infrastructure, cramped sleeping arrangements, poor ventilation, no discrete food preparation areas, limited potable water access, suspect drainage systems leading to problems associated with rising damp.

Cultural mores and economic costs of alternative designs and materials discount opportunities for improvements. Lack of regulation and guidelines fosters sub-standard construction in both the public and private sectors.

International standards are applied in rebuilding and rehabilitating damaged public infrastructure. Meanwhile, much of the building stock to be rehabilitated continues to be occupied by government or private individuals and families despite its inadequacy and unsuitability for the current role it plays.

Strategy 9: **Strengthen health through the promotion of building and housing standards in Timor-Leste**

Indicators 9:

MOH assistance in developing practical guidelines on the health benefits of healthy housing

Guidelines available to the general public through MOH facilities nation-wide

MOH district workforce includes a person trained in public health aspects of healthy housing who is available to offer advice on demand and to engage in dissemination when requested

MOH districts actively provide public health comments on the design of existing or proposed new buildings when requested

Situational Analysis Air:

Fire is the major source of air contamination in Timor-Leste. Wood-based cooking, removal of landfill and subsequent clearing of land and burning of grasses combine to pollute all areas of the country, especially the major towns and urban centres. Vehicle exhaust emissions, power plants, small industry (solvents, exhaust fumes, vapours and generators) and cigarette smoking add to the problem. Chemical spills and other industrial accidents are possible. Most of the air pollution in Timor-Leste is man-made and therefore controllable.

Strategy 10: **Improve indoor and outdoor air quality to minimise illness and death from respiratory and other air-pollution related diseases in Timor-Leste**

Indicators 10:

MOH districts provide advice on the public health aspects of clean air on demand

MOH districts provide BCC/BCI material and interventions as identified in the district and sub-district operational plans

Implementation Summary:

Programme and Service Activities

Confirm and socialise environmental health priority areas according to BSP and relevant MDG targets
Ensure optimal integration of environmental health programmes and services within all health facilities at both community and referral levels according to the distinctive roles and service directives of the BSP
Develop and strengthen family and community participation and engagement to support appropriate environmental health programmes and services

Management and Support Activities

Manage, supervise and champion environmental health priorities across all tiers of the health system
Consolidate and systematically extend environmental health capacity development across the health workforce
Ensure effective financial, procurement and distribution systems to guarantee the availability of adequate supplies of essential equipment, assets and other resources for effective environmental health practice

Monitoring and Coordination Activities

Establish and apply appropriate monitoring and assessment systems to promote environmental health programme and service quality, consistency and conformity to approved standards
Establish and promote partnership arrangements with NGOs, community-based agencies and health service consumers locally to embed environmental health strategies
Collaborate with all major stakeholders in operationalising environmental health strategic priorities
Engage inter-sectorally across government and the private sector to promote and institutionalise the benefits of appropriate environmental health strategies

Assumptions and Risks: Many of the strategies noted are dependent on the availability of significant financial, human and other resources. Equally important, however, is the need for clear and energetic political and policy commitment to follow through and sustain strategies that will often require extended lead time to demonstrate positive benefits. It is assumed that the necessary resources will be made available to support the strategies listed and that political and administrative commitment will remain strong. Lack of any of these fundamental inputs jeopardises the viability of the environmental health programme.

Time Frame: The five year timeframe of the HSSP (2008-2012) will be insufficient to see the resolution of many of the environmental health challenges facing Timor-Leste. Progress will be incremental in many cases. It is important, therefore, that an early start begin in:

- human resource capacity building
- developing scientifically sound and culturally sensitive legislation, protocols and guidelines
- consolidating a promising beginning to inter-sectoral teamwork, and
- engaging with local communities and population sub-groups

Accordingly, it is recommended that the first two years of the current HSSP cycle, in particular, should be devoted to these four critical foundation areas in each of the major environmental health strategic components. Rolling revisions to the HSSP should be responsive to continuing need in these areas.

Detailed Service and Programme Policies – Referral

Detailed Service and Programme Policies – Referral

A principal feature of a smoothly functioning health care system is the effectiveness of the relationships between the different components of the system – in Timor-Leste's case the mobile clinics, health posts, health centres, district teams, referral hospitals and beyond. Theoretically, every client who comes forward for some form of health care intervention in a well oiled system will be managed in such a way that s/he will arrive eventually at the appropriate level of service capable of offering optimal care (including being treated at a relatively convenient location close to home) given the presenting problems.

There is an underlying assumption that the system comprises a series of articulated links well planned to ensure a seamless experience through an appropriate referral process. Of course, the reality in many countries including Timor-Leste is far different. There are many complicating factors (some system-derived, some provider, some consumer) that confound this model of a smoothly functioning and seamless process. Any clinician or manager working in the health sector will be aware of the obstacles that frustrate and hinder the implementation of a comprehensive and integrated referral process. Need is just one of many drivers that act to align health care attention with defined and delineated roles at different tiers of the system.

In Timor-Leste, as elsewhere, effective referral requires clear communication to assure that patients receive optimal care at each level of the system. Referral involves moving patients between facilities. Accordingly, the facilitation role of the managers of all facilities involved becomes central. The process requires good communication accompanying patients in both directions: upward (describing presenting problems at the lower tier facility and requesting specific help) and downward (information back to the lower tier facility describing findings, actions taken and follow-up needed).

A necessary aspect of any system of referral is the referral form. This should be designed to facilitate communication in both directions. It can involve written narrative on the patient- held record or it can be a stand alone report. Every patient referred upwards should be accompanied by a written record of the findings of examination, the questions asked, any treatment/s given and specific reasons for referral. There should also be an explicit statement of expectation from the lower tier facility – that is a request for feedback to assist in their clinical management development and to complete their statistical records. Such communication should accompany the patient (usually carried by the patient) and a clear designation of the facility to which the patient is being sent.

"Back-referral" from the higher tier facility to the original "triaging" facility is vital. This communication contains answers to the questions posed with specific findings, special investigations, diagnoses, treatment/s offered and follow-up expected from the referring facility. The back-referral may be written in the patient-held record. However, more commonly such information is provided on a separate form which should be delivered by the patient to the original post or centre.

The weakest part of this referral process is generally "back-referral" from the higher tier facility. Appropriate communication not only assures proper patient care and follow-up, but provides an important form of continuing education for the staff at the referring facility. The manager must ensure that such communication occurs as a matter of course. In its absence a report must be generated seeking completion of the patient record. Managers must review all referrals made to/from their facilities each month as part of an overall quality assurance process to promote

appropriateness of decisions to refer. Typically, between 5% and 10% of patients seen in a primary health setting are appropriately referred to a higher tier for either diagnostic or more specialised care. Managers and their teams should discuss referred cases as part of case management review. In analysing referrals the following points should be considered:

- Those cases that should have been more properly treated at the facility itself without referral
- Those cases that should have been referred but were handled locally
- The information gained through the back-referral process to determine whether the information is adequate and being acted upon by the original facility

Monthly review of referral upwards and back-referrals received is an important management function. To complete the cycle the manager must follow-up cases that have been referred with no feedback received to ensure that patients arrived at the higher tier facility and to determine what actions, if any, were taken and what follow-up, if any, is needed at the originating facility.

With the recent production of the BSP, Timor-Leste has entered into a new phase in health care delivery. Role delineations provide clear guidance on just what health care needs should be managed locally and what should be more appropriately dealt with through referral. The MOH appreciates the need for a formal policy on referral processes and has begun the task of drafting a comprehensive policy statement involving specific guidelines and protocols. As part of wide consultation, some preliminary work has been undertaken in drafting and piloting a simple referral form that allows for the various requirements of good communication noted above. This work will continue as a matter of urgency.

Detailed Service and Programme Policies – Support Areas

Detailed Service and Programme Policies – Support Areas

Detailed attention is given in Section 5 of the strategic plan to what are referred to as "cross-cutting" issues. These are the ten functional areas that have immediate relevance right across the health care system. Accordingly they are conceived of as priority areas for strategic action. The ten areas are:

- Health services delivery
- Behavioural change/health promotion
- Quality improvement
- Human resource development
- Health financing
- Asset management
- Institutional development
- HMIS
- Gender equity
- Research

All ten could be labelled "support areas" but have been given a higher status within the HSSP on the grounds of the breadth of their overarching significance. There are two other support issues that, while still important, are less comprehensive in their impact on sector-wide behaviour. Each contributes more particularly to specific aspects of the Ministry's operations. These, then, are the focus of this section of the HSSP.

Ambulance Services

The MOH anticipates an overall increase in utilisation of public health services as the initiatives driven by the BSP and HSSP take effect. It is expected that performance improvements within the system and increased awareness of the benefits of evidenced-based health seeking behaviour within communities will translate into higher attendances at public health care facilities.

This very desirable situation, when coupled with Timor-Leste's extreme geographic and climatic characteristics, will place additional pressures on the system's communications and transport networks to support what is likely to be an upsurge in ambulance-based referral and retrieval functions.

Currently, because of ill-defined roles, ambulance services in Timor-Leste function in a less than consistent and purposeful mode. They tend to be managed idiosyncratically in most districts and larger centres, and often serve purposes other than those for which they were introduced. These circumstances combined with the (well described) challenges in road networks and the long distances between communities and their local health facilities and between facilities at different tiers of the system, have created a chaotic arrangement of isolated and irregular transport outside major urban areas.

Strengthening patient retrieval and transfer is an important adjunct to aspects of quality improvement as described in the HSSP. The donation of several new, well equipped ambulances to the MOH is a much needed technical fillip. However, in itself this input will be insufficient to guarantee sustained improvement. What is required in addition is an enhanced management and administrative capability to marshal resources in the best interest of service populations. The Ministry acknowledges the requirement for a situational analysis of the ambulance service in Timor-Leste to determine how best to proceed in strengthening the service throughout the country. Such an analysis involving inter- and intra-sectoral

partners, will consider financial, asset management and human development needs.

Drugs and medical supplies

The MOH currently oversees the financial administration of the pharmaceutical and medical supplies programme for Timor-Leste. However, in keeping with the prevailing philosophy of devolving management decision-making where appropriate and the enacting of the Decree Law on SAMES, it is anticipated that as the planning period is ushered in, SAMES will increasingly assume control over its entire operations. The agency will then function in a largely autonomous fashion, operate commercially and on a self-sustaining basis while remaining a "not-for-profit" business entity accountable to the Ministry.

Several of the recommendations in the MOH functional analysis relating to SAMES have been adopted for implementation:

- Monitoring findings of the SIHSIP BSP and HSP roll-out and review in terms of organisational or other systems improvements that may be required at SAMES
- Supporting SAMES in its efforts to establish itself as a viable business entity subject to its obligations under law
- Subjecting the SAMES management processes and operating systems to the same forms of scrutiny as private sector agencies through licensing and regulation processes in order to promote accountability

Technical assistance to SAMES in several areas is planned to continue until the agency can demonstrate evidence of sustained ability to meet its obligations under law. Details of the technical assistance to be provided to SAMES are noted in Annex E. The MOH has determined that the assistance will focus on:

- General Management
- Forecasting
- Warehousing
- Distribution
- Procurement
- Financial Management

While SAMES is not a complicated organisation, the development of an asset, human resource and financial plan leading to an overall business plan has been unattainable. The appointment of a general manager/technical adviser with business acumen and with entrepreneurial flare is being promoted as an essential first step in energising SAMES. The MOH through its senior executive team will work in tandem with the General Manager in structuring the future of the agency and will agree on a suitable M&E programme to monitor achievement of predetermined milestones.

SECTION 5 STRATEGIC PLAN: CROSS CUTTING ISSUES

Cross-cutting issues

Stakeholder consultation during the development of the HSSP highlighted ten cross-cutting areas of activity as of particular importance to the MOH in its efforts to reach strategic goals. The ten areas are shown below in Box 8.

Box 8: Key areas of work

- Health services delivery
- Behavioural change/health promotion
- Quality improvement
- Human resource development
- Health financing
- Asset management
- Institutional development
- HMIS
- Gender equity
- Research

The ten areas are listed in a conceptually logical order. Unless circumstances change in how and where health care services are delivered the MOH will not succeed in reducing the seriously high levels of mortality and morbidity in Timor-Leste, especially among mothers and children. Issues surrounding communication, lifestyle (health promotion) and quality are linked to the demand for, and use of, health services. Whatever is done over the next five years will have major implications for human resources and for the financial and asset management of the health sector. Unless there are changes in the health system as a whole - that is at the institutional or organisational level - the chances of successful achievement of intended outcomes are limited. Affirmative action for women and a focus on (operational) research to translate systematic enquiry into improved modes of current and future practice are also vital.

During the implementation phase of the HSSP, health services delivery will remain the top priority area. However, all other cross-cutting areas noted need to be considered as vital to each other and to health services. Therefore due weight should be given to all areas depending on the needs and problems at each tier of the health system.

There are 17 essential strategies relating to the ten cross-cutting areas. They have been grouped according to the key areas of work. The strategies are the priorities for the system as a whole. They reflect the underlying values and working principles of the MOH. They are listed in Box 9 on the following page. The criteria for choosing these 17 cross-cutting strategies were urgency, cost-effectiveness and feasibility.

Box 9: The 17 essential cross-cutting strategies

Health services delivery

1. Further improve coverage and access to health services especially for the poor, the remote and other vulnerable groups through appropriate location of health facilities and the strengthening of outreach services
2. Strengthen delivery of basic health services by ensuring that the directives of the BSP are implemented at all mobile clinics, health posts, health centres and hospitals
3. Strengthen delivery of quality care, especially maternal and child health services, in all facilities through capacity development measures such as BEOC, IMCI and nutrition continuing professional development programs

Behavioural change / health promotion

4. Change for the better the attitudes of health care providers sector-wide to effectively communicate with consumers especially in relation to the needs of the poor and other vulnerable groups through sensitisation and the building of good interpersonal skills
5. Strengthen BCC activities to promote better community appreciation of the value of effective evidence-based medicine and health care

Quality improvement

6. Develop a culture of quality in public health service delivery and management through the use of MOH quality practice and professional standards

Human resource development

7. Strengthen human resource planning to reduce mal-distribution of the numbers and type of workforce through identification of posts and the reallocation of staff.
8. Introduce a broad-based incentive scheme to assist in appropriate deployment of qualified staff across the health care sector
9. Increase the number of skilled midwives through enhanced pre-service and articulated training opportunities and through improved supervision and control measures at work
10. Strengthen the capacity of nurses and allied health professionals in community-based work
11. Strengthen the skills, know-how and attitudes of managers at all tiers of the health system

Health financing

12. Further develop the evolved system of financial management and strengthen financial management capacity throughout the sector

Asset management

13. Develop a systematised approach to asset management that includes appropriate standards, technical guidelines, protocols and audit practices for asset procurement, maintenance and replacement, renewal and disposal
    Institutional development

Organisational Development

14. Organisational and management reform of structures, systems and procedures in the MOH to respond effectively to change as per the accepted recommendations of the functional analysis

HMIS

15. Prepare an information master strategic plan that would guide the appropriate phasing-in of different information sub-systems

Gender equity

16. Promote gender mainstreaming in the MOH, improve awareness of gender issues throughout the health workforce and provide affirmative action opportunities for women

Research

17. Establish an operational research centre to assist in developing research capacity within the health sector of Timor-Leste to address health and system challenges and to inform clinical and public health practice

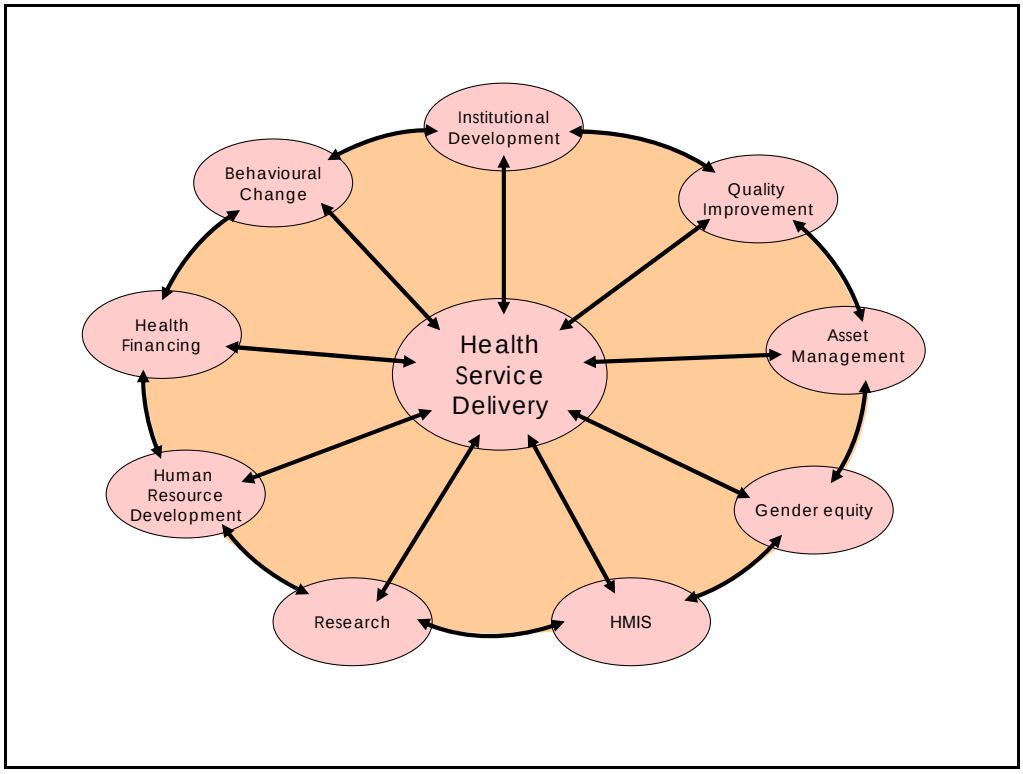
Health services delivery

Since 2002 the MOH has progressed significantly in advancing accessibility of health care services. Less attention has been given to equity of coverage and affordability (broadly defined) over the past five years. The implementation of the BSP and the heightened movement towards decentralisation (with or without municipalities) have introduced additional pressures to rectify this situation. If the MOH is to have a sustained impact on reducing the extremely high levels of mortality and morbidity especially among mothers and children there is a need for sector-wide work on priority challenges in health service delivery. These include:

- Improving coverage and utilisation of services
- Integrating national programmes at central, district and sub-district levels
- Implementing a quality and evidence-based approach to interventions
- Promoting community and private sector participation in the planning and practice of heath service delivery

Health services have a central place in the HSSP. Strategies in the other areas can be seen in support of achieving health service delivery outcomes, see Figure 1 below. This circumstance is right for this time in Timor-Leste but will need to be reassessed in the next planning period – that is, from 2013 onwards.

Figure 1: The central place of health services



During the process of developing health services delivery strategies, the MOH considered the catalogue of micro-policy initiatives (listed in Section 4), the priority health service interventions of the situational analysis (included in Section 3 and reproduced again below in Box 10 for ease of reference) and the BSP-defined facility role delineations.

Strategies:

- Further improve coverage and access to health services especially for the poor, the remote and other vulnerable groups through appropriate location of health facilities and the strengthening of outreach services
- Strengthen delivery of basic health services by ensuring that the directives of the BSP are implemented at all mobile clinics, health posts, health centres and hospitals
- Strengthen delivery of quality care, especially maternal and child health services, in all facilities through capacity development measures such as BEOC, IMCI and nutrition CPD programmes
- Strengthen the integrated management of cost-effective interventions to control communicable diseases

Outcomes:

- Improved coverage
- Increased utilisation of preventive and curative services especially by the poor and those from remote areas
- Reduction of prevalence rates of communicable diseases
- Increased availability of supplies and functioning equipment
- Effective referral system

Box 10: Priority health service interventions

Maternal, new born and child health
- Basic emergency obstetric care including institutionally-based delivery
- Essential newborn care
- IMCI
- Infant and young child feeding

Prevention and control of epidemic prone disease

Health prevention, protection, and promotion
- National immunisation programme
- Bednet use
- Nutrition education and growth promotion and healthy diet
- Mental health
- Alcohol, drugs and tobacco
- Reproductive choice and family planning (including STIs, HIV/AIDS etc)
- Eye care
- Oral care
- Safe drinking water and food safety
- Vitamin A and iron/folate supplementation and iodine

Integrated Management of selected disease
- Malaria
- Dengue fever
- HAST [STIs & HIV/AIDS TB]
- Leprosy
- Respiratory tract infections
- Diarrhoeal diseases
- Parasitic diseases (especially intestinal parasites and lymphatic filariasis
- Hypertension and diabetes

Smoking related diseases

Emergency care for trauma and accidents
- Road traffic accidents
- Accidents in the home and at work

Behavioural change / health promotion

(So named to differentiate the cross-cutting area from the programmatic area of health promotion and to highlight the sector-wide requirement that all health service professionals adopt a "behaviour change attitude" as part of their core business)

Consumers and potential consumers need information and insights that will enable them to make considered decisions about what they will do to promote better health for themselves, their families and their communities.

Some Timor-Leste MOH personnel are acknowledged as excellent communicators with their patients, clients and communities. However, overall the public health sector has a less than glowing reputation for responsiveness to consumer needs, especially of the poor and of people from remote areas. This may in part account for the significant reliance on traditional healers and on sections of the private health care sector care, and the concomitant low rates of utilisation of cost-effective primary health interventions in the public sector.

While simultaneously improving quality of care, the MOH intends both to enhance the capacity of providers to be more responsive to, and communicate better with, consumers (and potential consumers) and to empower consumers and communities more broadly to have a say on how, when, where and why health care is provided.

The MOH has put considerable effort into strategies for saving lives and treating acute conditions, particularly those related to infectious and vector-borne diseases and malnutrition. This work needs to continue because mortality and morbidity rates for women and children remain high. However, there is a need now for a major effort to promote healthy lifestyles to prevent the burden of chronic conditions such as cancer, tobacco related diseases, diabetes, cardiovascular disease and depression. Similarly, there is a need to combat the alarming incidence of road traffic accidents and to address emerging public health issues such as substance abuse and work and environmental safety.

Preventing a rise in chronic conditions cannot be addressed by the MOH acting alone. Inter-sectoral collaboration and coordination is crucial, for example in areas such as legislative and policy development for healthy environments and on mass media campaigns and advertising. Within the Ministry there is a pressing need for all professional staff to assume a health promoting attitude and to adopt health promoting as a central feature of their working lives.

Strategies:

- Change for the better the attitudes of health providers sector-wide to effectively communicate with consumers, especially regarding the needs of the poor and other vulnerable groups through sensitisation and the building of good interpersonal communication skills
- Empower consumers, especially women, to interact with other stakeholders in the development of quality health services through mass media and inter-personal communication
- Strengthen BCC activities to promote better community appreciation of the value of effective evidence-based medicine and health care
- Promote healthy lifestyles and appropriate health seeking behaviour through advocating for healthy environments and implementing counselling and behavioural change activities

Outcome:

- Appropriate practices and healthy lifestyles as a result of informed decisions, especially by women

Quality improvement

The need to improve various aspects of quality has been a topical issue in the health sector of Timor-Leste for some time. The MOH has entered into this discussion with some energy. Unfortunately, there has been little action to substantiate the interchange. What advances have occurred have been patchy. The Ministry is genuine in its concern to ensure quality of prevention, promotion and cure for consumers, quality of life and health improvements for the population, and quality management of its operations and systems.

Quality improvement presents a huge challenge to all stakeholders in the health sector and beyond. It is pivotal to health services delivery and behavioural change/health promotion for it is concerned with issues such as equity, accessibility, effectiveness, efficiency, appropriateness and responsiveness. For the HSSP, the MOH has nominated two key priorities. These are covered in the following strategies.

Strategies:

- Develop a culture of quality in public and private health service delivery and management through the use of MOH quality practice and professional standards.
- Respond to legislative enactments regarding quality standards and systems for the private for-profit sector

Outcomes:

- Institutionalised capacity in the health sector for quality improvement and assurance
- Culture of quality management in the health sector is developed
- Improved quality of health services sector-wide

Human resource development

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

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

Formulating sound HRD policies is dependent on reliable information obtained from various sources - epidemiology, demography, social sciences and economics. The catchphrase frequently applied to the HRD field internationally is very apt for the Timor-Leste health sector at the commencement of the current planning period:

"Ensuring the right staff are in the right place, in the right numbers, at the right time, with the right skills and attitudes" to meet national health status improvement needs.

Strategies:

- Strengthen human resource planning to reduce mal-distribution of the numbers and type of workforce through identification of posts and the reallocation of staff
- Introduce a broad-based incentives scheme to assist in appropriate deployment of qualified staff across the health sector
- Increase the number of skilled midwives through enhanced pre-service and articulated training opportunities and through improved supervision and control measures at work
- Strengthen the capacity of nurses and allied health professionals in community-based work
- Strengthen the skills , know-how and attitudes of managers at all tiers of the health system
- Enhance the management and technical skills and competence of all MOH workers through quality, comprehensive training, education, retention and support measures

Outcomes:

- Better basic and emergency obstetric care, IMCI care and nutrition services available more widely
- Improved (more equitable) performance, deployment and distribution of health staff
- Improved management and technical skills of health staff throughout the sector
- Effective and sustained management and supervision of health personnel

Health financing

The introduction of the MTEF to replace the SIP further substantiates the overall sound policy framework for financing the health sector. As has been noted, the sector is currently well resourced through both the general state budget and donor sources. The MOH can look optimistically to a future of continuing financial support.

However, regardless of the overall solid financial state, of fundamental significance to effective health care delivery is good financial practice based on transparent and efficient budget preparation and expenditure. To achieve an adequate level of financial management expertise throughout the system will require a significant programme of capacity development.

The issue of the adequacy of salaries and wages for health workers is a looming problem and part of the bigger issue of incentives. It requires the attention of government.

Strategies:

- Further develop the evolved system of financial management and strengthen financial management capacity throughout the sector
- Distribute financial resources by equitable and transparent means to improve the accessibility of health services for the poor and those from rural and remote areas through alternative resource allocation schemes

Outcomes:

- Improved system of devolved financial management
- Increased cost-effectiveness and efficiency of health service delivery systems
- Enhanced equity in resource allocation on the basis of need
- Reduced barriers to service accessibility for the poor and those from rural and remote areas
- Improved transparency in management of funds

Asset management

In essence, asset management is about caring for the wide range of items that comprise an organisation's inventory of holdings. For the MOH it means ensuring the viability and operational readiness (through an ongoing system of repair, maintenance and renewal – or RMR) of the following classes of goods - buildings, plant, biomedical equipment, information technology, vehicles, general equipment and grounds. As the functional analysis suggested the MOH has had difficulty in ensuring the availability and supply of several classes of essential assets. Certain cost-ineffective practices have become embedded in a less than comprehensive system and transparency of procurement and logistics functions is less than ideal.

Strategies:

- Develop a systematised approach to asset management that includes appropriate standards, technical guidelines, protocols and audit practices for asset procurement/renewal, maintenance and replacement/disposal
- Strengthen asset management capacity throughout the sector

Outcomes:

- Improved system of asset management with in-built transparency and accountability
- Increased asset management capacity throughout the system to support health services delivery

Institutional development

The health sector is under pressure. Mortality and morbidity are high, there is significant demotivation among staff despite commitment, resources are not always available when and where needed, quality concerns exist within service communities and, as a result, utilisation rates in the public sector at least are well below acceptable levels. The role of the MOH is undergoing change as concepts such as sector wide management are discussed and as a clearer understanding of the duality of stewardship and provider is developed. The scale of institutional strengthening needed to address these and other issues is considerable.

As was highlighted in the functional analysis of the MOH undertaken in 2006, a major shift is required to move the organisation from a bureaucratic, process-driven style of behaviour based on civil service practices and regulations to a more flexible and creative managerial culture focused on outcomes and health status improvements.

The stress on managers that is likely to accrue from proposed alterations to their traditional work practices within a climate of significant change will be daunting. It is proposed, therefore, that much of the strategic activity in the first two years of the planning period will focus on capacity building in management, leadership and technical areas and clarification of revised or new roles and functions at all tiers of the sector but particularly at central and district (municipal) levels.

As an institution, the MOH needs to improve its management and leadership capacity across the organisation. It also needs to appreciate how activities in one component or tier impact on all others. It needs to be better at listening to what its component parts are saying.

Technically, the MOH needs to be more alert to the advantages of integration of services and programmes. It needs to be conscious of the need to sustain or embed capacity to implement approved practices and protocols. It needs to be more vigilant in monitoring and supervising professional staff. It needs to appreciate the value of acknowledging and rewarding superior performance. It needs to be aware of the dangers of accommodating many agendas – taking on too much to please/placate external interests. It needs to learn how to prioritise. It needs to address emerging public health issues proactively.

The MOH needs to address these major issues strategically and with calm reflection. Not all will be possible immediately or within the medium term. It will be progress towards a better organisational demeanour that will count in assessing success in the face of widespread pressure for change.

Strategies:

- Legislative, organisational and administrative reform of management structures, systems and procedures in the MOH to respond effectively to the change agenda Increase in the effectiveness of public-private partnership to improve accessibility, and quality though the promotion of wider stakeholder participation and enforcement of regulations
- Further development of health sector management by encouraging a culture of leadership, increasing effective decentralisation and de-concentration, and institutionalising sector wide management and decision-making
- Enhancement of MOH capacity to develop and support stronger systems of technical supervision and control throughout the sector to promote quality and encourage utilisation

- Increase attention to the advantages of integration of services and programmes in the communicable, non-communicable and public health, and environmental health domains

Outcomes:

- Increased efficiency, effectiveness, and accountability of the MOH at all levels
- A reflective organisation
- Obligations under law are met
- Improved supervision and regulation of private services
- Increased participation of private sector in health service delivery
- Increased public participation in decisions about health
- Effective and efficient approach to sector wide management through joint planning, monitoring and evaluation
- Improved accountability and effectiveness of the health system
- Improved stewardship of the sector by the MOH

HMIS

The MOH has been anxious to strengthen the existing Health Management Information System since its inception in 2002. Realising the value of timely and accurate data as an aid to appropriate management and clinical decision-making, the Ministry has sought technical assistance in the development of a workable system of collection, retrieval and analysis customised for Timor-Leste conditions. Recent short-term advisory input offers promise of rectifying errors of the past.

The goal of having a fully functioning comprehensive, integrated and inter-ministry shared system that encompasses the various types of information that the health sector requires – routine data on health care activity, service and programme utilisation, health status indices, epidemiological surveillance, human resources, asset management, environmental health, public health, etc. – is some way off and unlikely to be achieved in the current planning period.

The Ministry's proposal is to phase in a HMIS as part of a broader-based health information master strategy. This will be developed and implemented with longer-term technical assistance. The current HMIS is relatively simple and yet still problematic without hands-on expert support. Technical assistance will need to build on recent advances and continue to develop capacity centrally.

Strategies:

- With technical assistance prepare an information master strategic plan that will guide the appropriate phasing-in of different information sub-systems as follows:

  2007: review and strengthen the primary health care information system
  2008: review and strengthen the disease surveillance and hospital information systems
  2009: develop the human resource and facilities, equipment, logistics and assets information systems

- Consider the adoption of the Government-wide Personnel Management Information System (PMIS) implemented by the Ministry of State Administration when planning for the human resource information system within the MOH and determine how health-sector specific data will feed into the national data collection system
- Begin software development in 2008 after the HMIS, disease surveillance and hospital information systems have been fine-tuned. The software for these three sub-systems will be developed together to ensure that they interface easily and smoothly with each other
- Development of legislation, regulations, policies and operational guidelines on HIS-related issues like the confidentiality of medical records, data collection from the private health sector and the vital registration system.

Outcomes:

- Production of a health information master strategic plan
- Functioning HMIS as part of a wider health information system
- Development of a data dictionary, preparation of instructions manuals, training of health workforce personnel in HMIS data collection and reporting
- Development and implementation of training programmes on data analysis and utilisation at all levels
- District computer systems upgraded to enable electronic sharing of data between districts and the HMIS Department

Gender equity

Awareness of gender mainstreaming and affirmative action for women is low within the MOH. While there is evidence of ample opportunity for men to assume more significant and higher paying posts, and to progress in their career paths, the same cannot be said for women.

Surprisingly, the HPFP makes no mention of gender (other than in terms of gender-centric health care) as an issue for the MOH to attend to despite sustained attention in the Constitution and the National Development Plan. The health sector in Timor-Leste is atypical internationally in that there are far more men working in the system than women. This is a reflection of the fact that nursing tended to offer one of the few accessible professional career paths for both men and women during the latter period of Indonesian sovereignty. Currently, in the MOH men outnumber number women at a ratio of about 2:1. This is not the case in the private sector where anecdotally it seems that there are more women than men. The overall impact of these circumstances is that the culture within the Ministry is male-dominated.

Strategies:

- Promote gender mainstreaming in the MOH
- Improve awareness of gender issues throughout all health programmes and the health workforce
- Provide affirmative action techniques to the appointment of women to management and senior clinical posts in the MOH
- Strengthen the role of male MOH personnel in adolescent health
- Monitor and evaluate gender impact on policies, services and programmes

Outcomes:

- Appropriate representation (on the basis of gender proportionality) of women in decision making posts at the different tiers of the health system

Research

Currently, research plays little part in the day-to-day operations of the Timor-Leste health system other than, perhaps, substantiating clinical innovations that have been introduced on the grounds of international, evidence-based practice. One means of promoting research in the health sector would be to establish a research entity or centre to assume overall responsibility for research and research related activities on health and health care matters. The need for such a structure is widely acknowledged. Seed funding is available through AusAID to begin the process of determining how best to constitute such a centre that would, in the local context, establish and consolidate the natural links between research and informed clinical and public health practice.

Strategy:

- Establish an operational research centre to assist in developing research capacity within the health sector of Timor-Leste to address health and systems challenges and to inform clinical and public health practice

Outcomes:

- Establishment of a centre of research excellence which will, among other things, approve research proposals, monitor research outcomes and advise on applications in the field, socialise research results and co-assure follow-up of adopted recommendations, participate in the design and organisation of pilot schemes, provide practical training opportunities in operational (action) research for health service staff, coordinate research activities, assist in identifying potential partners (individuals and institutions) for networking and for establishing a researcher resource pool, and accrediting partner organisations
- Research-based evidence directly informing clinical and public health practice and contributing to M&E activities

SECTION 6 COLLABORATION AND COORDINATION

Commentary in this section of the plan appears under several sub-headings for ease of reference. This does not imply that the topics presented in each sub-section are separate or should be considered as discrete areas. By their very nature the topics addressed are inter-related and should be recognised as such at a practical, implementation level.

Community participation and engagement

The twin processes of "working partnerships" and "public/community participation" are praised worldwide as worthwhile goals of all health care systems. In Timor-Leste the policy position is clear - informed consumer involvement is part of quality health care. This position is central to the enlightened and comprehensive Intersectorial Action Framework for Wellbeing and Health policy document produced in 2005.

In many ways Timor-Leste is a leading light in community participation for health. Many developed countries continue to struggle to produce explicit guidelines that establish the context and mechanisms for public participation and that provide communities, health professionals and others with specific strategies to stimulate and strengthen the public voice.

The Intersectorial Action Framework notes the MOH's (and the Government's) commitment to a shared responsibility for health and wellbeing. Mechanisms, actions, and implementation and evaluation strategies are listed for various tiers in the health system. The framework is sound.

Yet in Timor-Leste, as in many other countries, the vision of community participation in health is far different from the reality. Perhaps this is not surprising given the fact that many health care professionals believe in the superiority of their understanding of health and feel that they know best how health should be protected and promoted. The low level of community participation in Timor-Leste reflects also a limited appreciation among health care providers and managers of what the concept means at both individual and group levels. In particular, it highlights a lack of awareness of the benefits that can flow from genuine efforts at involving patients and clients, and the public more generally, in "working partnerships" to help determine matters of health care planning, delivery, monitoring and evaluation - especially at the local level.

Barriers also exist because of:

- Non-existent or ill-defined roles and responsibilities of community level committees that might act to oversee the functioning and performance of health posts, health centres and hospitals
- Inexperience of community representatives in the areas of health and management
- Inappropriate mechanisms to select community representatives
- Lack of resources needed for such committees

The HSSP reaffirms the principles of the Intersectorial Action Framework. The MOH recognises the need to follow through with the policies and related strategies contained in this document. To further assist the Ministry in promoting community involvement and engagement, the following initiatives (which can be operationalised at different tiers of the system) are proposed:

- Improving consumer relations by means of staff sensitivity training, improved administrative procedures, better information dissemination and enhanced physical surroundings
- Enhancing service quality by using evidence-based approaches to service provision, encouraging empathy and trust between practitioners and consumers, and using information from consumers - including complaints - to improve services
- Facilitating access to information by developing a range of outreach strategies, providing consumers with access to their files, and using secure and ethically designed computerised information systems
- Increasing consumer choice by providing timely and sufficient information about services, programmes and evidence-based treatment options
- Addressing issues of equity and access by developing access services and processes, clarifying and monitoring access policies, monitoring the equity of treatment practices, developing programmes to enhance equity in treatment and service, and supporting anti-discrimination practices
- Promoting consumer participation by facilitating consumer feedback and evaluation, involving consumers on boards, committees and task forces, encouraging consumer involvement in service provision and treatment decisions, promoting policies of consumer groups in the organisation, and providing support to consumer organisations
- Restructuring the organisation by management strategies, use of multi-disciplinary teams, and decentralised approaches to enhance local decision making
- Establishing consumer rights by endorsing declarations and incorporating these into protocols, procedures and standards of service
- Creating opportunities for redress by developing an effective consumer protection system that supports consumers' right to complain, and providing information about, and access to, the complaints process
- Undertaking consumer advocacy by accessing external and independent advocacy, performing internal consumer advocacy and creating avenues for self-advocacy

Intersectoral collaboration and coordination

The vision statement of the MOH acknowledges the multi-dimensional nature of health and the wide range of determinants influencing health status. Accordingly, since its establishment in 2002 the MOH has sought to adopt an intersectoral approach to strategic planning. With the production of the Intersectorial Action Framework document and the formation of an Intersectoral Working Group (comprised of several ministries) in 2006, the MOH's focus on inter-sectoralism has been given a more practical platform.

Despite this advance, an encouraging beginning at senior level collaboration has not translated into consistent interaction across portfolios. The requirement of leading this process has taxed the Ministry's capacity to engage systematically and regularly. This is not to suggest that positive initiatives between ministries have not occurred. Especially in times of crises (both natural and man-made) it is apparent that various ministries do work well together for the common good. Currently, however, collaboration and coordination is not automatic and is not institutionalised. The story is the same at both central and devolved tiers of the government system.

The imperative to act inter-sectorally remains urgent. For meaningful implementation of the HSSP, it is vital that the MOH:

- Re-energises the Intersectoral Working Group through the scheduling, chairing and agenda setting of regular (quarterly) meetings as stipulated in the Framework
- Organises meetings with individual ministries to mutually determine action plans to foster collaboration and coordination
- Demonstrates leadership in implementing these plans across the MOH
- Specifies and monitors outcomes linked to indicators and budgets

In the medium term (within the timeframe of the current planning period) a mechanism for cross-sector collaboration and coordination at district (municipal) level is also needed with local intersectoral action plans being developed and implemented.

A good example of effective strategic inter-sectoralism can be seen in the Ministry's efforts in developing a comprehensive and integrated environmental health strategy founded on New Public Health principles and illustrated by numerous examples of practical local applications across sectors (and involving community participation). The micro-policy document on environmental health provides a model template that could be used constructively across the Ministry (and across other ministries) as contemporary policy statements are produced.

Collaborative partnerships with external agencies including NGOs

Close interaction between the MOH and local NGOs and private not-for-profit agencies with a health focus have been a hallmark of the health sector in Timor-Leste both before and since independence. Recent examples of mutually advantageous arrangements can be seen in the Ministry's commitment to fund pharmaceuticals for, and to station professional staff at, several grass-roots NGOs in return for the continued provision of services and programmes to local communities.

Regular (three monthly) liaison meetings are held between the MOH and the NGO sector to foster common interests and share information. However, as in the area of intersectoral collaboration, this style of communication exchange is relatively unstructured and not designed for follow-up activity and reporting back. A more progressive and action-oriented forum is needed to strengthen progress and allow for a broader agenda.

A more constructive mechanism is proposed to activate and energise sector-wide thinking between external agencies and the Ministry. This will involve a streamlined, rotational representative committee meeting more frequently (monthly), focusing on policy and strategic issues, and being directly accountable to its broader constituency.

However, whether or not sector wide management is feasible in the future, the MOH recognises the need to assume a more prominent role immediately in governance across the sector. The Ministry's strategic planning process provides it with useful tools to accomplish this task:

- The HSSP itself presents a vision and related strategies within an outputs/outcomes context to be shared by all stakeholders and to guide inputs to the sector
- The MTEF indicates explicitly the resource support required from all organisations to achieve targets
- The monitoring and evaluation framework (to be developed) outlines agreed outcomes and provides the basis for joint reviews and performance monitoring

Donor coordination and harmonisation

The MOH is the organisation with ultimate responsibility for health service and programme management and coordination in Timor-Leste. Through the strategic plan the Ministry has identified ways of promoting collegial and integrated action that involves all stakeholders sharing a common strategic perspective. Concurrently, several donor partners have indicated their willingness to consider movement towards a Sector Wide Approach (SWAp) for health (and perhaps for other public sector areas) which would incorporate, among other things, complementary budget pooling.

In essence, a health SWAp would represent the harmonisation and coordination of available resources and expertise within the MOH and its development partners to obtain the most efficient and effective use of scarce resources to achieve the best health outcomes for Timor-Leste. While recognising that each development partner is constrained by particular sets of priorities and related reporting frameworks, the SWAp process seeks to minimise these differences and bring the policies and practices of all parties into line as much as possible in order to avoid duplication.

Recent discussions in the Timor-Leste health sector on donor coordination and harmonisation have identified specific steps that need to be taken in advancing progress towards the SWAp vision:

1. A willingness on the part of the Timor-Leste Government and the development partner community to support in tangible ways the concept of public sector harmonisation. The development of a government-wide "harmonisation plan of action" is often a beginning focal point for more sector-specific initiatives. Often such a plan of action results in initial work on supporting the establishment of common procurement and financial procedures and practices
2. The existence of an appropriate and well constructed strategic plan for the health sector linked with a mid term expenditure framework. This is considered by all development partners as an essential prerequisite condition. A well formulated strategic plan offers promise of an efficient process whereby health priorities are targeted and the impact of donor expenditure can be determined through careful monitoring
3. Agreement on a standard Memorandum of Understanding that articulates the basis for exchange between the Ministry and all its development partners
4. Customising the standard MOU to match particular arrangements and circumstances characterising the individual relationships which the MOH has with each of its partner organisations. The standard agreement would include broad goals of collaboration, a code of conduct and an agreed mechanism and process for conducting joint technical sector-wide reviews. Fundamental to the MOU is acceptance of the need to strengthen alignment between all signatories on matters of cooperative activities, and to promote transparency and openness, in particular during donor design missions and reviews
5. Capacity within the sector to meet the obligations outlined in the MOU in a sustained and timely fashion.

In Timor-Leste early signs of interest in SWAp development for health have not translated into widespread and ongoing support. The hoped-for coordination described in the HPFP (and reflected in multi-partner contributions to early micro-policy development) has failed to flourish in part because of civil unrest, in part because of capacity problems within the Ministry, and in part because of reluctance among development partners to demonstrate sufficient willingness to collaborate.

The coordination situation within the health sector at present is such that:

- Development partners do not systematically and consistently provide the MOH and other agencies with details of their proposed initiatives nor do they inform stakeholders of the consequences of their inputs
- The MOH remains reluctant, for various reasons, to establish a formal platform for dialogue with the donor community on strategic and sector reform issues
- The MOH lacks capacity to lead donor coordination, let alone a SWAp, and participates without serious commitment in the few isolated donor coordination initiatives that occur

Recently there has been some effort to revitalise a previously established but inactive Sector Working Group and to extend the Joint Donor Review Mission concept. Despite this, however, systematic and scheduled exchange between the MOH and development partners, the major NGOs and other stakeholders is inadequate on maters relating to the development and implementation of national health policies and plans.

The HSSP offers some promise of rekindling the required commitment for harmonisation within the MOH and the major partner and stakeholder groups. However, should structured and regular dialogue, an essential precursor for harmonisation, with development partners and others not be established in the near future, the MOH recognises that there is a real risk that major donors are likely to:

- ignore the directives of the HSSP when planning their own strategic initiatives
- maintain their own, largely isolated, project/programme specific log frames, management procedures, reporting mechanisms, etc
- be reluctant to provide financial and technical support to enable the implementation of the HSSP in a coordinated and complementary manner

In order to improve communication and coordination between the Ministry and development partners, and to bolster the implementation of the HSSP, the MOH appreciates the need to commit to the principles underlying harmonisation and, within it capacity, to foster not only bilateral but also multi-lateral dialogue across the development partner community. The Ministry also considers that the same communication effort is necessary for informing and involving other ministries on matters of mutual interest.

Apart from the formal "statutory" meetings with development partners (primarily in the form of Annual Sector Reviews), the MOH is determined to promote harmonisation through the initiation of an annual planning summit where, in the context of round table discussion, a suitable mechanism to establish donor coordination activities will be developed. This could mean, for example, the holding of periodic coordination meetings called for and chaired by the MOH.

At coordination meetings, the MOH and development partners will exchange information and ideas, and discuss specific technical, administrative and financial issues. Agendas will be outcomes-based rather than merely an exchange of information and aspirations. To achieve this, agendas for subsequent meetings will be developed in advance. Participation at these meetings will vary according to the agenda but should involve, on a continuing basis, all major donor organisations.

The MOH intends that a mapping of all external aid to the health sector will be an output of this forum. The map will detail current support areas, modalities, and commitments now and into the future. Areas of duplication and unfulfilled need will be highlighted.

The MOH is eager for donor partners to supply timely information about their flexibility to adapt their support modalities and packages to the HSSP and the MTEF in order to foster harmony and complementarity. On the basis of this information, the MOH will determine potential for developing new partnership arrangements. An ultimate goal of this form of exchange will be to reach agreement on specific pre-conditions for a health SWAp.

The value, and feasibility, of establishing an inter-departmental oversight structure for the coordination and monitoring of international technical assistance within the Ministry will also be determined and implemented.

Private sector collaboration

The Law on the Health System (Law 10/2004) firmly establishes the private sector as a "complementary partner" in an harmonious system designed to promote and protect health as a fundamental right. Given the pluralist nature of the Timor-Leste health system, the Government through the MOH has worked towards establishing an enabling environment for private sector activity.

To promote effective harmonisation, four prerequisites are needed:

- Clarification of the functional basis of MOH responsibility for leading and coordinating partnership activities with the private sector (who is responsible and what resources are required to support the activity?)
- Comprehensive profiling of all private sector actors in health care - type of services provided, geographical coverage, catchment area populations, financing sources, human resource capacity, etc. (A list of existing agencies is just a beginning not an end in itself))
- Coordination mechanisms between MOH and each of the different types of private sector partners for planning, policy and strategy development, service and programme delivery, and monitoring and evaluation functions. For example, coordination with for-profit agencies and commercially based practitioners will require a different set of approaches than for NGOs and faith-based organisations
- Explicit minimum standards for private sector delivery services and related professional activities founded on legislative guidelines on which to base MOH regulation and monitoring

Significant opportunities for fertile collaboration between the MOH and the private sector exist. There are already many examples of effective engagement at both central and local levels. However, what is required now, as part of an enhanced emphasis on strategic planning, is greater attention to systematising successful initiatives sector-wide.

Much of the public-private inter-activity in Timor-Leste to date has been directed at working arrangements between the MOH and NGO and faith-based agencies. The public-private focus needs to be extended to include engagement with traditional healers, birth attendants and alternate health providers, all of whom continue to play a very significant part in the provision of health care at community level. The advantages in such collaborating include the useful transfer of approved protocols and sanctioned standards of practice (and referral) to the alternate therapy cohort and an increased opportunity to monitor their health care practices.

Summation

In general, the key principles for partnership building and collaborative action between the MOH and other stakeholders that emerge from the HSSP are:

- A respect for the primacy of the MOH's strategic policy position on matters of health, health promotion and health protection in Timor-Leste
- A recognition that all organisations have particular and specific areas of expertise that complement the contributions of others and that, in combination, provide a more substantive service
- An approach to planning and consultation that prioritises actions and channels technical and financial support accordingly
- An emphasis on coordinating, monitoring and evaluating activities and on tracking progress with implementation
- An allocation of resources based on assessed need, efficiencies, reduced duplications, gaps and shortfalls in financing

SECTION 7 STRATEGIC PLAN: IMPLEMENTATION

Implementing the HSSP

This section of the strategic plan outlines the process to implement the various strategies - that is, planning annual activities, deciding on resource allocation, arrangements to finance the implementation process, priority areas in need of technical assistance, and the monitoring and evaluation of performance. As the strategic plan underpins a common vision for all stakeholders in the health sector, building partnerships is critically important. Ways of achieving this are also addressed in this section.

Implications for ways of working, for resources and for legislation

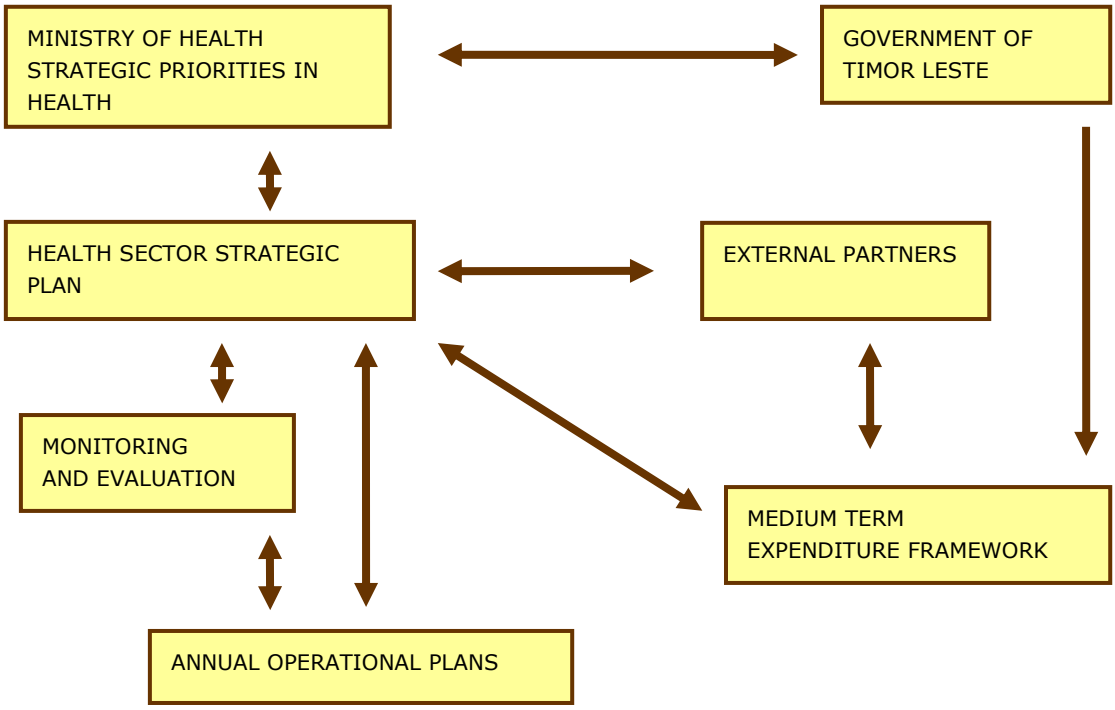
The implications of implementing this strategic plan are significant:

- The values and working principles of the MOH must be adopted by all stakeholders
- There must be sustained emphasis on systems development and capacity building
- Creating competence for the management of change and organisational development must be seen as pivotal
- Increased delegation and authority to devolved levels to manage services and programmes must be supported by capacity development both centrally and locally
- Increased decentralisation and deconcentration as proposed by the MOH must be understood and accepted throughout the organisation
- Planning, budgeting and financial management cannot be separated
- Integration and operationalisation of national health programmes must occur at the district level
- Development partners and collaborators must work within the framework of the strategies and their desired outcomes
- Systematic and regular monitoring and evaluation using appropriate health, management and financial indicators must occur
- Because additional resources for some strategies will be required some initiatives will have to phased in as those resources become available
- Advocacy to change current legislation to support the implementation of the MOH strategic plan must be guaranteed
- A commitment to health outcomes at the population level must be fundamental to all strategic implementation activities

The implementation of the strategic plan is a challenge for all stakeholders, the government, all tiers of the MOH, NGOs, private sector providers, local communities and development partners.

Figure 2 on the following page shows how the strategic plan leads to the development of district operating plans according to the Ministry's revised planning cycle (see Annex E). Over the planning period and as capacity develops, district plans will be scaled to match available funding as detailed in the MTEF. Performance will be measured against the strategic plan and the district annual plans through an ongoing monitoring and evaluation process.

Figure 2: The Strategic planning & implementation process



Implications for change management during implementation and beyond

To move from strategic planning to implementation and sustained institutionalisation means assigning responsibilities for the strategies within the key areas of work to the appropriate "lead departments". This is appropriate. However, this approach should not detract from one of the guiding principles of the HSSP - that operational integration is more than mere rhetoric. If the MOH is to meet its MDG targets (and adopting the strategic directives of the plan is designed to support this mission) then collaboration between departments, services and work teams will be essential. Shared responsibility within coordinated structures and processes that enable staff at the periphery as well as the centre to participate in decisions that affect sector-wide priorities is the key.

Support from MOH central offices to sub-district and district level planning and implementation is essential. Coordination mechanisms will need to be established to help identify roles and responsibilities of all tiers to ensure aggregate accountability for the achievement of planned outcomes. Ultimately, however, ownership of strategy implementation has to be at the line management level. It is here that most activities happen - hence the emphasis on building management capacity and leadership skills. Currently, those with operational responsibility have limited authority for expenditures. As part of moving towards effective decentralisation, the devolution of authority will be mapped out particularly for human resource and financial decisions.

The period 2008-2012 also calls for closer working relationships between the Department of Planning and the Department of Finance, particularly in terms of integrating planning and budgeting, and in monitoring expenditures against activities and validating reported expenditures and outputs through performance budgeting and performance audits. Likewise, closer linkages between the

Department of Planning and the (approved but yet to be defined) Division of Human Resource Development are also envisaged.

Another key task is to support the planning process of some lead central level departments and programmes as their roles and contribution to the sector more broadly becomes clearer with the strategic direction for the next five years. There is a critical need for institutional measures that strengthen teamwork at all levels.

Bottom-up approach and integration

A bottom-up approach is a key guiding principle for this planning-budgeting process. The planning process will start with sub-district level plans that will merge into district plans that relate national strategic priorities to work at the local level. The Planning Department of the MOH will continue to take the lead in guiding the development, and quality control of plans from central, district and sub-district levels. It will also assist customised services in their plan development activities. Proposed plans and budgets will be assessed by both the Department of Planning and the Department of Finance who will then make joint decisions to recommend the allocation of financial resources against activities.

Stakeholder consultation is valued and representatives from other government and non-governmental agencies, the private sector, and consumer representatives will participate in identifying priorities. Their participation will later extend to joint monitoring at the field level.

Efforts will also be made to integrate the operational plans of national programmes into district plans. Coordinating with the Department of Planning, each programme will convey national level objectives and targets to the district health teams before the operational district planning process starts. In turn, these will then be translated into district targets and activities. All programme activities, including training, supervision, special campaigns (with the exception of epidemic outbreak responses), will be integrated into the district planning cycle.

None of the above represents a major change in emphasis in terms of the articulated planning structure and process which the MOH has been intent on institutionalising for the past three years. What it does introduce is a more defined set of components and an imperative to incorporate prioritised national cross-cutting strategies as the cornerstone of plan development at all tiers. Throughout the first two years of the planning period it is proposed that long term technical assistance be provided to support the Department of Planning in its national leadership role.

Technical assistance

Given the development of the HSSP and the MTEF, and the stated ambition of working towards the establishment of a health SWAp, it is appropriate here in the strategic plan to reflect on current technical assistance practices and to project how TA could best be provided and organised for immediate and longer term implementation needs and longer term over the course of the current planning period (and beyond).

Agreement is needed soon between the MOH and development partners on:

- What technical assistance is needed throughout the period of the HSSP (in what service and programme areas, what format, what location, what duration, etc)
- How technical assistance will be provided by development partners
- How best to coordinate and manage technical assistance to ensure optimum benefit to the MOH

The goal is to formalise these matters in a policy strategy on technical assistance. Ultimately, agreement on technical assistance needs to become an integral part of an over-arching Memorandum of Understanding between all development partners and the Ministry.

International experience at harmonising the planning, funding, management and evaluation of technical assistance in a comprehensive "pooling" framework shows the exercise to be extremely ambitious and replete with sensitivities. The reluctance of development partners to engage meaningfully and the typical isolated, vertical programme approach of most projects that are supported by bilateral agreements remain the two key sticking points to effective integration.

Technical assistance pooling is more likely to be adopted widely when the MOH and donor partners have settled on a more uniform manner of working together collaboratively in priority areas.

Given the current state of development of the Timor-Leste health system and the significant challenges facing the sector, formal integration of technical assistance is not recommended at this point. Nevertheless, the opportunity for the MOH to manage technical assistance more systematically and cost-effectively should not be missed. The following strategies are recommended:

- Develop a comprehensive and integrated policy position on technical assistance to guide both the MOH and development partners in the area. Part of the current strategic planning process will involve: a) a prioritisation of technical assistance needs for the health sector throughout the five year planning period and beyond; and b) a rationalisation and explanation of the nomenclature used to describe technical assistance
- Undertake an audit of all technical assistance in the health sector (included in which will be distinction between "genuine" technical assistance and staff substitution, programme management, volunteerism, etc)
- Socialise the HSSP within current technical assistance ranks to engender practical support from all members of the group
- Where necessary, and as possible, renegotiate TORs, contracts, technical assistance management, etc. to better match HSSP priorities. Where this is not feasible, indicate in relevant review fora the need to restructure current arrangements at the next scheduled negotiation phase
- Mutual agreement between the MOH and development partners on a comprehensive technical assistance package for longer term assistance
- Mutual agreement between the MOH and development partners on a set of uniform procedures for recruitment, orientation, ongoing management, reporting protocols, and monitoring and evaluation of technical assistance (whether long or short term, national or international)

A list of priority technical assistance requirements for the current planning period and beyond is included in Annex D. The list has been developed in consultation. In considering the list the following issues need to be understood:

- Ongoing technical assistance needs (beyond the period of the HSSP) are acknowledged
- Some reorientation of existing assistance to promote more effective and efficient support is proposed
- No mention of who implements current technical assistance is provided. Thus, for example, the NGO sector which supports a significant amount of technical assistance is not identified
- The feasibility of the total of proposed technical assistance still needs to be evaluated. Funding capacity and potential marginalisation of key national staff are two problematic areas that require attention. Part of the solution to the latter concern is the role adopted by technical assistants with mentorship and coaching being seen widely (although not universally) as more likely to be productive in the longer term than task implementation approaches
- Proposed technical assistance input focuses on areas of MOH skills need and are not limited to project or donor specific historic priorities
- Programme management or administrative team leader functions are not included. This issue needs to be considered on a case-by-case basis
- "Substitution" staff without clearly defined technical assistance functions are not included. Therefore, the Cuban medical brigade and international medical specialists are not included. This does not mean that substitution is not needed. Temporary positions for expatriate specialists will be required when national staff with requisite qualifications and experience are not yet available. Moreover, as OOC study development programmes necessitate the prolonged absence of senior MOH personnel, substitution will be the preferred option
- Decisions about recruitment of new technical assistance will be considered in conjunction with the role redefinition of MOH central office and district (municipal) positions
- Current vaguely defined technical assistance inputs need to be clarified to ensure appropriate mentorship and coaching occurs and to allow for more adequate assessment of performance
- As a matter of urgency an assessment is needed of the appropriateness of the various roles being performed by the large contingent of non-clinical Cuban health professionals stationed in Dili and elsewhere in Timor-Leste

Financing the Health Services

Introduction

As part of the HSSP process a Medium Term Expenditure Framework (MTEF) was developed by the MOH, outlining the resources required to achieve HSSP objectives. The MTEF document is available from the MOH on request.

The MTEF is a rolling medium term estimate of expenditure required to achieve the goals and objectives of the HSSP for the period 2007-2012. It forecasts expenditures, presented in the current budgetary structure and broken down by different programme areas and population groups. It is comprehensive, including capital and recurrent costs and governmental and external funds. It should provide the link between macro-financing plans (SIP) and resource allocation within the MOH, thereby ensuring funds are directed to implement broader strategic plans. It can be used together with current accounting and budget tracking systems to provide the framework for annual budgeting. Finally, by matching expenditure requirements with revenues, it provides the MOH and its financing partners with a comprehensive overview of financing gaps.

Based on a situational analysis of health sector financing and the costing of HSSP objectives, the Ministry of Health has identified several indicators for each MTEF objective and set targets for 2012. Where possible, targets were set based on the examination of past trends, whilst becoming more ambitious over the years. It is anticipated that these indicators and targets will be used in the future to support Annual Sector Reviews as a key component of a SWAp.

Brief summary of MTEF

The MTEF expenditures were calculated primarily on the basis of HSSP objectives. A summary of the main trends in expenditure and their justification is presented here.

Proposed Expenditure 2007-12 (Table 1)

Overall expenditure will be roughly equivalent at the beginning and end of the MTEF period. Expenditure is expected to fall slowly in the first two years of the plan, but then rise steadily from 2009/10 to around $41 million per annum in 2012. This is due to two separate effects. Firstly, recurrent expenditure is expected to rise throughout the period, reflecting MOH plans to scale-up health services in line with the MDGs. The rise is significant from $16 million in 2007 to $29 million in 2012. This should enable the Ministry to improve the number of visits to health services per capita from just over 1.3 in 2007 to 3 by 2012. Secondly, capital investment in the period will fall from $26 million in 2007 to $11.4 million in 2012.

District recurrent expenditure

In the HSSP the Ministry of Health (MOH) outlines a plan to expand the Basic Service Package (BSP). The aim is to reach the Millennium Development Goals (MDGs). The MTEF table for district health services are based on an estimate of the cost of providing a district health system which can deliver the basic service package.

The expenditures for 2012 are estimated based on the following BSP targets:

- 100% of sick children and infants receiving medical care
- 80% of women receiving antenatal and postnatal care
- 80% of women having a safe delivery (performed by skilled birth attendant)
- 40% contraceptive prevalence rate
- 100% DOTS coverage
- 75% of Tuberculosis (TB) cases detected and treated
- 90% of pregnant women and children using bed-nets

Staffing costs are estimated on the basis of staffing norms presented in the BSP manual, and increased funds are provided for other recurrent costs such as fuel and repair and maintenance.

The net result is a recurrent expenditure increasing from 2007-2012 from $7.8 million to over $18.4 million annually.

District capital expenditure

Capital expenditures are based on costing the plans laid out in the HSSP. District physical capital expenditures (major capital) will remain broadly constant over the period of the MTEF. Nevertheless several key areas will be funded, to support the implementation of the BSP. These include: a moderate increase in the number of health posts, equipping facilities with new maternity suites, building houses for rural/ remote area staff and equipping municipal health offices. Funding is also includes to increase the number of cars and motorcycles available to provide community health services.

A substantial Technical Assistance (TA) programme to the BSP will commence as outlined in the HSSP, although funding will decrease over the years of the HSSP as capacity develops. Likewise for training, funding has been ring-fenced for the anticipated health workforce training plan in 2007, although the amount will also slowly reduce over the years as capacity builds.

The net result is a capital expenditure higher than existing levels, focusing increasing on human capital investment, but decreasing over the period of the HSSP to $4.7 million in 2012, as the need for TA and training programmes reduces.

Hospital recurrent expenditure

The HSSP does not outline a clear programme for the expansion or reform of hospital services. However, it clearly identifies this as a need. It recommends a series of steps to arrive at a hospital reform programme and the Ministry is committed to begin to carry these out in 2007. In the absence of this plan, the MTEF broadly continues the existing funding pattern, with several small adjustments. These are:

- Maintenance is increased to ensure sufficient funding for new infrastructure
- Salaries are increased in line with the expected public sector salary review
- From 2008 drugs and consumables costs are increased assuming that more referrals arrive from the higher utilisation at the district level

The net result is that recurrent expenditure increase over the period from $6.4 million to $9.5 million in 2012.

Hospital capital expenditure

Following the end of the major building programme in 2007, major capital investment for hospitals remains constant at $1.5 million annually. This investment will primarily be aimed at converting some district health centres into district or municipality hospitals, depending on the outcome of the government's decentralisation process. TA and training costs will also be increased to support the hospital reform programme, but will decrease slowly over the years.

The net result is that capital expenditure into hospitals fall slowly from around $5.9 million to $3.4 million over the HSSP period

Central and support services recurrent expenditure

The HSSP lists many objectives related to improving planning and management at the central level. Therefore the central services budget includes a modest increase in staffing levels, equipment and communication costs. It also includes increased maintenance costs for the new central building. However, at present the costs of SAMES are currently included in the central budget (item operational expenses). When SAMES is capitalised in 2008 then this will be no longer needed, and therefore a slight reduction in expenditure can be observed.

Support services include the Institute of Health Sciences. This will be substantially expanded in 2007. However, aside from some increases in maintenance costs no new additional expenditure is included in the MTEF. Substantial increases in funding will be made available through the MOH financing of rising student numbers.

The net result is a slight fall over the period of the HSSP in the central services recurrent budget from $1.3 to $1.1 million annually, whereas the support services budget remains relatively constant at around $0.7 million annually.

Central and support services capital expenditure

Planned major capital expenditure for central and support services, includes the following (based on HSSP plans):

a) The capitalisation of SAMES
b) The development of a system of maintenance workshops
c) Expansion of central services buildings
d) Building of the new Institute of Health Sciences

There is also additional funding for TA and training, based on the list provided in the HSSP, which outlines a substantial programme of international TA at the central and devolved levels, but decreases over the years of the MTEF.

The net result is a capital expenditure significantly higher than in those years prior to the MTEF, but decreasing over the period from around $11 million to $3.3 million annually.

Resource gaps 2007-2012 – (Tables 2,3,4)

Table 2 presents current CFET/GSB financing. Table 3 presents the difference between this and planned CFET/GSB expenditure. Table 4 compares this to anticipated donor funding. The following can be observed:

a) Over the period of the MTEF, the health services will become significantly less reliant on donor financing.
b) Most of the funding gap between CFET/GSB funding and total resource needs lies at the district level.
c) The gap for capital financing will decrease over the years (to around $1.3 million in 2012), but the gap for recurrent financing will increase as service utilisation increases (to around $5.4 million in 2012)
d) Likewise for hospital funding, the gap for recurrent financing will steadily increase to around $4.3 million in 2012. The gap for capital expenditure will fall significantly to around 00,000 in 2012.
e) There will be a need at the beginning of the period for continue investment by donors in capital in central services ($5 million in 2007), but this will decrease over the years ($1.4 million in 2012)
f) Aside from the capital expenditure for the Institute of Health Sciences and the Maintenance workshops in 2007 and 2008 (around $2.5 million per year) only moderate level of external funding of capital (TA and training) for support services will be required for the remainder of the HSSP period.
g) Comparing resource gaps to current donor plans shows that the MoH has presented a reasonable MTEF within the currently expected total resource envelope. The difference between requirements and total expected funding is under $1 million per year. Only the fall n donor expenditure from 2011 is predicted to presents a concern.
h) Whether this remains a concern will depend on which CFET/GSB can takeover the recurrent financing requirements of goods and consumables from donors. In order to reduce the risk of a shortage of funds occurring the MOH is committed to exploring and identifying new sources of financing including the expansion of internally generated revenues.

Resource allocation to districts and programmes

One of the core MTEF objectives is to move towards a more equitable pattern of financing between population groups and geographical areas. However, it may take time to achieve this. In principle the long-term aim is to allocate resources equally to different population groups taking into account poverty, their differing health needs, and factors that effect cost, such as geography. However, at present data on most of these factors by population group or area is limited. This makes complex resource allocation formulas impracticable at the current time. The MTEF therefore adopts the following approach:

a) In the first year of the MTEF allocations are made following existing patterns, whilst districts are trained in improving costing and performance based budgeting. Resources do not rise significantly in the first year of the plan at the district level, and therefore any reallocations made would result in significant losers. In addition, this will provide the time to explain the principles of new resource allocation approaches to the districts, thereby improving acceptability.
b) The medium term aim in 2012 is to allocate capital and salaries costs according to BSP norms by facility. In the meanwhile a limited new number of health posts will be built and remote area strategy developed to ensure that facility coverage is complete and equitable. Other recurrent costs (for

example drugs and consumables) will be allocated on a population basis. This may also be modified at a later stage should better data become available on poverty, health need or geography. It should be noted that this approach implicitly assumes that by 2012 the population is using services in a more or less equitable way. Should utilisation still vary significantly by different populations then consideration may be given to a more utilisation based approach.

c) In the interim the change will be phased in even steps. However, increases in allocations will be conditional on achieving performance (including eventually utilisation) milestones and objectives), which will be mutually agreed as part of the district planning process. The Ministry had considered a combination of an utilisation and population based formula to refine the MTEF. However, utilisation data is currently weak, so it was difficult to make calculations based on estimated utilisation in the coming years. In addition this approach is more consensual, allowing districts to contribute to the definition of their own performance.

d) Finally, there are several different ways that resources can be allocated to hospitals, each providing different incentives. At the current time the MTEF the Ministry has selected to locate resources on the basis of admissions. This provides a broad incentive to increase performance without an incentive to over-provide treatment. It is anticipated that this will be phased over the MTEF period, dependant on hospital reforms and hospital performance plans agreed between the MOH and hospital managers. Again should hospital information systems be improved then it may be possible to move towards more sophisticated funding systems.

Socialising the HSSP

In socialising the HSSP, the following approach should be adopted.

Health service delivery will focus throughout the current planning period on the adoption and implementation of the BSP and related standardised work practices. Capacity development based on BSP practice norms will see an increase in the overall level of activities at facility and programme level.

For behaviour change/health promotion the most important challenges will include socialising a revised and more prominent national policy on IEC and BCC across all facilities with the goal of institutionalising communication and behaviour change strategies as core business for all health care providers. This will mean providing capacity development in the following areas:

- Using IEC/BCC materials
- Using the mass media
- Using inter-personal communications skills
- Using advocacy and other techniques to encourage consumers to adopt appropriate health seeking behaviour and to use quality health services
- Monitoring and evaluating systems to measure behaviour change among providers and consumers

However, while the above may seem daunting, the areas requiring most attention are those of institutional development and quality improvement. For institutional development, required actions in the current planning period are dependant on strengthening management and leadership in the MOH. In addition, working towards more systematic collaboration and coordination with partner organisations to ensure optimal use of available resources, both internal and external is essential.

Activities in the area of quality improvement will entail the development of a quality culture throughout the health sector by implementing quality standards, quality awareness, and awards for quality.

Within the area of human resource development, the focus will be on developing systems of practice and ensuring appropriate quantity, quality and deployment of prioritised health staff, in particular community midwives and community nurses.

The area of HMIS has had a troubled history within the MOH since its establishment. Recent advances need to be maintained through the sustained effort of the Department supported by technical assistance. This will involve the development of a master plan for information management. This will provide much needed direction for the MOH as a whole.

Little attention has been paid thus far, in the MOH, to the two areas of gender equity and research. Accordingly, this will require a commitment on the part of the Ministry to ensure sufficient resources are available to foster progress.

Monitoring and evaluating the HSSP

There is a critical need to build capacity for monitoring and evaluation at all levels within the Ministry. With technical assistance, the Planning and the HMIS Departments will take the lead in providing support and will coordinate with all departments, services and programme areas in the monitoring process. The monitoring and evaluation system will also involve field audit activities to verify service output indicators as well as expenditures according to plan activities. Efforts will be made to discuss achievements and shortcomings with health care providers, managers and stakeholders at the local level to provide feedback and incorporate monitoring data into the planning and decision-making process. Findings from monitoring and evaluation will be incorporated into system-wide planning, decision-making and resource allocation actions.

All levels of the health system need to incorporate the key 17 cross-cutting strategies noted in Section 5 of the HSSP into their monitoring and evaluation activities as a central part of the planning cycle. To help with this the MOH will - with technical assistance:

- Develop a matrix for use by central level departments, districts and sub-district facilities
- Align the key 17 cross-cutting strategies with activities, planned outputs, targets, indicators and means of verification as capacity do so develops. Indicators and verification tools should be based on routinely collected information. To allow for differences between districts and to encourage flexibility, activities to be undertaken will be determined locally
- Develop a matrix for use by the MOH centrally that gives outcomes instead of targets. Over time indicators will include equity and poverty-related factors. Targets set by others should contribute to achieving the outcomes. The means of verification here will include surveys and reviews
- Invite all development partners and collaborators to use the MOH HMIS when it is functional to promote efficiency and common understandings

A preliminary approach to the M&E of the HSSP is provided at Annex C.

Integrated HMIS applying to both the private and public sectors will encompass:

- Epidemiological surveillance
- Services within health facilities
- Referral
- Human resource development
- Financial management
- Institutional management
- Facilities management
- Asset management
- Encourage the development of a monitoring and evaluation process or approach that is seen as useful by implementers, allows accountability and transparency, and is efficient and effective

The working principle underlying the HSSP monitoring and evaluation process is based on linking indicators to implementation progress and financial allocations. The scale of action includes developing a bottom-up system that brings in local level indicators to be compiled for a summary of progress centrally.

The following scope of work is envisaged:

- Routine monitoring through monthly, quarterly and annual reports on activities, plan outputs and expenditures from 2008 onwards
- Annual system-wide performance review on outcome indicators and the implementation and expenditures of major activities
- Mid-term evaluation in 2010 to review strategic plan performance at the system level
- Final evaluation through an overall sector-wide review and a national survey in mid 2011

Impact evaluation

The overall impact of the strategic plan will be evaluated at a system-wide level on the basis of the following categories of indicators:

- Improvement in health outcomes including health status
- Improvement in healthy lifestyles and behaviour of the population especially among the poor and those from rural and remote areas
- Improvement in environmental healthiness
- Improvement in the capacity of the MOH to manage institutional and other required change

Outcome evaluation

At the outcome level, the following groups of indicators will be monitored as corresponding to the priority areas of work:

- Access to, utilisation and coverage of health services especially among women, the poor and those from rural and remote areas
- Improvement in the quality of health services in both public and private sectors
- Adoption of appropriate health seeking behaviour and healthy lifestyles among the population
- Improvement in responsiveness and skills of health providers sector-wide
- Wider interaction between providers and consumers at all levels
- Improvement in leadership and management capacity sector-wide at all levels

Where appropriate – and with technical assistance - indicators will be disaggregated to urban/rural location, district and gender, to the extent permitted by data availability.

Output evaluation

At the output level, on an annual basis, the MOH and development partners and other stakeholders will jointly review the operational plans and budgets, their implementation and expenditures. The progress with major work and the level of support channelled for implementation in terms of technical and financial assistance will be monitored through the management information system and the MTEF.

The major performance indicators and interpretations of the outcomes will be disseminated widely using appropriate structures. Issues raised will feed into joint decisions and the ongoing strategic planning process within the health sector.

ANNEXES

ANNEX A: SUPPORT AND COORDINATING LOGFRAME

A Logframe of Support and Coordinating Strategies and Indicators

The purpose of this logframe is to list and identify strategies, activities, indicators and the person or department who has primary responsibility for overseeing these activities, with an indication of an appropriate schedule which fit with the three goals detailed in Section 4 Table 7.

This logframe is not to be considered a logframe for Service Delivery planning, which is contained in a separate document as a Guide to the Implementation of the Health Sector Strategic Plan.

This logframe is primarily for the guidance of, and for the use of Ministry of Health staff at the Central Offices.

GOAL 1: improved accessibility, demand and quality of health services

I = Input (investments), OP = Output (services generated), OC = Outcome (utilisation)

Objective 1.1 To improve coverage and use of primary health care services with a focus on the BSP and integration of priority programmes.

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
1.1.1 Prepare and implement the Basic Services Package.	1. Establish a BSP support team at DHSD	# of Districts trained in BSP (I)	SPWG/HSD	X					
	2. Establish mechanism to extend, revise and integrate micro-policies in line with international best practices for MDGs	Micro Policy catalogue completed	PP	X					
	3. Strengthen guidelines for integrated planning and implementation strategies		PP	X					
	4. Establish monitoring mechanism for implementation of BSP		SPWG/HSD	X					
	5. Evaluate BSP training of facility staff in 4 pilot districts		HSD/IHS		X				
	6. Train health facility staff of remaining districts in BSP integrated approach and focus on MDGs		HSD/IHS		X				
	7. Monitor operationalisation and impact of BSP and produce an evaluation report to MOH Executive	% of PHC facilities in which BSP is implemented by trained staff (OP)	SPWG/HSD		X	X			
1.1.2 Improve utilisation and coverage of PHC services.	1. Complete the PHC facilities network i.e. the creation of some additional HPs		PS/HSD						
	2. Carry out the planned patient satisfaction survey in conjunction with the Health Seeking Behaviour Study		DHProm		X				
	3. Ensure staffing according to BSP minimum norms in all health facilities		HRD		X	X			
	4. Ensure adequate provision of drugs, reproductive and other consumables to all health facilities		DPharm/SAMES		X	X			
	5. Ensure staff sensitisation is in line with BSP directives		HSD		X	X			
	6. Ensure appropriate knowledge and skill mix of staff, according to established staff profiles		HSD/IHS		X	X			
	7. Ensure continuity of services and an adequate referral system		HSD		X	X			
	8. Implement and monitor outreach activities and remote area strategies in line with identified needs		HSD		X	X			

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
	9. Sensitise population with behavioural change/health promotion activities		DHProm	X	X	X			
	10. Strengthen day to day management of PHC services at the district/municipal level		HSD	X	X				
	11. Expand and consolidate partnership arrangements with private sector providers, NGOs and others		M/VM/PS	X	X	X	X		
1.1.3 Improve effectiveness and efficiency of priority programmes through better coordination and integration and by focussing on district / municipality services.	1. Strengthen the link between PHC and Referral services by creating 2 vice directorates for these levels. The Referral Services Vice Directorate becomes responsible for coordinating and supporting hospital sector reform in terms of the HSP and autonomy	DHSD re-organised and refocused. (OP)	PS/HSD		X				
	2. Strengthen the strategic function of the DHSD in view of the need to better harmonise and coordinate priority programmes	Action plan for harmonisation and decentralisation of priority programmes is implemented. (OP)	HSD/PP		X				
	3. Identify the competency base of both sub Directorates, conduct a skills audit and elaborate a capacity development plan	Harmonisation of supervision and training activities effective in % of priority programmes (OP)	HSD/HRD		X	X			
	4. Ensure staff deployment/recruitment meets identified needs		HSD/HRD		X	X	X		
	5. Operationalise DHSD's facilitation role in establishing an integrated BSP (distinguish between supervision / management coordination role of District Liaison Office)		HSD/Dili Liaison Officer		X	X			
	6. Decide jointly with DPS about the areas, degree and modalities of harmonisation of vertical programmes: in planning, resource allocation, logistics and HR		HSD/PP		X	X			
	7. Review and integrate management of DHSD programmes where appropriate		HSD		X				
	8. Verify programme priorities and ensure rational and equitable resource allocation and delineation of roles between programmes according to agreed priorities in core work areas		HSD		X				
	9. Redefine existing roles in light of 1-5 above		HSD/HRD		X				
	10. Undertake a needs assessment in terms additional staff and training investments		HSD/HRD		X				

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
	11. Analyse and establish new positions and recruit new staff		HSD/HRD		X	X			
	12. Establish orientation and ongoing training programmes for new staff and new posts		HRD/IHS		X				
	13. Document and communicate changes and TORs to service and programme units and TORs resulting from institutional changes		HSD/HRD		X				
	14. Develop a multi-year action plan for programme integration and harmonisation in line with micro policy directives and priorities		HSD/HPP		X	X	X	X	X
	15. Redesign and simplify organisational and coordination mechanisms		PP		X	X			
	16. Implement organisational changes		M/VM/PS		X	X			
1.1.4 Improve the infrastructure and equipment of PHC health facilities	1. Adopt a rational service network configuration plan (public and private) and plan for infrastructure construction and rehabilitation needs, based on reviewed criteria for existing and new health facilities (district profiles)	% of combined HPs and HCs with staff housing (I) % of combined HPs and HCs with delivery rooms (I) % of public health district facilities with functional radio or telephone communication system. (I)	HSD/PS		X	X			
	2. Undertake construction work i.e. staff accommodation, laboratories and maternity units in HCs and HPs		HSD/PS		X	X			
	3. Conduct a comprehensive needs assessment of equipment for public PHC facilities (HPs and HCs)		HSD/PS		X				
	4. Procure and replace/complete materials and equipment		HSD/PS		X				
	5. Conduct a comprehensive review of MOH accommodation linked to the Functional Analysis to clarify the need for new infrastructure at central level		HSD/PS		X	X			
	6. Assess the need for a radio communication network at the health post level		HSD/PS		X				
	7. Undertake a vehicle management audit – procurement, maintenance and deployment – in line with service needs i.e. delivery, supervision, control and retrieval		HSD/PS/Proc/Logistics		X	X			

Objective 1.2 To improve Hospital Services Package (HSP), quality of care and referral system

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
1.2.1 Prepare and implement the Hospital Services Package.	1. Based on the directives in the BSP, define the minimum HSP and tailor the HSP for each of the referral hospitals, according to their role delineation and service population requirements	*% of districts with functional secondary health care delivery evacuation and referral system (OP)*	PS/Customised Services/TA		X				
	2. Identify the resource/support needs for establishing the defined HSP i.e. staff, training, equipment and infrastructure		PS/Customised Services/TA		X				
	3. Procure resources to meet the needs identified in 2 above		PS/Customised Services/TA		X	X			
	4. Improve and complete treatment protocols, determine training needs and implement appropriate CPD programmes		PS/Customised Services/TA		X	X			
	5. Establish / utilise a monitoring and evaluation mechanism for implementation of HSP		PS/Customised Services/TA		X	X	X	X	X
1.2.2 Improve performance and management of hospitals by planning and preparing a hospital reform programme	With assistance from an international specialist: 1. Undertake a functional analysis of all hospitals	*% of hospitals with developed business plan being implemented (OP)* % of hospitals with operational Board: having organised at least 2 annual meetings. (OP) (or where at least 2 Board decisions were implemented in the course of the year) (OP)	PS/TA/DPP		X				
	2. Undertake a review of GVNH's referral system and application (Aspects are service package, technical norms, protocols, documentation, communication, transport, facilities/ equipment, financing / patient's costs, staff qualification, continuity of care (24/24)		PS/TA/PP		X				
	3. Draw up individual hospital profiles and hospital development (business) plans		PS/TA/PP		X				
	4. Define role of each hospital in training, practica, supervision and outreach		PS/TA/PP		X				
	5. Link hospital development plans with the workforce planning process		PS/TA/PP		X				
	6. Plan for individual hospital improvement packages i.e. management system development, training, quality improvement, TA etc, to be implemented		PS/TA/PP		X	X	X	X	X
	7. Implement the adopted referral system.(establish/improve CEOC and BEOC at referral hospitals: system, training, equipment e.g. basic elective and emergency surgery requiring general anaesthesia		PS/TA/PP/IHS		X	X	X		
	Start implementation and monitoring of individual hospital business /development plans, with TA., to Include construction works, clinical general and financial management training, asset management, etc		PS/TA/PP		X	X			

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
	8. Institute boards of directors for GVNH and referral hospitals, and revise TORs for Board of Directors, plan for, and conduct training of Board members		PS/TA/PP		X	X			
	9. Encourage hospital autonomy to embrace business principles, performance management systems and practices		PS/TA/PP		X	X	X		
	10. Establish an External Auditor Committee to periodically review hospital compliance with regulations and standards constituted by WHO, Comissao do Parlamento para a Saude, Provedoria dos Direitos Humanos etc		PS/TA/PP		X	X			
	11. Appoint a focal point for each hospital from the External Review Committee		PS/TA/PP		X	X			
	12. Establish clinical audit and Quality Assurance (QA) processes and structures in the referral hospitals and integrate these into core business		PS/TA/PP		X	X	X	X	X
	13. Establish procedures for rapid and more efficient acquisition of capital assets		PS/TA/PP		X	X			
1.2.3 Improve utilisation and coverage of referral services (in hospitals)	1. Ensure minimum package of referral services in each hospital is being provided	Clinical audit and organisational review	PS/TA/PP			X	X		

Objective 1.3 To strengthen and expand Community based Health Services and Community Participation

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
1.3.1 Strengthen and expand community based health services	1. Implement the pilot of the FHPP and ensure systematic monitoring	FHPP evaluated and followed up by decision on further development of community based health services (OP) *% of TL covered by a programme of community based health service*	DHProm	X	X				
	2. Review other community level initiatives before deciding on expansion		DHProm	X	X				
	3. Monitor and evaluate the effect of the FHPP on community based health services including access, service package, availability of candidates, required training/ qualification, responsibility towards the community and district health authorities, motivation, workload, target population, remuneration, supervision, supplies, cost sharing (fees, products)		DHProm		X	X			
	4. Revise FHPP as appropriate and implement programme nationwide		DHProm	X					
1.3.2 Develop a comprehensive incentive scheme to promote staff willingness to work in rural and remote settings	1. Analyse workforce geographic deployment and align findings with population dispersion and BSP staffing norms		HSD	X					
	2. Develop strategies to promote equitable staff distribution - funding, housing, family support, training etc		HSD/PP		X				
	3. Advocate an incentive scheme intersectorally and with GOTL		M/VM/PS		X				
	4. Implement scheme and monitor impact				X	X	X	X	X
1.3.3 Strengthen the Rural Areas Strategy to improve equity of access to health services	1. Evaluate the effectiveness of Mobile Clinics	utilisation, # visits # referrals	HSD		X				
	2. Develop alternative strategies based on feasibility and sustainability e.g. Village Health Workers	alternative strategies evaluated and followed up by decision on further development of Remote Areas Strategy: (OP)	HSD		X				
	3. Implement a pilot of alternative strategies		HSD			X			
1.3.4 Strengthen community participation in health care	1. Sensitise communities to become involved in and to assume responsibility for health care, taking into account the future role of municipalities		HProm/TA		X	X			
	2. Formalise the role/responsibilities of community level structures for community involvement in health care				X	X			
	3. Train community level persons and structures in the areas of their responsibility: community mobilisation around campaigns e.g. vaccination, sanitation etc, and co-management of community level health services, etc					X	X	X	X

Objective 1.4 To assure quality of care throughout the health system

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
1.4.1 Reaffirm MOH commitment to MDGs and use goals as framework for Directorate of Health's operations.	1. Focus on MDGs in evidence-based practice, monitoring and evaluation	See impact indicators BSP	HSD		X	X	X	X	X
	2. Ensure resource allocation to MDG planning, service delivery, monitoring and evaluation				X	X	X	X	X
	3. Prioritise MDGs in strategic and annual plans and in political decision making				X	X	X	X	X
	4. Clarify MDG-related policy and protocol framework for professional and technical practice				X				
1.4.2 Improve quality of care by establishing Quality Assurance mechanisms	1. Locate overall responsibility for and coordination of QA system in Directorate of Service Delivery (creation of a QA Unit)	% of MOH central services and hospitals where QA mechanism /instruments have been introduced and are effectively used for decision making (OP)	PS+TA/HSD		X	X			
	2. Ensure integration of a QA function in each department and priority programme and plan and provide training in QA				X	X	X	X	X
	3. Elaborate guidelines / tools for monitoring quality; adopt indicators for QA				X	X	X	X	X
	4. Introduce Clinical Audits and standardised treatment regimes					X	X		
	5. Ensure harmonisation of new QA mechanisms with the role of Directorate Health Inspection for supervision of practices					X	X		
	6. Establish collaboration with professional associations to gain input into QA and establish periodic assessment of professional and technical practices based on agreed and published standards				X	X	X	X	X
	7. Prepare and disseminate professional standards of practice				X	X			

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
1.4.3 Improve and strengthen pharmacy services, in terms of drug availability, storage, distribution, quality of drugs, prescription practices, etc.	1. Review pharmacy policy and implement accordingly	*% of district depots that experienced stock outs of tracer drugs in the course of the year. (OC)*	DPharm		X	X			
	2. Develop a drug and reproductive consumables security plan		DPharm		X	X			
	3. Undertake a functional analysis of the Pharmacy Department to determine capacity to meet obligations		TA		X				
	4. Ensure regular supervision and support/training of district managers in districts.		DPharm						
	5. Ensure regular and accurate reporting on drug/contraceptive stocks and ordering		DPharm		X	X	X	X	X
	6. Structure and intensify links between the Department of Pharmacy and SAMES (collaboration and harmonisation, control, support)		DPharm/SAMES		X	X			
	7. Strengthen the role of the Pharmacy Department in capacity development functions with IHS		DPharm+IHS	X	X				
1.4.4 Strengthen IBCC/ Health Promotion	1. Promote ownership of BCC/Health Promotion within the MOH and partner organisation workforces	comprehensive IEC/BCC inventory and needs assessment carried out and translated into recommendations (OP) Coordination of all actors in IEC/BCC operational. (OP) Nr of annual campaigns (OC)	HProm + TA		X	X	X	X	X
	2. Develop and adopt an BCC/HP strategy and guidelines for the health sector, encompassing all areas of health care and various communication strategies (methods and levels)		HProm + TA		X				
	3. Ensure comprehensive BCC/HP inventory and needs assessment, production of messages and organisation of campaigns (where appropriate, consider outsourcing)		HProm + TA		X	X			
	4. Ensure systematic testing of new products and undertake an impact evaluation		HProm + TA		X	X	X	X	X
	5. Ensure adequate coordination of all actors involved in BCC/HP including local community members		HProm + TA		X	X	X	X	X

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
1.4.5 Establish a system for emergency and disaster planning and management.	1. Work intersectorally to develop a master risk management policy and operational guidelines		PS/EH		X	X			
	2. Clarify in-house responsibility for leading MOH action in risk management/emergency management		PS		X	X			
1.4.6 Improve the quality of infrastructure and equipment for PHC services and central services	1. Ensure PHC infrastructure development programme is in line with BSP directives	# new/rehabilitated HPs and HCs identified	DHS		X	X			
	2. Start extension/construction work for central MOH services, including IHS.		M/VM/PS/IHS			X			
	3. Procure equipment		DProc/Log(DevF/M/L)			X			
1.4.7 Systematise and regulate public private partnership options	1. Identify a structure within MOH that is to be responsible for coordination / management / focal point for collaboration with private sector partners. Develop mechanisms for MOH coordination with each type of private sector partner	Database created, used and systematically updated (OP)	M/VM/PS		X				
	2. Create a private sector data base (status, organisation, location, care package, staffing levels, attendance rates, etc)		HRD/HMIS		X	X	X		
	3. Further institutionalise the involvement of NGOs and faith based organisations, not only in health care provision, but also in planning, policy/strategy development, M&E. Encourage devolved public-private sector integration activities		PS/HSD/PP		X	X	X		
	4. Formalise authority for hospital administration's capacity to contract out / outsource non medical services to the private sector (including security, laundry, cleaning, and catering)	Guidelines for contracting out by hospitals developed and socialised (OP)	PS/Customised services		X	X	X		
	5. Establish minimum quality standards for private health facilities and health practitioners and regulate accordingly	*# of formal partnership contracts signed (OP)*	PS/PP/HRD			X	X		

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
	6. Study the feasibility of private sector partnership agreements. Define: actors, structures, objectives, complementary coverage, input, norms/standards, referral protocols/practices, expected results, work plan, monitoring and time table	% of private sector facilities having been supervised in the course of the year.(OP)	PS			X	X		
	7. Sign formal partnership arrangements, specifying outsourcing mechanisms, supervision / inspection of facilities, treatment protocols, referral system, access to MOH staff training, drugs and equipment		M/VM/PS			X	X		
	8. Explore incentives to encourage provision of health services, and issue relevant legislation to facilitate registration and licensing of private and NGO health providers		M/VM/PS			X	X		
	9. Monitor safety of practices in the private sector. (using legislation, registration, licensing, accreditation)		PS/HRD			X	X	X	X

Objective 1.5 Comprehensive Health District development in the light of administrative decentralisation

STRATEGIES	MAIN ACTIVITIES	INDICATORS	RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
1.5.1 Elaborate for each district (municipality) a medium term development plan	1. Based on the results of a national workshop, propose recommendations and guidelines for a Health District (municipality) Development Strategy	# of districts who elaborated a district profile. (OP)	PS/HSD		X	X			
	2. Train health facility staff in 4 pilot districts in the BSP integrated approach and focus on MDGs, with participation of international doctors		HSD/IHS		X	X			
	3. Elaborate district profiles		HSD		X				
	4. Develop and implement a 5 year support programme for health district development: service network, service packages, staff capacities, management systems, procedures, coordination mechanisms, etc		HSD/HRD			X	X	X	X
	5. Utilise BSP minimum workforce norms to redistribute and progress equitable health facility staffing		HSD/HRD		X	X	X		
	6. Undertake a job analyses and review job descriptions	# of districts where revised protocols and procedures are being used. (OC)	HRD		X	X			
	7. Review protocols and procedures re planning, financing, coordination, etc		HSD/PP		X	X			
	8. Strengthen leadership capacity through leadership courses, local mentor and coaching programmes.		HRD/IHS	X	X	X	X	X	X
	9. Plan for an international master in public health graduate in every DHMT		HRD			X	X		
	10. Develop a referral policy	# of districts benefiting from TA for comprehensive health district development (I)	PP/TA	X					
	11. Establish a M&E mechanism for the HD development process.		TA/HSD		X	X			
	12. Undertake a skills needs assessment in each district/municipality		TA/HSD/HRD/IHS		X	X			
	13. Based on 12 above, undertake technical and management training/TA including a structured local visitation programme		TA/IHS			X	X		
	14. Continue with phased construction works.		PS		X	X	X	X	
	15. Procure motor cycles for HCs to undertake mobile clinics, etc		Dev AFL	X	X	X			
	16. Procure sufficient ambulances to fulfil referral needs in each district		HSD/AFL	X	X	X			
	17. Procure radio communication equipment for a network at the health post level and install it		AFL		X	X			

STRATEGIES	MAIN ACTIVITIES	INDICATORS	RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
1.5.2 Prepare for the consequences of future administrative decentralisation of the district health system	1. Identify the implications of future decentralisation to municipalities i.e. management of HPs/HCs	plan exists for devolution of health care authority to municipalities adopted by GOTL (OP) # of districts where devolution of health care authority to municipalities has started (dialogue, training, staff transfer,..) (OC) # of districts where the Council's role has been reviewed and training has been provided. (OC) *# of districts, where responsibilities for health care have been transferred to municipal authorities (OC)*	PP/HSD	X	X				
	2. Identify and make recommendations on sector specific issues as a result of decentralisation		PP/HSD	X	X				
	3. Review the community participation aspect of the FHPP in the light of decentralisation i.e. responsibility of municipalities for FHPs		PP/HSD		X	X			
	4. Plan the phasing of transfer of responsibilities to the municipalities		PP/HSD	X	X				
	5. Ensure health sector decentralisation is linked with the broader context of administrative decentralisation: Ensure formal and regular coordination with the responsible body i.e. Direcção Nacional de Administração do Território		PP/HSD	X	X				
	6. Determine capacity building needs for Council members and plan and implement training and support		PP/HSD+IHS	X	X				
	7. Develop a mechanism to assess and strengthen community governance capacity across municipalities		PP/HSD+IHS		X	X			
	8. Carry out training as required		PP/HSD+IHS			X	X	X	
	9. Prepare phased transfer of health authority		PP/HSD+IHS	X	X				
	10. Put in place MOH coordination, managerial and reporting mechanisms		PP/HSD+IHS	X	X	X			
	11. Start transfer of health authority under GOTL direction		PP/HSD+M/VM		X				
	12. Monitor the performance of municipalities in managing health care		PP/HSD+IHS		X	X	X	X	X
1.5.3 District basket approach to planning and funding with DHM and DHMC central to the process	1. Access donor preparedness for SWAP funding modalities	District Basket concept developed. (OP) concept and implementation aspects of basket socialised (OP) # of districts, where basket is operational OC)	M/VM/PS	X	X				
	2. Define a tailored district basket approach		VM+Fin		X				
	3. Agree rules and regulations for district basket funding with DPS		VM+Fin		X				
	4. Define disbursement, accounting and reporting mechanisms and procedures		VM+Fin		X				
	5. Provide guidelines for operationalising district basket		VM+Fin		X				
	6. Communicate and promote the district basket concept to all actors in the health sector and to local administration authorities		VM+Fin		X	X			
	7. Strengthen DHMT capacity to manage district baskets		VM+Fin+IHS		X	X	X		

GOAL 2: Strengthened support services and management

* I = Input (investments), OP = Output (services generated), OC = Outcome (utilisation)

Objective 2.1 To improve overall governance and management of the health sector

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
2.1.1 Introduce and stimulate a more entrepreneurial spirit and management style at all levels in MOH Central Offices	1. Review job descriptions: determine fit between staff norms, job description, and skills	% of job descriptions reviewed (OP)	PS/HRD		X	X			
	2. Strengthen staff management and leadership capacities through training, mentoring, coaching and other forms of skills enhancement	# of central MOH staff trained in management and /or leadership (OP)	HRD/IHS		X	X	X	X	
	3. Institutionalise delegation to subordinates as part of a capacity building mechanism		HRD/HSD		X	X	X	X	X
	4. Create opportunities for interchange between central MOH and districts as part of capacity development and as a means of promoting integration/ harmony	% of planned measures towards capacity building implemented	PS		X	X	X	X	X
2.1.2 Clarify and review role and responsibilities within the MOH senior executive management team	Concerning Minister and Vice Minister 1. Review current legislation of these positions in terms of delegation, reporting and communication, with an emphasis on strategic tasks and overall leadership, and a movement away from day to day operational management	current legislation reviewed and implemented (OP)	Executive MoH/TA		X				
	Concerning Permanent Secretary and Vice Minister 2. Review current legislation of this position in terms of delegation, reporting and communication, with an emphasis on operational oversight and M&E		Executive MoH/TA		X				
	3. Reflect analysis in role definitions		Executive MoH/TA		X				
2.1.3 Improve the effectiveness of Board of Directors	1. Update MOH organic law to accommodate role	organic law, internal regulations and procedures reviewed and implemented (OP) annual review of membership carried out (OC)	Executive MoH/TA		X	X			
	2. Review the role of the BOD and revise relevant legislation to promote central governance, stewardship and corporate development		Executive MoH/TA		X	X			
	3. Define internal rules and procedures within the context of the revised organic law		Executive MoH/TA			X			
	4. Induct Board members through in-house training and structured experiences		Executive MoH/TA		X	X	X	X	X
	5. Celebrate organisational change for MOH personnel and governors		Executive MoH/TA			X			
	6. Introduce an annual review of membership of BOD		Executive MoH/TA			X	X	X	X
2.1.4 Re-organise Administration and Finance functions to	1. Recruit long term TA for capacity building and system development in MTEF financing		TA+A/F/L		X				
	2. Separate procurement and logistics functions into two different		TA+A/F/L		X				

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
reflect a focus on a revised mix of departments	departments	DAFL re-organised, departments created, additional staff recruited (I) asset management system established and operational (OP)							
	3. Add asset management to the responsibility of the logistics department		TA+A/F/L		X				
	4. Establish a system for asset management (registration, distribution, warehousing, value/depreciation, replacement)		TA+A/F/L		X	X			
	5. Create and staff a new department for maintenance - architect, bio-medical engineer etc		TA+A/F/L			X	X		
	6. Assess training, TA and additional staff needs. Recruit and train staff in procurement and in asset management		TA+A/F/L			X	X	X	
2.1.5 Improve governance and public accountability by strengthening the status and capacity of the Inspector General's Office	1. Review current structure, role and function of the Inspector General's Office (IGO)	IGO re-organised in terms of legislation, training and procedures (OP) IGO reports available (OP)	TA+IGO		X				
	2. Revise current legislation as necessary		TA+IGO		X	X			
	3. Publish ministerial decree on IGO		TA+IGO			X			
	4. Identify capacity development and TA needs		TA+IGO			X	X		
	5. Review procedures of IGO to ensure autonomy/impartiality		TA+IGO			X	X		
	6. Define reporting format and follow-up mechanisms		TA+IGO			X	X		
	7. Provide capacity development and TA support		TA+IGO			X	X		
2.1.6 Follow up MOH central services reforms	1. Establish a calendar and milestones for central services reforms, as well as a mechanism for monitoring the progress (changes in MOH organogram and within MOH structures)	Revised central MOH organogram adopted and approved (OP) MOH revised organogram and institutional framework for HSSP coordination implemented (OP)	M/VM/PS/TA		X				
	2. Monitor the implementation, and evaluate the impact, of reform measures, as part of the annual joint sector reviews		M/VM/PS/TA		X	X	X	X	X
	3. Adjust, as necessary, reform approach and measures of specific structures		M/VM/PS/TA			X	X	X	X
2.1.7 Establish a systematic approach for para-legal documents	1. Identify and collate all existing legal documents	Filing system and agenda for legal documents established (OP)	TA/IGO		X				
	2. Set up a filing system and mechanism for review and action		TA/IGO		X				
	3. Review all existing laws, drafts, regulations etc compiled by, or affecting, MOH, including laws that impact on environmental health		TA/IGO			X	X		
	4. Prepare a comprehensive and integrated analysis for submission to GOTL on recommended changes to legislation and advocate for the changes		TA/IGO			X	X	X	

Objective 2.2 To improve human resources planning, recruitment, deployment, training and management

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
2.2.1 Improve human resource development and management through institutional and organisational reform	1. Consolidate HRD within a Directorate that provides clear functional responsibilities for workforce planning, education and training, personnel management and occupational health and safety	Revised Workforce Plan adopted and being implemented (OP)	TA/HRD		X	X			
	2. Create a new Directorate with 4 Departments with creation documentation, mission statement, TORs and staffing norms for each department	HRD Policy document developed and policy implemented (OP)	TA/HRD		X				
	3. Adopt a 3 year work plan for the new Directorate, including finalisation of an HR policy, education and training strategic document and OH&S policy	DHR created and staffed, comprehensive HR Development action plan adopted. (OP)	TA/HRD		X	X			
	4. Assess resource needs in terms of staffing, training, infrastructure, equipment and operational budget		TA/HRD		X	X			
	5. Develop an HR recruitment, training and information system		TA/HRD			X	X		
	6. Organise a suitable location for new Directorate Departments and purchase furniture/equipment, vehicles, etc		TA/HRD			X			
	7. Establish centrally located protocols for minimum standards for staff, i.e. numbers, qualifications and skill mix, for each type of health facility	HR information system developed and operational (OP)	TA/HRD		X	X			
	8. Develop and utilise a basic HR management information system which is flexible enough to be integrated into the planned Government-wide HR management information system	Supervision concept and system strengthened and socialised. (OP)	TA/HRD			X	X		
	9. Develop, adopt and implement a set of core HR management guidelines, rules and procedures, including the introduction of routine supportive supervision, performance assessment and procedures for incentives and sanctions		TA/HRD			X	X		

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
2.2.2 Identify human resource needs in MOH Central Office Departments, based on the FA results, by further in depth analysis	1. Clarify and revise each department's mission statement, and their contribution to the MOH's overall objectives	Staffing norms and profiles and staff resource needs projection adopted and implemented. (OP) % of planned new recruitments realised Redistribution of staff, according to norms and rational needs implemented (OP) National training capacities reviewed and capacity strengthening measures being implemented (OP)	TA/PP/HSD/AFL			X	X		
	2. Verify the logic and coherence of the internal organisation, including equity in workloads		TA/PP/HSD/AFL		X	X			
	3. Verify that staffing norms, i.e. minimum qualification, profile etc, are adequate, attainable and sustainable for each post		TA/PP/HSD/AFL		X	X			
	4. Determine additional workload required by reforms to policies, strategies and practices and secure additional staff, with detailed TORs for each position, to meet this extra workload		TA/PP/HSD/AFL		X	X			
	5. Identify protracted vacancies and their causes		TA/PP/HSD/AFL		X	X			
	6. Identify alternative, viable recruitment strategies		TA/PP/HSD/AFL		X	X			
	7. Redeploy staff to deal with identified workload inequities		TA/PP/HSD/AFL		X	X			
	8. Identify training needs in order to meet qualification requirements and determine appropriate CPD and training courses and secure enrolment with IHS and elsewhere		TA/PP/HSD/AFL		X	X	X		
	9. Secure replacement staff for the duration of absence due to training		TA/PP/HSD/AFL		X	X			
	10. Plan HR needs for existing vacancies and new positions created in terms of training and recruitment requirements		TA/PP/HSD/AFL		X	X			
	11. Verify national education and training capacity training requirements and identify additional capacity development options both in and out of country		TA/PP/HSD/AFL		X	X	X		
2.2.3 Professional development of senior MOH staff in business management and corporate development	1. Conduct a needs assessment and develop a plan to meet these needs	# of MOH senior staff (Department Heads, Directorate Heads and higher) on training in a given year.(OP)	TA/Exec		X	X			
	2. Identify options and sensitise GOTL		TA/Exec		X	X			
	3. Prepare replacement for senior MOH staff during training		TA/Exec		X	X			
	4. Provide training for, and capacity development of senior staff		TA/Exec	X	X	X	X		
2.2.4 Estimate additional health facility staff needs for the planning period	1. Take stock of current staff capacity in the health sector (civil service, contracted staff, volunteers); review distribution of staff, forecast staff departure and new staff recruitment, define the gap between current staffing and future needs, in terms of qualification, numbers and skill mix, verify adequacy of staff training capacity. Take into account: ▪ The cohort of international doctors	Workforce plan developed, approved and implemented Comprehensive staff pre-service training plan, based on projection of	TA/HRD	X	X				

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
	▪ The return of graduating allied health professionals e.g. medical students from Cuba ▪ Reform to services provided by all levels of health facility in accordance with BSP, HSP, MDGs ▪ Institutional/organisational reforms at central level and the forecast implications of decentralisation	additional needs, being implemented (OP)							
	2. Integrate outcome of update in MOH recruitment and capacity development strategies		TA+IHS		X	X			
	3. Recruit and skill in line with strategies		TA		X	X	X	X	X
2.2.5 Extend opportunities for non-civil service appointments to professional and technical posts	1. Undertake a need assessment for non-civil service appointments	# of non-civil service appointments (OP)	TA/HRD		X				
	2. Develop and implement a policy for contracting out /outsourcing of professional services and make it attractive		TA/PP			X			
	3. Recruit in line with approved protocols		TA/HRD			X			
2.2.6 Improve the effectiveness and impact of the scholarship programme and overseas study tours	1. Review scholarship programme, protocols and procedures	scholarship programme, protocols and procedures reviewed, including equitable and transparent candidate selection process and criteria. (OP) # fellowship-employment contracts signed in a given year. (OP) List of scholarships and fellowships evaluated and reviewed. (OP)	IHS/HRD		X				
	2. Institute a quarterly meeting of the selection committee on scholarships and fellowships and appoint the Director of HSD to sit on each scholarship/ fellowship selection panel		IHS/HRD		X				
	3. Consider the appropriateness of offered scholarships, based on objective health sector priorities and in keeping with the Health Workforce Plan principles		IHS/HRD		X				
	4. Determine an equitable and transparent candidate selection process and criteria		IHS/HRD		X				
	5. Link scholarship courses to current and future roles of relevant staff		IHS/HRD		X	X	X	X	X
	6. Sign and monitor fellowship-employment contracts for beneficiaries		IHS/HRD		X	X	X	X	X
	7. Monitor, evaluate and reports on the outcome of all scholarships and study tours		IHS/HRD			X	X	X	X
	8. Evaluate the impact of courses on health service delivery		IHS/HRD+HRD			X	X	X	X
2.2.7 Initiate / accelerate the IHS overhaul so that it starts to fulfil its mandated role	1. Develop comprehensive administrative and academic infrastructure and systems to support IHS operations	Partnership contract IHS with foreign teaching institute signed and being implemented. (OP)	TA/IHS		X				
	2. Establish organisation-wide assessment criteria to monitor the IHS's performance against agreed targets and milestones		TA/IHS		X				
	3. Coordinate the type of support and technical assistance needed, with AusAID and other development partners		TA/IHS		X				

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
	4. Develop and agree an MOU between MOH and MOE	MOU between the MOH and MOE signed and implemented. (OP) # of planned trainings and clinical practica organised/ implemented by IHS (OC)	TA/IHS		X	X			
	5. Establish internationally recognised accreditation of the IHS within the education sector		TA/IHS		X	X			
	6. Establish liaison between IHS and international educational institution(s)		TA/IHS		X				
	7. Recruit TA for IHS		TA/IHS		X				
	8. Establish a language laboratory		TA/IHS		X	X			
	9. Acquire major items of equipment – computers, audio-visual equipment, etc		TA/IHS		X				
	10. Complete rehabilitation and construction of classrooms and laboratory		TA/IHS		X	X			
	11. Promote opportunities for appropriate clinical practica.		TA/IHS		X	X	X		
2.2.8 Prepare a system of executive management performance review and consider incentives	1. Review current legislation on the issue of performance management	incentive system for executive performance management operational (OP)	TA/HRD			X			
	2. Study options for defining and measuring targets, decision making and incentives related to specific staff positions		TA/HRD			X			
	3. Socialise the concept of performance management, its objectives and its consequences		TA/HRD			X			
	4. Based on experience, adopt and establish a system for performance management, linked to incentives		TA/HRD			X	X	X	
	5. Establish management contracts		TA/HRD				X		
	6. Ensure performance management capacity all levels e.g. performance evaluation		TA/HRD				X	X	
	7. Monitor and evaluate the impact of the performance management process		TA/HRD				X	X	X
2.2.9 Ensure priority TA for the HSSP implementation period, including long and short term, and national and international	1. Create a committee for a comprehensive needs assessment and monitoring of TAs in the health sector	% of ongoing TA that is in concordance with comprehensive TA needs assessment (OP) MOH structure for TA management in place and operational. (OP)	TA/SPWG		X				
	2. Undertake a comprehensive needs assessment of TA and substitution staff		TA/SPWG		X				
	3. Develop and implement a policy on TA		TA/SPWG		X				
	4. Create a TA recruitment plan and implement		TA/SPWG		X	X			
	5. Make day to day coordination and management of TA the responsibility of the new Directorate of HR		TA/SPWG		X	X			
	6. Start with the recruitment of the most urgent TA		TA/SPWG		X				

Objective 2.3 To improve procurement, distribution and management of health commodities

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
2.3. Improve performance of SAMES in all key areas of responsibility	1. Undertake a rapid appraisal of the current state of implementation of SAMES' business plan and identify main obstacles in coordination with the Department of Pharmacy and TA	% of annual plan of Business plan realised (OP)	TA/SAMES/DPharm		X	X			
	2. Review the TORs, functioning and membership of the SAMES Board		TA/SAMES/DPharm		X				
	3. Recruit required long term TA	# of tracer drugs (essential) for which there has been a central level stock out in a given year. (OC)	TA/SAMES/DPharm		X	X	X	X	X
	4. Review the business plan and identify key factors/conditions for successful operationalisation of SAMES as an autonomous agency		TA/SAMES/DPharm			X			
	5. Decide on conditions and scheduling for the capitalisation of SAMES		TA/SAMES/DPharm			X			
	6. Articulate mile stones for strengthening SAMES and establish a monitoring mechanism		TA/SAMES/DPharm		X	X			
	7. Implement and monitor the SAMES business plan		SAMES		X	X	X	X	X
2.3.2 Review the organisation and capacity of the Department of Pharmacy	1. Transfer food safety function to Department of Environmental health	# of qualified pharmacists recruited by MOH. (I)	TA/EH		X				
	2. Induct new pharmacy graduates through a mentoring programme by experienced pharmacists to promote desired attitudes/practices		TA+Pharm/SAMES		X	X	X	X	X
	3. Strengthen operational links between the Department of Pharmacy and SAMES	DPS strengthened as per plan. (I)	TA+Pharm/SAMES		X	X			
	4. Update essential drugs list, standard treatment guidelines, etc. In accordance with recommendations in the BSP/HSP (All drugs to be registered, either in the National Essential Drug List or Non-Scheduled Drug List)		TA+Pharm/SAMES		X				
	5. Undertake a training needs assessment for medical supply managers at district and hospital level	# of supervision missions by DPS in a given year (OC)	TA+Pharm/SAMES		X	X			
	6. Undertake a training needs assessment for prescribing health facility staff in rational prescribing and use of the approved formulary		TA+Pharm/SAMES		X	X			
2.3.3 Improve pharmacy management and drug prescription practices	1. Implement training for medical supply managers at district and hospital level	# of Depot Managers trained. (OP)	TA/Pharm/Customised services		X	X			
	2. Implement training for prescribing health facility staff in rational prescribing and use of the approved formulary	% of prescriptions by health facilities made according to protocol (OC)			X	X			

2.4 To strengthen management of other support services

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
2.4.1 Review the Health Promotion strategy and the role of the Department of Health Promotion	1. Make a clear distinction between 3 areas: (i) IEC/BCC, (ii) community based health care, and (iii) responsibility of communities in health care	HP strategy reviewed and being implemented, role of HPD reviewed (OP)	TA/Health Prom		X				
	2. Redefine the role of the DHP in accordance with the 3 areas and ensure the necessary internal DHSD and DHP reform, strengthening and liaison with other services		Health Prom		X				
2.4.2 Review of laboratory and blood bank services: institutional set-up, role, physical structure, environment and safety, and network configuration	1. Assess the adequacy of the present laboratory system and determine needs	Department of Laboratory and Blood Services disbanded and services re-organised (OP) # of hospitals where a blood product stock out occurred in a given year (OC) # of product quality tests carried out by the central lab in a given year (OP)	TA/HSD/various		X				
	2. Rationalise pathology services in the MOH, linking pathology services with BSP/HPS internalised practice		TA/HSD/various		X	X			
	3. Ensure appropriate re-assignment and location of staff		TA/HSD/various		X	X			
	4. Strengthen collaboration between GVNH's blood bank with the Laboratory Services of the Referral hospitals in a National Blood bank network		TA/HSD/various		X	X			
	5. Coordinate with St John of God on technical expertise and resources		TA/HSD/various		X	X			
	6. Plan for the development of an appropriate education programme in laboratory technology		TA/HSD/various		X				
	7. Identify non-compliance in systems and testing arrangements with agreed international standards (short term TA)		TA/HSD/various		X				
2.4.3 Strengthening of research capacity in MOH	1. Adopt a research capacity development plan for MOH to ensure a minimum of research capacity in MOH for planning and evaluation purposes	agenda for priority research adopted and being implemented (OP) Planning, coordination, quality assurance and validation of study results is systematic (OC)	TA/IHS		X	X			
	2. Plan the agreed package of measures for increasing research capacity including the creation of a health research centre		TA/IHS		X	X			
	3. Decide on the functions of the structure which is to become responsible for research coordination, quality assurance, etc		TA/IHS		X	X			
	4. Implement these functions		TA/IHS			X			

2.5 To improve management and maintenance of the health infrastructure, equipment and other assets

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
2.5.1 Ensure adequate preventive and remedial maintenance of all infrastructures, medical and non-medical equipment, vehicles, as part of asset management	1. Develop, with TA, a comprehensive health sector maintenance concept and system, which takes into account standardisation of equipment, training of health staff in correct utilisation and preventive maintenance, training of maintenance technicians, establishment and equipping of maintenance workshops, availability of spare parts, all linked to Asset management / administration	Concept for comprehensive maintenance system adopted (OP) Maintenance system in place for bio medical equipment, office equipment, vehicles and infrastructure OP) % of biomedical equipment in hospitals that is out of order (non-functional) at a given point in time. (OC)	TA/AFL		X				
	2. Consider outsourcing maintenance tasks, including delegation to communities and district councils		TA/AFL		X				
	3. Link MOH system for procurement of new equipment with medical equipment management and maintenance systems.		TA/AFL		X	X			
	4. Strengthen hospital administration's capacity in the area of procurement, ensuring compliance with technical standards for the choice of equipment		TA/AFL		X				
	5. Develop and implement a comprehensive asset management system for the public health sector: software, inventory, norms for renewal, staff, maintenance of the database, including periodic spot checks of inventories		TA/AFL		X	X	X	X	X
2.5.2 Manage spatial accommodation issues arising from central MOH restructuring	1. Secure more space: identify renovation/construction needs	% of planned construction works realised (OP) % of planned equipment procured (OP	PS/AFL		X				
	2. Re-allocate spatial accommodation appropriately		PS/AFL		X				
	3. Identify equipment, furniture and vehicle needs for central MOH services		PS/AFL		X				
	4. Enhance availability of technology for communication, data storage and retrieval, computing/wireless intranet, etc		PS/AFL		X	X			
	5. Implement renovation/construction works		PS/AFL		X	X			
	6. Procure equipment, furniture and vehicles for MOH central services		PS/AFL		X	X			
	7. Install intra-MOH system for wireless communication, data storage and retrieval, computing		PS/AFL		X	X			

GOAL 3: Strengthened coordination, planning and monitoring

* I = Input (investments), OP = Output (services generated), OC = Outcome (utilisation)

Objective 3.1 To fine-tune and complete policy definition

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
3.1.1 Improve internal and external MOH communication: organisational self-promotion; dissemination to operational levels and external bodies important to the development of the health sector	1. Develop a master plan for communication - who, what, when, how etc	master plan for communication adopted and being implemented (OP)	PS/Proc/TA		X				
	2. Re-define the role of Protocol/MM,		PS/Proc/TA		X				
	3. Identify ICT needs: wireless networks or existing telephone communications with District offices for the HMIS		PS/Proc/TA		X	X			
	4. Identify required skills and training need assessment		PS/Proc/TA			X			
	5. Socialise the expanded role of Protocol/MM		PS/Proc/TA			X			
	6. Provide necessary training		PS/Proc/TA			X	X		
	7. Produce easy to read, summary descriptions of major changes in the health system, targeting health facility staff, NGOs, local administration and communities	*# of practical and articulated guidelines for policy documents produced and disseminated in a given year (OP)*	PS/Proc/TA			X			
	8. Elaborate practical and articulated guidelines of all policy documents to ensure proper understanding and practical implementation of policies and plans		PS/Proc/TA			X			
	9. Ensure widespread dissemination of policies, guidelines, etc		PS/Proc/TA			X			
3.1.2 Develop, adopt, disseminate and implement new policies/ strategies	1. Identify the need for new or revised strategies, e.g. Human Resource Development, Health District Development and Decentralisation, Hospital referral services, Maintenance and Asset management, Laboratory services, Technical assistance, private sector collaboration and development	# of new policy and strategy documents produced, adopted and socialised in a given year (OP)	TA/PP/HRD		X	X	X		
	2. Ensure that national policies on crosscutting issues, such as gender, human rights, equity and poverty reduction are reflected in all MOH policies and strategies		PP		X	X	X	X	X
	3. Adopt a calendar for 1 and 2 above and implement.		PP		X				
	4. Establish working groups for development, elaboration/review of strategies and recruit, as required, specialised short term TA		PP		X	X			
	5. Ensure a procedure for validation /adoption of these documents and implement		PP		X	X			
	6. Work with IHS and HPD on preparing learning documents/strategies for policy applications locally		PP+IHS+DHProm		X	X	X		
	7. Develop learning materials and a roll out IEC schedule		PP+DHProm		X	X	X		

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
3.1.3 Regularly review and update strategy papers	1. Establish a strategy implementation committee, comprising senior staff, which reviews strategy documents and guidelines to ensure implementation of an annual review and validation.	# of policy and strategy documents reviewed and socialised in a given year (OP)	PP		X	X	X	X	X
	2. Determine guidelines for each strategy, clarifying implementation issues, including the current capacity of the system to implement the strategies and current resource and capacity development needs (An example is the need to test the waiting homes strategy for pregnant women).		PP		X	X			
	3. Integrate strategies with BSP directive at every level of facility		PP+HSD		X	X			
	4. Test strategies for alignment with international best practices for MDGs		PP		X	X			
3.1.4 Strengthen MOH's capacity in policy development, sector planning and in Monitoring and Evaluation	1. Replace the Department of Policy and Planning with higher level Policy, Planning, M&E Units directly responsible to the PS	DPP strengthened according to plan (training, additional staff, mission review, ..) (OP)	TA/PS/PP			X	X		
	2. Assess staff and other resource needs, capacity development needs, TA needs in these areas		PS			X	X		
	3. Plan and implement recruitment and training		PS			X	X		
	4. Establish an HSSP annual planning and M&E framework		PS			X			

3.2 To improve coordination with various stakeholder groups

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
3.2.1 Strengthen coordination with Development Partners	1. Clarify the purpose of meetings with development partners, adopt TOR for different types of meetings dealing with technical, problem solving, implementation and negotiation issues	mechanism(s) for donor coordination adopted and established (OP)	M/VM/PS		X	X			
	2. Map donor activities and plans. (who does what, how much, where, when, how; for current and planned support)	comprehensive donor mapping carried out (OP)	M/VM/PS		X	X			
	3. Explore scope of coordination and harmonisation (an initial exercise might be to take stock of the willingness, intrinsic motivation of donors to adapt their support management modalities to identify like minded partners)	% of scheduled coordination meetings carried out in a given year. (OP)	M/VM/PS		X	X			
	4. Establish an agenda with donor partners to identify issues for which exchange, negotiation, consensus is needed		M/VM/PS		X	X			
	5. Organise and document meetings according to the agreed agenda and ensure follow-up		M/VM/PS		X	X			
	6. Prepare and sign statements of intent, Codes of conduct, MOUs with donor partners		M/VM/PS		X	X	X	X	X
3.2.2 Ensure adequate day to day coordination and management of major externally funded programmes	1. Create a Service Support Unit (SSU) by transforming the GFATM PMU - functions, structure, internal organisation, procedures, required resources (human and financial), required investments (infrastructure, equipments)	PMUs disbanded; SSU created and operational (OP)	TA/SSU	X	X				
	2. Organise the transition of responsibilities from PMU to SSU: staffing, job descriptions, procurement, etc		TA/SSU	X	X				
	3. Negotiate and make plans for progressively integrating the management of other financial support from multi- and bilateral development partners into the SSU		TA/SSU	X	X				
3.2.3 Prioritise inter-sectoral role to improve health status, especially vulnerable groups	1. Mainstream the intersectoral function of the Minister and Vice Minister into the organic law of government and MOH	# of ministries in an action plan/agenda for intersectoral activities was adopted. (OP)	M/VM		X	X			
	2. Promote the importance of acknowledging the intersectoral nature of Health to all government staff and relevant ministries		VM		X	X	X	X	X
	3. Translate the intersectoral approach to all programme policy/guidelines	% of annual intersectoral action plans that was carried out in a given year. (OP)	VM+PS		X	X	X	X	X
	4. Set up an intersectoral coordination mechanism		VM+PS		X	X			
	5. Expand joint action with other ministries		VM+PS			X	X		

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
3.2.4 Strengthen the role of professional bodies in the improvement of quality of services	1. Review the role of and partnership with professional bodies – medical, nursing and midwifery and (over time) other groups, including their role in the Professional Health Council	# of partnership agreements and action plans with professional bodies (OP) % of collaboration action plans realised (OP)	PS		X	X			
	2. Establish partnership agreements and action plans with professional bodies to deal with technical and ethical norms, accreditation of private sector services, etc		PS			X	X		
	3. Ensure the availability of financial resources for the implementation of these action plans		PS+A/F/L			X	X		
	4. Socialise, implement and monitor action plans		PS			X	X		
3.2.5 Improve collaboration with the traditional medicine sector	1. Assess the role and efficacy of the traditional medicine sub sector	Role of traditional medicine sub sector reviewed and framework for collaboration adopted (OP)	HRD/PP		X	X			
	2. Determine appropriate opportunities for collaboration with the sub sector		HRD		X	X			
	3. Implement and monitor collaboration as appropriate		HRD		X	X			
3.2.6 Initiate the environmental health component of the public health system	1. Appoint a qualified, experienced Environmental Health Advisor	DEH strengthened according to plan (I) annual action plans adopted and implemented (OP)	TA/Environ Health		X	X			
	2. Elaborate on the core "umbrella" strategic plan by developing specific implementation and institutionalisation guidelines and protocols		TA/Environ Health			X			
	3. Prioritise sector initiatives		TA/Environ Health		X	X			
	4. Proactively lead inter-sectoral engagement and to coordinate a Public Health approach to environmental challenges		TA/Environ Health		X	X	X	X	X
	5. Agree on an intersectoral agenda for environmental action		TA/Environ Health		X	X			
	6. Undertake a training needs assessment within the Department of Environmental Health		TA/Environ Health		X	X			
	7. Develop the capacity of staff and implement the intersectoral agenda		TA/Environ Health		X	X			

Objective 3.3 To strengthen planning and budgeting

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
3.3.1 Adopt and establish a bottom-up procedure for HSSP annual planning and/ budgeting	1. Recruit TA for assistance in the revision of planning	Comprehensive planning and budgeting system adopted (all levels) (OP) % of departments and district teams trained in new planning and budgeting (OP) % of departments and district teams implementing new planning and budgeting system (OP)	TA/PP/SPWG		X				
	2. Review and revise, as necessary, planning and budgeting for departments, districts, HCs, HPs in line with the HSSP, BSP, HSP, MDG priorities and MTEF		TA/PP/SPWG		X	X			
	3. Establish planning and budgeting guidelines, consolidating all actors, interventions, stages in planning, norms /unit costs, etc		TA/PP/SPWG		X	X			
	4. Plan capacity development of departmental and district and facility staff in planning/budgeting		TA/PP/SPWG		X	X			
	5. Adopt procedures for analysing plan/budget proposals for comprehensiveness, coherence and feasibility		TA/PP/SPWG		X	X			
	6. Adopt procedures for approving and aggregating plans/budgets		TA/PP/SPWG		X	X			
	7. Start planning and budget reform in 4 pilot districts through training and elaboration of plans/budgets		TA/PP/SPWG+District Mgrs		X	X			
	8. Evaluate and revise, as necessary, methods, procedures and formats for BSP-based decentralised planning and budgeting at district level		TA/PP/SPWG+District Mgrs		X	X			
	9. Implement training in planning and budget reform in remaining districts for comprehensive needs based planning and budgeting		TA/PP/SPWG+District Mgrs			X	X		
	10. Support all 13 districts with preparation of annual plan/budget		TA/PP/SPWG+District Mgrs		X	X	X	X	X
3.3.2 Start strategic and annual planning for each MOH directorate, department and other ministerial units	1. Define medium term goals for each unit, based on the unit's TORs or mission statement	% of departments for which a strategic medium term plan has been adopted (OP) % of departments for which a strategic medium term plan has been adopted (OP)	TA/PP/SPWG		X	X			
	2. Maintain focus on MDGs, decentralisation, integration, strengthening devolved levels, and improvement of efficiency and effectiveness in service deliver		TA/PP/SPWG		X	X			
	3. Define annual objectives, expected results and indicators for each unit		TA/PP/SPWG		X	X	X	X	X
	4. Verify compliance with policies and national priorities and determine budgetary requirements		TA/PP/SPWG		X	X	X	X	X
	5. Ensure strategic plans, annual plans and budgets are approved at the Joint Annual Planning Summit.		TA/PP/SPWG		X	X	X	X	X

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
		% of departments for which a strategic medium term plan has been adopted (OP)							
3.3.3 Introduce the concept of strategic medium term planning at district level	1. Ensure all DHMTs develop, jointly with their local stakeholders and with assistance from the Planning Department, a mid term plan on how and in which areas their district is to develop, in terms of health facility coverage, provision of service packages, community participation, etc	% of districts for which a strategic medium term plan has been adopted (OP)	TA/PP/SPWG+Districts		X	X			

Objective 3.4 To establish and implement a sector monitoring and evaluation system

STRATEGIES	MAIN ACTIVITIES	INDICATORS	PRIMARY RESPONSIBILITY	Yr0 '07	Yr1 '08	Yr2 '09	Yr3 '10	Yr4 '11	Yr5 '12
3.4.1 Improve the performance of the Health Management Information System	1. Develop an information management master plan	HMIS revised and implemented accordingly (OP) *% of HMIS reports (revised) compliance in a given year. (OC)*	TA/HMIS		X				
	2. Adopt an action plan for improvement of the existing HMIS (ongoing, with WHO TA) in terms of simplification, relevance, indicator definition, inclusion of basic management indicators, accuracy of denominators, software, accuracy (cleaning of data), compliance in data submission, transfer of data, systematic analysis of data, report editing with feed back mechanisms to the service delivery level		TA/HMIS		X	X			
	3. Establish functional links and harmonisation with other information systems and especially disease surveillance		TA/HMIS		X	X	X		
	4. Induct HMIS and Disease Surveillance staff in dual systems of data collection and management and recruit additional staff	# of district teams trained in new HMIS (OP)	TA/HMIS		X	X	X	X	X
	5. Ensure service and administrative staff use data in decision making and priority setting		TA/HMIS		X	X	X	X	X
	6. Ensure adequate utilisation of data at all levels for analysis and follow-up, supervision, planning, priority setting and performance evaluation	ICT link between HMIS and other information systems established (OP)	TA/HMIS		X	X			
3.4.2 Adopt and establish an HSSP Monitoring and Evaluation System	1. Establish an M&E group	M&E system adopted and being implemented (OP) *% of JASR recommendations followed up with decisions and actions (OP)*	TA/PP		X	X			
	2. Adopt an HSSP Monitoring and Evaluation System, specifying responsibilities, instruments, procedures and timing		TA/PP		X				
	3. Adopt a set of core indicators with targets for annual HSSP monitoring (joint annual sector review)		TA/PP		X				
	4. Ensure preparation and dissemination of 6-monthly and annual reports on performance of health service delivery and support services		TA/PP			X	X	X	X
	5. Recruit TA for preparation of Joint Annual Sector Review (JASR)		TA/PP			X			
	6. Agree with main stakeholders on specific objectives for the JASR		TA/PP+PS			X			
	7. Ensure data collection and organisation of studies on specific issues for analysis by JASR		TA/PP+PS			X	X		
	8. Ensure follow-up of JASR recommendations		TA/PP+PS			X	X		

ANNEX B: FUNCTIONAL ANALYSIS EXECUTIVE SUMMARY

The report presents the findings of the two month SIHSIP functional analysis technical assistance consultancy undertaken in September-October 2006. The consultancy was designed to support Timor-Leste's Ministry of Health in identifying appropriate management and organisational structures and related processes and systems to help promote its capacity to meet mandated obligations. Findings are to be incorporated in the planning process leading to the development of the Health Sector Strategic Plan (HSSP) 2007-12 and (with wisdom) beyond.

In accomplishing these tasks the consultant worked closely with Ministry staff and project colleagues. Various methods were used in obtaining information and opinion – observation, formal and less formal interviews, small group focus sessions, larger (at times, unwieldy) meetings, questionnaire and other survey tool responses, and a (not so technical) meta-analysis of many relevant documents. The culmination of the information gathering phase of the consultancy was a national consultative workshop involving government health workers from across the country and from all sectors and tiers of the organisation – truly a democratic occasion. The majority of the interactive initiatives were conducted in one of the national languages of Timor-Leste with minimal real time translation to English.

Recommendations stemming from the enquiry are numerous and wide-ranging in keeping with the broad-based terms of reference. This circumstance also reflects the state of development that the MOH has reached in its brief four year history. Born out of a thrown-together coalition of national clinicians inexperienced in the ways of management and administration (but anxious to learn) and a small group of willing international advisors, the Ministry has progressed far in its efforts to establish functioning facilities and services to improve the health of the people. Unfortunately, some of the very tangible energy and commitment characteristic of this process has had less impact than desired. Key national health status indices persist in remaining worryingly poor.

All of the 130+ recommendations contained in the report are designed ultimately to strengthen and empower the real "engine room" of the Ministry – the district and community teams and the primary and secondary health care services and programmes which they provide for their service communities. For it is here, in the districts and sub-districts, where the real health status gains for Timor-Leste are to be had.

Readers might question this assertion as they trace through the long list of recommended actions, many of which appear on the surface to favour enhancements or modifications at central office level. Reflection will show, however, that the district is more often than not the major beneficiary of recommended changes. So, for example, proposals about clarifying principles of governance, delineating strategic from operational problem solving, demanding prioritisation in decision making, tagging planning to the budget process, delegating authority for implementing strategies, promoting more perceptive and sustained methods of management and supervision, introducing an incentives-based and evidence-based performance management system, reconfiguring divisions and departments to more closely align corporate structures with grass-roots delivery processes, and institutionalising more effective means of collaboration and communication, etc. - all promise to improve systems within the Ministry as a whole to the benefit of local practitioners and their service communities.

Recommendations have been made to increase the staffing establishments of a number of centrally-based units. The persuasive argument in all such cases relates to the advantages to accrue at the local health care delivery site. Improved coordination, communication and liaison between the different tiers of the organisation is essential for the Ministry to measure up to (and surpass) community expectations. Inability to provide a well coordinated and articulated programme or service at district level is a consequence frequently of inadequate or inappropriate staffing centrally.

The pivotal recommendation in the report is for the appointment of a district "champion" – the Director of Health - to work in the Caicoli offices of the Ministry with a brief to maintain unswerving attention to the wellbeing of the local health care delivery system. The Director of Health – with the support of new organisational structures built around this senior executive position – will be responsible for driving the Ministry towards a more target-driven, needs-based and locally managed service configuration.

One section of the report provides readers with a summarised overview of the recommendations. This summary could be thought of as a mini action plan for each recommendation with aligned indicators, verifications, assumptions and responsibilities attached. What the summary does not flag is the relative priority of any of the recommendations. This task belongs most properly to the Strategic Planning Working Group (SPWG) as they formulate the Ministry's HSSP for the next five years.

All analyses of the type reported on here are constrained by features of the enquiry itself and by the changing contextual circumstances of the host organisation. Limited time and logistical difficulties interact with poor corporate memory, strong organisational distracters ("I can't answer your enquiries right now - I'm busy responding to the Minister!"), embedded rules with difficult-to-define origins, untested but vigorously defended assumptions about core values, etc., etc. There is nothing new in this list. However, what is atypical and what has added to the complexity of the enquiry has been the state of social unrest and civil disturbance bedevilling Timor-Leste and limiting opportunities for sustained debate with the Ministry's governing and executive staff. Reviewers need to bear these circumstances in mind when assessing the output of the enquiry.

Finally, it must be stressed that undertaking an organisational review (perhaps a more accurate description than a functional analysis) such as reported on here is as much to do with process as it is with outcome. The MOH entered into the spirit of the enquiry with unanimous gusto. It demonstrated to many observers that, as an organisation, it is genuinely keen to commence the next phase in its development. The lessons learned during the 2006 functional analysis should reinforce useful techniques that the organisation will need to apply again in the future as it consolidates its capacity development programme. Accordingly, the (English language versions of) the tools of enquiry are reproduced in the attachments to the report for information and later reference. The SIHSIP office retains all original documents cited and forms completed.

ANNEX C: HSSP MONITORING AND EVALUATION FRAME

HSSP MONITORING AND EVALUATION DRAFT INDICATORS

The BSP provides **key** performance indicators by **programme** (Annex 3) and **MDG** interventions and key performance indicators by **goal** (Annex 4). These sets of indicators will form the core monitoring and evaluating tools for the HSSP. In addition the following draft sets of indicators will need to be developed and extended over time as capacity improves and HMIS strengthens to augment the key sets in priority work areas.

REDUCE INFANT MORTALITY RATE

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Perinatal mortality rate per thousand live births					
2	Percentage of vaccination coverage					
3	Diarrhoea case fatality rate per thousand					
4	Crude death rate per thousand population					
5	Percentage of deaths from ARI					
6	Percentage of children whose weight for age & height are below acceptable level					
7	Percentage of children born with low birth rate					

REDUCE MATERNAL MORTALITY RATIO

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Contraceptive user rate					
2	Percentage of pregnant women receiving four ANC check-ups					
3	Percentage of pregnant women receiving two doses of TT					
4	Still birth rate					
5	Percentage of deliveries attended by skilled personnel					
6	Percentage of children born with low birth weight					
7	Percentage of pregnant women with anaemia					

ACHIEVE ZERO MORBIDITY STATUS FOR ALL IMMUNISABLE DISEASES EXCEPT TB

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage infants fully immunised before first birthday (TT)					
2	Percentage infants fully immunised before first birthday (DPT)					
3	Number of cases acute flaccid paralysis					
4	Number of cases of measles					
5	Number of cases of neonatal tetanus					

REDUCE MALARIA STATUS

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Density of anopheles mosquito					
2	Percentage of high risk sub-districts for anopheles mosquito					
3	Number of positive slides					
4	Percentage of malaria cases confirmed					
5	Malaria case fatality rate ≤ 5 years					
6	Early warning and prompt response system in place					

REDUCE POPULATION GROWTH RATE BY PROMOTING REPRODUCTIVE HEALTH AND FAMILY PLANNING

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Contraceptive user rate					
2	Percentage of sub-districts where contraceptive items area are freely and readily available					
3	Percentage of pregnant women with access to prenatal care, and skilled attendance at delivery					
4	Percentage of pregnant women with access to referral facilities for high risk pregnancy and obstetrical emergencies					
5	Percentage of women with last open birth interval of ≥ 3 years					

REDUCE HIV/AIDS PREVALENCE

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Number of cases of HIV positive					
2	Condom usage rate especially by youths					
3	Percentage of health care facilities with capacity to provide universal precautions					
4	Number of sentinel surveillance facilities sites					
5	Percentage of population ≥ 15 years with knowledge of HIV/AIDS					
6	Percentage of sub-districts with skilled counsellors					
7	Proportion of those seeking care in health facilities for STIs who are appropriately managed					

REDUCE TB PREVALENCE

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of health care facilities with appropriate diagnostic capacity					
2	Percentage of true positive slides					
3	Drop-out rate					
4	Relapse rate					
5	Primary drug resistance rate					
6	Cure rate					

REDUCE LEPROSY AND FILARIA RATES

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Number of leprosy new cases detected					
2	Number of filaria new cases detected					
3	Percentage of identified hyper-endemic sub-districts covered					

PREVENTION OF EPIDEMICS

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Early warning systems in place					
2	Time of incidence, reporting and response					
3	Duration of epidemic					
4	Containment period					
5	Percentage of sub-districts where essential supplies and facilities for control of epidemic are available					

100% ACCESS TO SAFE WATER

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of villages with assured safe water access					
2	Percentage of villages with functioning working water systems					

ELIMINATE PREVENTABLE BLINDNESS

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of children with vitamin A deficiency					
2	Percentage of unattended cataract cases					

REDUCE INCIDENCE OF ORAL DISEASE

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of health care facilities with capacity for dental check-ups and management					
2	Percentage of school children with dental caries and/or gum diseases					
3	Percentage of people ≥ 40 who are edentulous					

ENSURE AVAILABILITY OF ESSENTIAL DRUGS AND PROMOTE RATIONAL USE

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of sub-district facilities with adequate supplies of essential drug stock					
2	Percentage of health care staff appropriately skilled in rational use of drugs					
3	Percentage of ARI cases prescribed with antibiotics					

STRENGTHEN AND EXPAND HMIS AT ALL LEVELS TO FACILITATE PLANNING AND MONITORING AND EVALUATION

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of reports dispatched, received and responded to regularly and on time					
2	Percentage of health districts producing a health status report based on data collected					
3	Percentage of health care facilities using health data in assessing their activities					
4	Accuracy of data					

ELIMINATE SEVERE AND MODERATE MALNUTRITION

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of low birth rate children					
2	Percentage of pregnant mothers with severe/moderate anaemia					
3	Total goitre rate among children 6-11 years					
4	Percentage of sub-districts with guaranteed access to iodised salt					
5	Percentage of children ≤ 5 years with stunting					
6	Percentage of children ≤ 5 years with severe wastage					

REDUCE MORTALITY FROM PREVENTABLE AND TREATABLE NON-COMMUNICABLE DISEASES

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Number of cases registered by disease domain					
2	Mortality by disease domain					
3	Number of BCC activities conducted by disease domains					
4	Percentage of health care facilities with personnel skilled in BCC by disease domains					

REDUCE MORBIDITY AND MORTALITY THAT STEM FROM UNSAFE ENVIRONMENTS

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Occupational health regulations in place					
2	Environmental safety standards in place					
3	Water and sanitation regulations in place					
4	Proportion of work places meeting environmental health safety standards					
5	National environmental disaster management plan in place					

QUALITY ASSURANCE

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Standard guidelines in place for al common diseases and procedures					
2	Percentage of staff engaged in in-service education in priority work areas					
3	Percentage of health care facilities with capacity to provide BSP services in line with guidelines					
4	Quality assurance mechanisms in place					

HUMAN RESOURCE DEVELOPMENT

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Approved HRD policy developed and socialised					
2	Percentage of health care posts meeting BSP minimum staffing norms					
3	Percentage of health care centres meeting BSP minimum staffing norms					
4	Percentage of clinicians formally skilled in their area of clinical practice					
5	Percentage of managers with management qualifications					
6	Percentage of qualified workforce versus requirements					
7	Percentage of qualified educators versus requirements					

PHYSICAL INFRASTRUCTURE DEVELOPMENT

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of sub-districts with appropriate health care facilities					
2	Percentage of district and sub-district health facilities meeting BSP norms					
3	Percentage of health care facilities requiring physical upgrade					
4	Percentage of hospitals meeting BSP norms					

ACCESS TO HEALTH CARE FACILITIES

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of sub-districts served by a health post within 2 hours travel by foot					
2	Percentage of sub-districts served by health centre within 2 hours travel by foot					
3	Percentage of sub-districts served by medical retrieval system to referral centre					

MANAGEMENT AND COMMUNITY ENGAGEMENT

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of district health teams with qualified manager					
2	Percentage of sub-district health facilities with staff skilled in management					
3	Percentage of health care facilities that engage in inter-sectoral collaboration					
4	Percentage of health care facilities that engage in community empowerment					
5	Percentage of health care facilities that use HMIS data in management decision-making					

FINANCIAL MANAGEMENT

NR	INDICATOR	DENOMINATOR	NUMERATOR	FREQUENCY	BASELINE VALUE, SOURCE, DATE 2007	TARGET VALUE YEAR 1, 2, 3, 4, 5
1	Percentage of district health teams with qualified finance officer					
2	Percentage of sub-district health facilities with staff skilled in budget management					

ANNEX D: TECHNICAL ASSISTANCE NEEDS

LT = Long term ≥ 12 months
ST = Short term < 12 months
TBD = To Be Determined
C = Central Services
C&D = Central and District Services
D = District Services

Main Focus	AREA	OBJECTIVE	MOH UNIT	#	CURRENT TA			FUTURE TA NEEDS		
					Period (until)	LT / ST	Funding	Period	LT / ST	Funding
EXECUTIVE, POLICY, PLANNING, HRD, IHS, HMIS, DISEASE SURVEILLANCE and M&E										
C	Stewardship	Advisor to the Executive	Minister, V-M, PS	1	4/08	LT	WHO	08-12	LT	WHO
C	Policy	Currently areas covered by the SIHSIP TL: donor coordination, SWAp, remote area strategies, referral services, quality assurance	Policy	1	10/09	LT	EU/SIHSIP	09-12	LT	EU
C&D	Planning	Capacity building in planning, support HSSP implementation	Planning	1				08-12	LT	TBD
C&D	HMIS, Disease surveillance M&E	Develop, extend and support various information systems: HMIS, surveillance, M&E, HRD, hospitals	HRD	1	6/07	LT	WHO	07-09	LT	TBD
C	HRD	Overall HR development	HRD	0.5	10/09	LT	EU/ SIHSIP	09-12	LT	EU
C	Education & training	IHS system & capacity building	HIS	0.5	10/09	LT	EU/SIHSIP	09-12	LT+ST	AusAID/Twinning partner

Main Focus	AREA	OBJECTIVE	MOH UNIT	#	CURRENT TA			FUTURE TA NEEDS		
					Period (until)	LT / ST	Funding	Period	LT / ST	Funding
SERVICE AND PROGRAMME DELIVERY										
C&D	Service Delivery	Support integrated services & programme delivery; priority programmes; implementation of BSP; coordination TA for health district development (incl decentralisation)	HSD	1	3/07	LT	AusAID	08-12	LT	AusAID
C	Service Delivery	Support service &programme administration (SSU)	HSD	1	11/07	LT	AusAID	07-12	LT	AusAID
C	Pharmacy	System and capacity building; strengthen links with SAMES	Pharmacy	1	06/06	LT	Cuba substitution	07-09	LT	Cuba substitution
C&D	HIV/AIDS	Technical support to extend beyond current GFATM-funded activities	HSD/HIV/ AIDS Unit	1	06/08	LT	GFATM	08-12	LT	GFATM or WHO (current 2 positions to be combined into 1 new position)
C&D	HIV/AIDS	BCC - link with Health Promotion	HSD/HIV AIDS unit	1	06/09	LT	GFATM			
C&D	BCC	Partly linked to GFATM HIV/AIDS component. In future system and capacity building support BCC in general	Health Promotion	1	6/08	LT	AusAID/ GFATM UNFPA	08-10	LT	UNFPA: school & adolescent health
D	Community participation	Roll out and assess FHPP, incl training. Future: general community participation	Health Promotion	1	12/07	LT	EU	07-10	LT	TBD

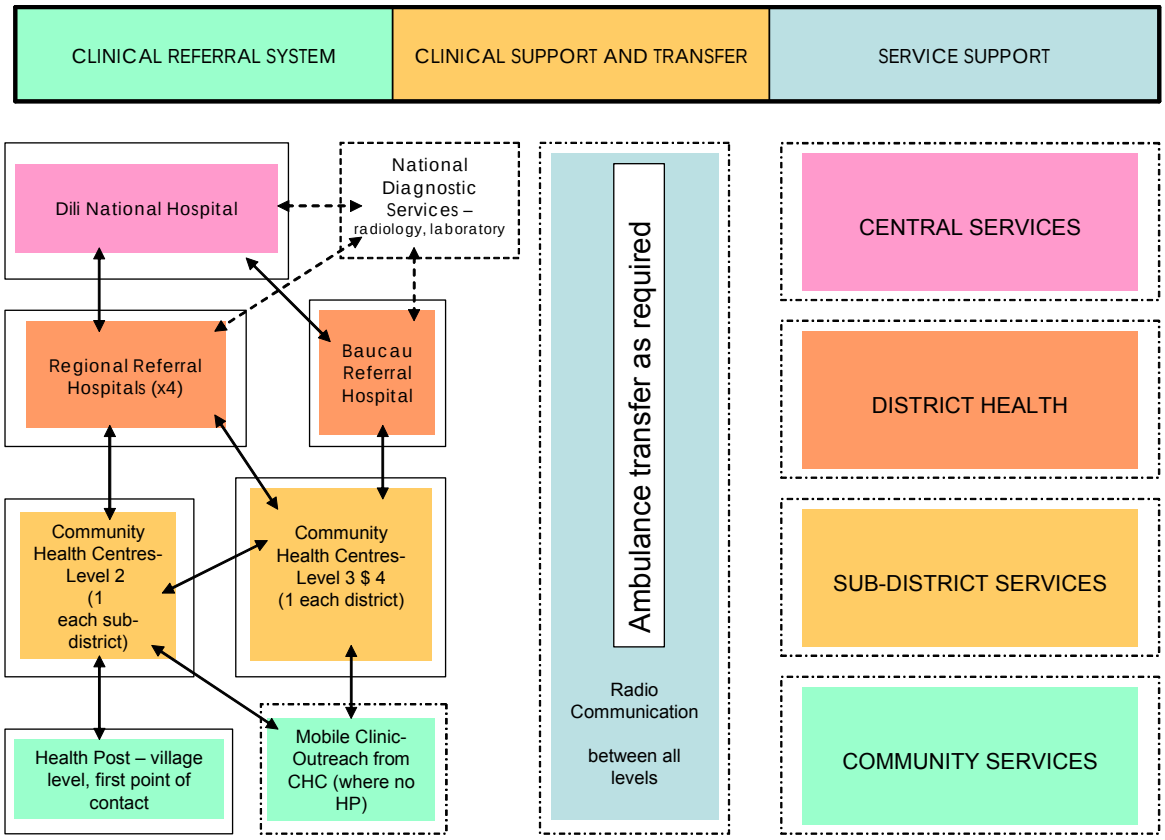
Main Focus	AREA	OBJECTIVE	MOH UNIT	#	CURRENT TA			FUTURE TA NEEDS		
					Period (until)	LT / ST	Funding	Period	LT / ST	Funding
C&D	MCH	Maternal and Child Health including child survival, EPI, breast feeding, nutrition, community mobilisation environmental health, health promotion,	MCH	10	08	LT	UNICEF/UNFPA/USAID/HAI	08-12	LT	UNICEF/UNFPA/ USAID/HAI
C&D	MCH	MCH Reproductive Health specific	MCH	5	06/08	LT	UNICEF/UNFPA/USAID/HAI	08-12	LT	UNICEF/UNFPA/ USAID/HAI
C&D	Disease Surveillance	Disease surveillance, epidemiology	HMIS		06/10	LT	WHO	010-12	LT	WHO
C&D	Disaster mgt	Risk management	Environ Health	1	06/08	LT	WHO	08-10	LT	TBD
D	Referral services; Hospitals	Situation analysis, development business plans, improve mgt/M&E, referral systems at all hospitals	Permanent Secretary	2				08-12	LT	TBD
D	Health districts	District Management Capacity: district teams: mapping, medium term planning, implementation BSP, integration programmes, coordination private sector, admin and decentralisation	HSD; District managers	3			USAID/TAIS	08-12	LT	TBD

Main Focus	AREA	OBJECTIVE	MOH UNIT	#	CURRENT TA			FUTURE TA NEEDS		
					Period (until)	LT / ST	Funding	Period	LT / ST	Funding
ADMINISTRATION, FINANCE AND LOGISTICS										
C&D	Financial Mgt & budget	Financial & strategic management; budget devolution	Finance	1	8/08	LT	WB	08-12	LT	WB
D	Financial systems & training	Accounting system, capacity building in districts	Finance; District Managers	1	10/08	LT	EU	07-09	LT	EU
C&D	Procurement	Procurement	Procurement	1	8/08	LT	WB	08-12	LT	TBD
C	Capital works	Construction design. National & referral hospitals, IHS, expansion MOH central offices	M/V-M/PS	1	8/08	LT	WB	08-10	LT	EC/WB
D	Capital works	Construction supervision; incl delivery rooms in HCs and HPs, staff accommodation	M/V-M/PS	2	8/08	LT	WB	08-10	LT	EC/WB TAs possibly also integrated into maintenance TA
C&D	Maintenance	Maintenance (infrastructure, bio-medical, office equipment, vehicles): system development and operationalisation	Logistics	1				08-10	LT	TBD
C&D	ICT	System development and maintenance	Logistics	1				08-10	LT	VSA
C&D	Asset mgt	Asset Management system development	Logistics	1				08-09	LT	TBD
C	Expenditure analysis	National Health Accounts	Admin, Finance & Logistics	1				08-09	ST	TBD

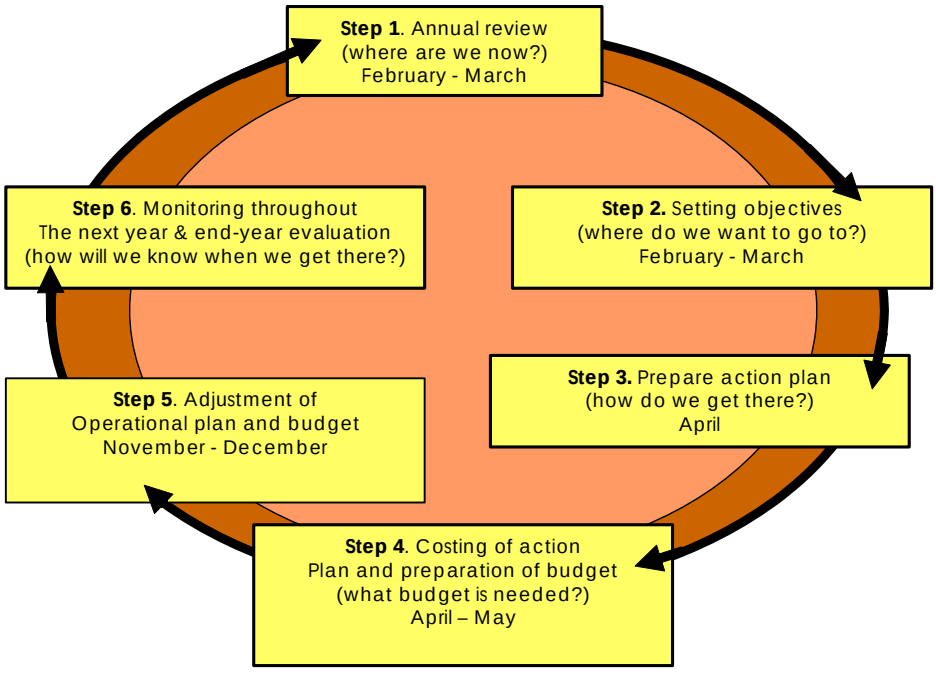
Main Focus	AREA	OBJECTIVE	MOH UNIT	#	CURRENT TA			FUTURE TA NEEDS		
					Period (until)	LT / ST	Funding	Period	LT / ST	Funding
C&D	Admin	Several administrative functions, incl admin & decentralisation. For future more precise TORs, inc communication by MOH (socialising HSSP, policies, etc)	Admin Finance & Logistics	4				08-12	LT	GSB
SUPPORT SERVICES										
C	Drug purchase, mgt & distribution	Pharmacy	SAMES	1	8/08	LT	WB	08-09	LT	WB/EU
C		Management (storage, ICT,)		1	8/08	LT	WB	08-12	LT	TBD
C		Finance management		1	8/08	LT	WB			3 previous positions combined into 1
C		Procurement		1	to start	LT	WB			
C&D	Laboratory	Laboratory system development, network and capacity building	Laboratory Network	1	01/06	LT	NGO St John of God	009-12	LT	NGO: St John of God

ANNEX E: FIGURES

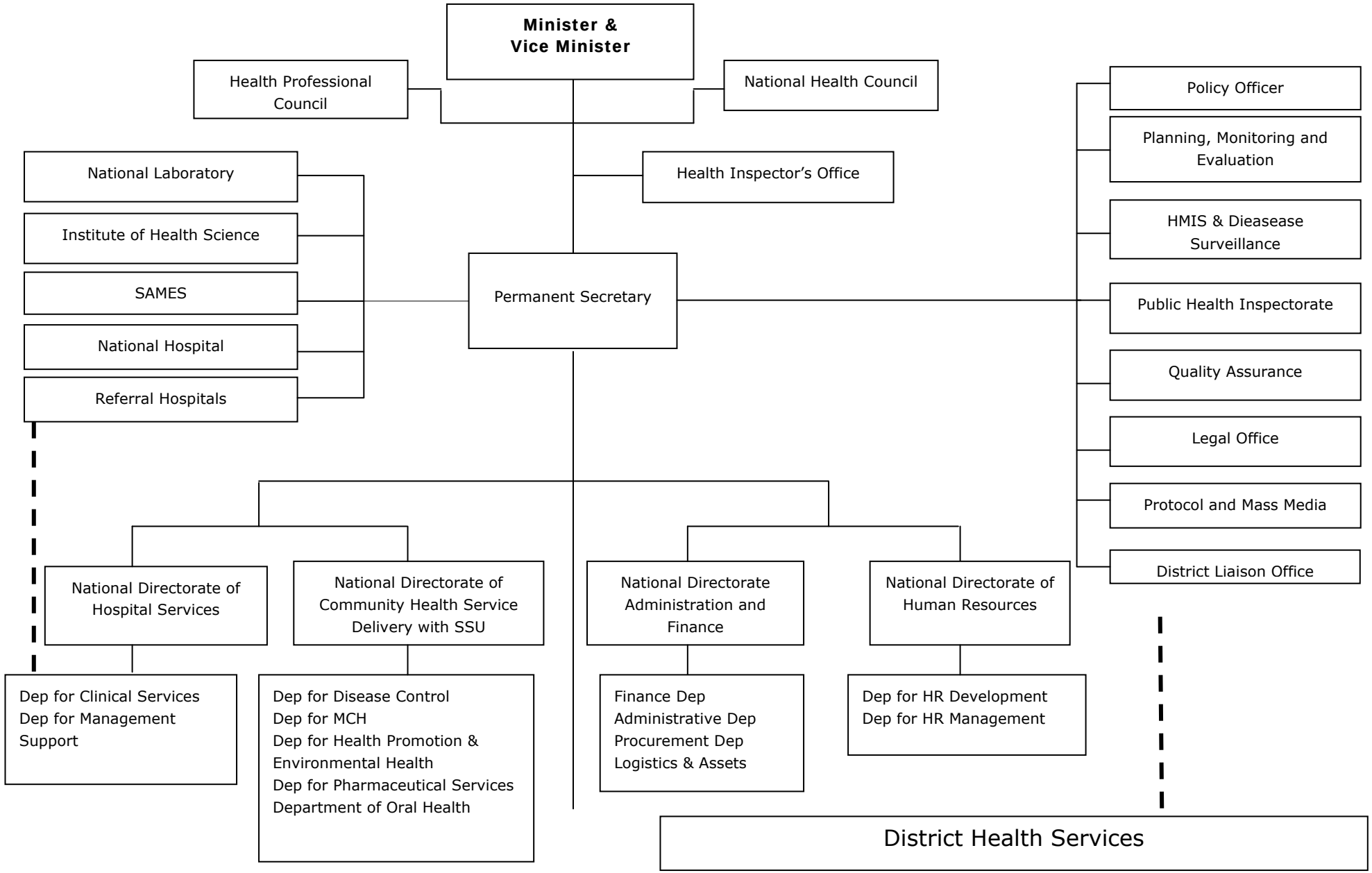
DIAGRAMATIC FUNCTIONING OF NATIONAL HEALTH SYSTEM – TIMOR LESTE



REVISED MINISTRY OF HEALTH PLANNING CYCLE



PROPOSED MOH ORGANOGRAM



PROPOSED STRUCTURE OF DISTRICT HEALTH SERVICES