MINISTRY OF HEALTH
Dili, Timor-Leste

NATIONAL HEALTH SECTOR STRATEGIC PLAN II
2020-2030

**Towards a
"Healthy East Timorese People In
a Healthy Timor-Leste"**

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Ministry of Health

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FORWARD

The National Health Sector Strategic Plan 2011-2030 (NHSSP 2011-2030) supports the Strategic Development Plan (SDP 2030) which expresses Timor-Leste people's aspiration for "Timor-Leste to be an Upper-middle Income Country with Educated and Healthy Population in 2030". A part of the NHSSP 2011-2030, the Second National Health Sector Strategic Plan (NHSSP II) builds on the significant expansion of the country's health services over the past decade alongside the overall improvements we have made in the social and economic status of the Timorese people.

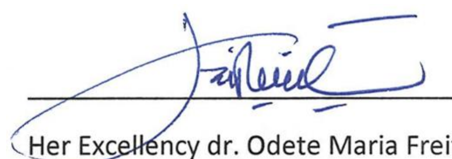
The NHSSP II has a transformative agenda which focuses on building robust and resilient health systems, following the assessment made in 2017 on the first phase of the implementation of the NHSSP 2011-2030 as well as the Government commitment to sustaining the progress and achievements made so far. It identifies strategies and programs which will ensure that people of Timor-Leste are healthy and able to contribute to economic development as articulated in the Vision 2030 which prioritize health as a key economic investment that will drive the socio-economic development agenda. Thus, this Plan focuses on delivering quality health services across the continuum of care which includes promotive, preventive, curative, rehabilitative and palliative care provided as close to the family settings as possible. The attainment of the universal health coverage will be made possible through primary health care with a focus on community health.

The system-wide strategic approach of NHSSP II will enable the Ministry of Health to deliver a genuinely integrated model of care that strives to achieve 'better health, better care and better value', helping to reduce the disease burden and accelerate the attainment of Sustainable Development Goals. Our new Strategy reflects a global shift in thinking by focusing on current and future generations and in particular, our most vulnerable individuals, including children, mothers, older people and those with special needs, as to ensure that "no one is left behind".

The Ministry of Health acknowledges that good health is a function of not only health care services, but also other socioeconomic factors which include education, agriculture, housing, water and sanitation. Therefore, NHSSP II emphasizes strong multisector collaboration to address all the social determinants of health.

It is my considered view that – with appropriate levels of commitment and support from the Government, Development Partners, health workers and other key stakeholders – this plan will significantly improve the health status of the Timorese people and significantly contribute to national development.

This Ministry is committed to ensuring the successful implementation of this plan and, thus, I urge all the people involved in the implementation of NHSSP II to fully dedicate themselves to this important national assignment.



Her Excellency dr. Odete Maria Freitas Belo, MPH
Minister of Health

ACKNOWLEDGEMENTS

I would like to acknowledge the all-inclusive and widespread consultative process that have facilitated the development of this 2nd Edition of National Health Sector Strategic Plan 2020-2030. The consultative process entailed engaging with varied stakeholders at the various levels of the health and support system in order to ensure that the outcome reflected the wishes and aspirations of all.

The Ministry of Health wishes to express special thanks to Dr. Rajesh Pandav, Mrs. Valérie Taton and Mr. Dageng Liu, Country Representatives for the World Health Organization, UNICEF and WFP, respectively, for enabling the consultative process to take place, alongside the technical expertise to the process.

Our gratitude also goes to the Australia's Department of Foreign Affairs and Trade (DFAT), for contributing to the development of this Strategic Plan through the experience from programs and projects implemented in partnership for health development.

Finally, but not least, I wish to pay special tribute to the core planning team under the MOH Commission for the Evaluation and Revision of NHSSP 2011-2030, for their leadership and steady commitment in the process of formulating the NHSSP II. Each and every one of the following contributors, mooted the process for the development of this Plan, in particular, Ms. Iris Hamelberg, Health Policy and Management Advisor and Mr. Narciso Fernandes, Director of Health Policy, Planning and Cooperation, who work tirelessly alongside the staff from Health Policy Department, namely Ms. Maria Natália, Ms. Francisca Castro Belo, Mr. Aleixo dos Reis and Mr. Filomeno Martins dos Santos, to put the document together.

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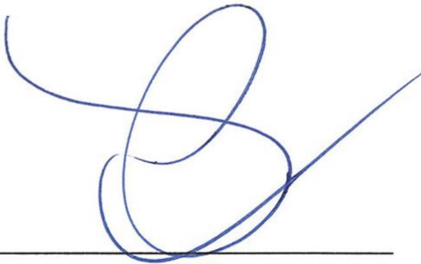
It is anticipated that other stakeholders will buy into the NHSSP II and support the Ministry of Health in order to achieve its overarching goals, in line with our agreed upon principle of one plan, one budget, and one monitoring framework.

I look forward to seeing this collective and coordinated work implemented in the coming years, and I am confident that the successful implementation of this strategy will enable Timor-Leste's population to benefit from better health and a more efficient and effective health system.



His Excellency Bonifácio Mau Coli dos Reis, Lic. SP
Vice-Minister of Health

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
BEOC	Basic Emergency Obstetric Care
BSP	Basic Services Package
CD	Communicable Diseases
CDP&C	Communicable Diseases Prevention and Control
CEOC	Comprehensive Emergency Obstetric Care
CHC	Community Health Centre
CIMCI	Community Based Integrated Management of Childhood Illnesses
CVD	Cardio-vascular Disease
DHS	Demographic and Health Survey
DOTS	Directly Observable Treatment Short Course
DP	Development Partners
EC	European Commission
ESnF	Saúde na Família Team
FHPP	Family Health Promoter Program
FP	Family Planning
FY	Fiscal Year (Jan-Dec)
GFATM	Global Fund for Aids, Tuberculosis and Malaria
GDP	Gross Domestic Product
GSB	General State Budget (OGE)
HAST	HIV/AIDS/Tuberculosis
HDI	Human Development Index
HRH	Human Resource for Health
HDR	Human Development Report
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HNGV	Guido Valadares National Hospital

HP	Health Post
HRD	Human Resource Development
HSP	Hospital Services Package
HSSP	Health Sector Strategic Plan (2008-2012)
ICS	Institute of Health Sciences (Instituto de Ciências de Saúde)
ICT	Information and Communication Technology
IDS	Integrated Disease Surveillance
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IYCF	Infant and Young Child Feeding
JAPS	Joint Annual Planning Summit
LLITN	Long Lasting Insecticide Treated Net
LSMS	Living Standard Measurement Survey
MC	Mobile Clinics
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoE	Ministry of Education
MOH	Ministry of Health
MoF	Ministry of Finance
MAEOT	Ministry of State Administration
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
MHC	Municipal Health Council
MHMT	Municipal Health Management Teams
NCD	Non Communicable Disease
NDP	National Development Plan
NGO	Non-Government Organization
NHA	National Health Accounts

NHSSP	National Health Sector Strategic Plan
O&G	Obstetrics and Gynecology
OH&S	Occupational Health and Safety
PER	Public Expenditure Review
PHC	Primary Health Care
QA	Quality Assurance
RH	Reproductive Health
SAMES	Autonomous Medical Supply System (Serviço Autónomo de Medicamentos e Equipamentos de Saude)
SBA	Skilled Birth Attendant
SIP	Sector Investment Program
SnF	Saúde na Família
SPWG	Strategic Planning Working Group
SWOT	Strengths, Weaknesses, Opportunities and Threats
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)
WFP	World Food Program
WHO	World Health Organization

1. Introduction

1.1 PURPOSE OF NHSSP II

The Ministry of Health is committed to providing and regulating quality health services for all while promoting community and stakeholder participation, as mandated by the Constitution of the Democratic Republic of Timor-Leste. To achieve this mission, Timor-Leste National Health Sector Strategic Plan 2011-2030 (NHSSP) was developed alongside the nation's Strategic Development Plan 2011-2030 (SDG) to guide a long-term vision for the development of the health sector.

In essence, the NHSSP 2011-2030 was 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

Since its approval the country has experienced undeniable significant progress to which the health sector is not an exception - many achievements can be reported, like the remarkable improvement in MDGs, with interventions that have been delivered under the guidance of the NHSSP. Nevertheless, this progress, like with any plan, needs to be properly monitored and, as directed in the same strategic plan document, it has to be revised as needed.

The NHSSP 2011-2030 also indicates that the first period, 2011 to 2015, will be the one for 'setting conditions' focusing at: a) Human Resources development and deployment, b) district health infrastructure development and logistic support; and c) institutional capacity building at central, district and personalized health services; followed by a consolidation phase.

Added to this, major changes have affected the global development agenda. The year 2016 has marked the beginning of the Sustainable Development Goals (SDG) era, to which countries committed by end September 2015 in the United Nations (UN) General Assembly. This new Agenda 2030 defines one health goal (SDG 3) among 17 development global objectives, but the SDGs stress the connections between the various elements of development, representing a horizontal approach and an integrated view of the sustainable development actions, requiring, more than ever before, inter-sectoral efforts for success.

This situation makes imperative to undertake not only a monitoring exercise of the first phase of implementation of the NHSSP but also a review of the strategies to ensure it responds to present

country context while also reflecting SDGs and the 8th Constitutional Government objectives set out for the health sector.

1.2 EVALUATION THE FIRST PHASE OF NHSSP (2011-2015)

As a twenty years operational document on the sector, "the NHSP is a living dynamic document that will be revised regularly and amended based on the outcome of its implementation and on constructive comments and feedback from stakeholders"[1] . Following this statement, the MOH engaged in an evaluation process consisting on an exhaustive analysis of achievements against the indicators and targets set in the plan. Data was collected in all municipalities with participation of health staff of all levels, whilst latest surveys and other studies and assessments were also considered as part of the information gathering phase.

The findings provided insights about internal strengths (positive progress, existing mechanisms in place, clarity and relevance), existing weaknesses (lack of mechanisms, negative progress), threats (existing barriers) and opportunities (expressed as recommendations). The results reported pretended to answer the following questions:

1. Clarity and relevance of strategies and targets selected
2. Mechanisms in place (or not) for implementing and managing the programs contained in the National strategy
3. The extent to which NHSSP is reflected in the MoH Annual action Plans
4. Recommendations and changes required to the NHSSP 2011-2030

General remarks are in line with the implementation recommendations of the NHSSP that defines the initial phase from 2011 to 2015 as a conditioning one, to set the base for "Human Resources development and deployment", development of "District Health Infrastructure" and "Institutional capacity building". Thus, producing or revising leading documents and setting implementing mechanisms was clearly something to be done and has been part of this phase.

However, the conclusion points directly to the stated barriers or bottlenecks that underline the need to strengthen efforts towards the implementation of the defined strategies. For this to happen it is necessary to define operational short to medium term plans to guide implementation and concentrate efforts in adequate dissemination of the NHSSP 2011-2030, thus, ensuring it is well understood and used to guide implementation of relevant interventions.

At the same time, and when addressing existing barriers, two main bottlenecks appears under all headings and require special mention:

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[1] NHSSP 2011-2030

a) The limitation of existing financial resources is a reality repeatedly noted that calls for efforts to, on one side, mobilization and advocacy to increase fiscal space for health while, on the other hand, undertake a proper prioritization that is conducive to a general growth of the sector and a coordinated approach that assures evidence-based quality and cost-effective public expenditure.
b) Human resources appear as another critical factor compromising bigger progress. Many efforts have been invested in this area; financial inputs, training –in-country and abroad, infrastructure, planning, etc. resulting in growing numbers of all types of health professionals, creation or improvement of training institutions of all levels and clearly improved capacities. Nevertheless, increase numbers, skills, distribution, attitude, commitment of health professionals at all levels of the system remains a challenge for next phases.

Finally, the next phase, guided by a revised NHSSP 2011-2030, is to represent consolidation in order to build a stronger health system and bring it to a mature stage that can be sustained over time. But there is also need to ensure the NHSSP is a document that moves the sector towards attaining the SDGs –mainly health related SDGs but taking into account as well how the plan in itself contributes to achieve other more general goals in the SDGs, like peace and stability.

1.3 METHODOLOGY OF NHSSP II

The following process was followed by the MOH in preparing the NHSSP II, embracing a methodical step-by-step approach:

i. **Starting up:** 8th Constitutional Government clearly programmed the need to implement the health strategies outlined in the SDP 2011-2030, and the Ministry of Health established a National Commission for the Revision of the NHSSP in alignment with the Government priorities for the health sector. Agreement was reached on the methods and approaches to be used to complete the task ahead and focal points were identified tasked with the role of extracting strategic information from different literature reviews corresponding to what the final product ("NHSSP II") would look like and what it would contain.

ii. Analysing the **situation**: The 2017 report on the in the implementation of the First Phase of the NHSSP 2011-2030 identified major progress, challenges and proposed recommendations to meet the vision and mission for 2030. During the assessment phase, the MOH also embarked on the protracted task of revising its core business for a Comprehensive Package of Primary Health Care Services, development of its National Strategic Plan for Human Resources and the National Strategy for Health Financing.

iii. **Preparing, reviewing and adopting the revised NHSSP**: 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 weaknesses of MOH leadership and management functions, the enormity of the social and economic determinants challenging the health profile of the Timorese people, 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 annual planning processes to flag options and to determine how best to develop and integrate new initiatives within the more programmatic strategic areas.

iv. **Implementing the plan**: The MOH has committed to implementing the Plan through widespread and sustained socialisation strategies and through appropriate financial support. The Plan will continue to be monitored and evaluated regularly, and will be adjusted and updated as required – at least every five years. Suitable flexibility and sensitivity will be required to accomplish this ongoing task.

v. **Communicating proposed changes clearly**: The MOH appreciates that the NHSSP II 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.

Table 1 Key documentation reviewed for the development of the NHSSP II 2020-2030

Sections of NHSSP II	Objectives of section	Documents to support development of section
Section I: **Introduction**	Sets out the purpose and context that generate demand for NHSSP 2011-2030 and it outlines the approach of the MOH in the 2nd NHSSP for the period 2020-2024. It presents the vision and mission statements of the Ministry and articulates overarching goals for the next five years of NHSSP	• SDP 2011-2030 • NHSSP 2011-2030 • Program of the VIII Constitutional Government
Section II: Situation Analysis	Comprises a succinct situational analysis of current circumstances relating to: • Health and demographic indicators • Role and structure of the MOH • Areas of positive progress • Challenges ahead	• Report on the 1st Phase of Implementation of the NHSSP: 2011 to 2016 • Census 2015; • Demographic and Health Survey 2016 • Business Activity Survey 2017 • Annual Health Statistics and Information Report 2018
Section III: Vision 2030 **Section IV: Governing the**	Highlight the Health Vision, Mission, Principles and Overarching Goals for 2030 Articulates a governance framework intended to improve access and ensure maximum health gains through focused, while outlining the arrangements for	All of the above documents were used in addressing this chapter, including: • SDP 2011-2030 • NHSSP 2011-2030 • Program of the VIII Constitutional Government

National Health System	engagement of all stakeholders for effective sector-wide approach.	• MoH Organic Law • Draft Strategic Plan on Health Quality Improvement
Section V: Strategic Framework for Health Services Delivery	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) in the following domains: • Comprehensive package of Essential Primary health care Services • Comprehensive hospital care Services • Referral Services	• Draft revision of the Primary Health Care Essential Service Package (PHC ESP) • Hospital Services Packages (BSP 2007) • Decree-Law Nº 11/12, 29 February regulating the Hospitals of the NHS • Draft manual for referral services • Current and draft Strategic Plans for priority health programs
Section VI: Support System & Services	Describes the support systems and services that make it possible to deliver the priority services set out above, including: • Drugs and Consumables • Diagnostic Services • Health Research • Health Management Information System	All of the above documents were used in addressing this chapter, including: • SAMES I.P Organic Law and Special Procurement Law • National Drug Policy Draft • Feasibility Studies Report for PPP on Diagnostic Services in Timor-Leste • Draft National Health Information Strategy • M&E Framework for Health
Section VII: Essential Resources	Overview of core HR needs and strategic plan of actions to achieve overall objectives Describes minimum infrastructure standards required for health facilities to deliver comprehensive package of services, including: • Medical Equipment • Means of Transport • Health Infrastructure Appraises the potential of various funding options to support the planned activities in the short to medium term	• Draft revision of PHC ESP • Joint Ministerial Diploma on Municipal Health Services Structure and Functions • Decree-Law regulating the organizational structures of NHS Hospitals • Draft National Human Resources Strategic Plan • Health Professional Career path legislation • Draft revision of PHC ESP • Joint Ministerial Diploma on Municipal Health Services Structure and Functions • Decree-Law regulating the organizational structures of NHS Hospitals • Draft National HR Strategic Plan • Health Infrastructure designs and plan • 2018 Budget Books and Reports • Draft National Health Financing Strategy 2020-2023 • Draft National Health Accounts
Section VIII: Implementation Arrangements	Guides priority setting for planning purposes as well as the organizational structure to monitor and evaluate the implementation of NHSSP II	• Ministerial Diploma on MoH Internal Regulation • Planning Manual • Monitoring and Evaluation Framework

Situation Analysis: Where are we?

2. Situation Analysis

2.1 DEMOGRAPHIC & SOCIAL PROFILE

Timor-Leste is a newly independent, lower middle-income nation in Southeast Asia with a population of 1.2 million that is growing at 3.2% per year. It is predominantly (74%) rural, characterized by small-scale subsistence farmers.

The Timorese consist of many distinct ethnic groups, with the number of languages spoken (32) being a reflection of both this ethnic mix and Timor-Leste's colonial history.

The country is comprised of 12 municipalities, each with three to seven sub-districts, 65 Sub-districts, 442 *Sucos* (villages) and 2,225 aldeias (hamlets)[2]. The Autonomous Administrative Region of Oecusse-Ambeno is an enclave located inside West Timor in Indonesia and accessible primarily by sea or air. The two largely dense urban centres, Dili and Ermera, are home to 29% of the population. Seventy percent of the population is rural with most people living in small, scattered villages often isolated by mountainous terrain and poor roads.

There are several distinct language ethnic groups, with the number of dialects spoken (32) being a reflection of Timor-Leste's colonial history.

Timor-Leste's economy is highly dependent on revenues from oil and gas. The country has established a sovereign wealth fund - the Petroleum Fund - that currently has USD 17 billion savings, which have been utilized by successive governments to meet annual public expenditure priorities and provide a cushion for future generations. Although one of the youngest countries in the world, the economy has grown significantly in the past 20 years. However, the pace of growth has been decelerating since 2011. GDP per capita declined by an average of 4.2 percent per year between 2002 and 2006, but subsequently recovered to a strong 8.3 percent growth from 2007 to 2010.

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[2] Idem

Between 2011 and 2016, per capita growth decelerated to about 2.4 percent. The economy contracted in 2017 due to the political impasse and a reduction in public spending. The economy also contracted in 2018, with GDP declining by 0.8 percent in 2018. In line with the global economic contraction due to COVID-19 pandemic, Timor-Leste is expecting a deceleration in its GDP. A range of factors influence the country's vulnerability; dependence on oil exports along with declining oil prices and fiscal vulnerabilities posed by relatively large fiscal deficit and low revenue share of GDP.

Economic factors are highly correlated with health outcomes: low incomes and low employment are unambiguously harmful to health. Current data[3] shows a steady economic growth in recent years, with a reduction from 41.8% in 2014 to that more than 30.3% by 2017 of the population living below the poverty line with less than US$ 1.90 per day, though there are significant variations between Municipalities. Timor-Leste continues to have an unequal distribution of wealth: about 41.8% of Timorese live below the national poverty line in 2015, especially in rural areas with an average of 47.1% and urban reached 28.3%.In 2018, gross national income was US$5080 per capita and gross domestic product growth was 4% per year (dollars are valued at purchasing power parity).

Timor-Leste operates a predominantly publicly financed and provided health system. Health services are provided free at the point of use and, as a result, proportionate government contributions to health care spending are large (about 80% of total health care expenditures). However, the absolute amount of government spending on health care is low, at US$101 per capita. This may mean that the low level of out-of-pocket payments compared with other countries in the region is also an indication of limited infrastructure and the availability of health services rather than low-cost access to a full range of health care services.

The quality of housing and its basic conditions (water, sanitation and electricity) have a considerable influence on the health status of individuals and populations as they can facilitate the spread of respiratory, skin infections and vector-borne diseases.

According to the World Health Organization, 10% of the global burden of the disease could be prevented by improving the availability of drinking water, sanitation and hygiene, and water management. Indeed, much of the occurrence of diseases such as diarrhea, malnutrition, malaria and neglected tropical diseases is attributable to the unavailability of drinking water, inadequate sanitation or poor hygiene.

3

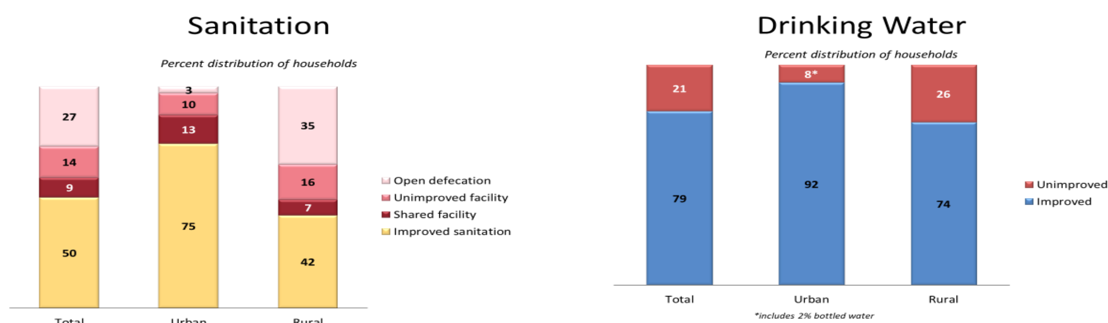
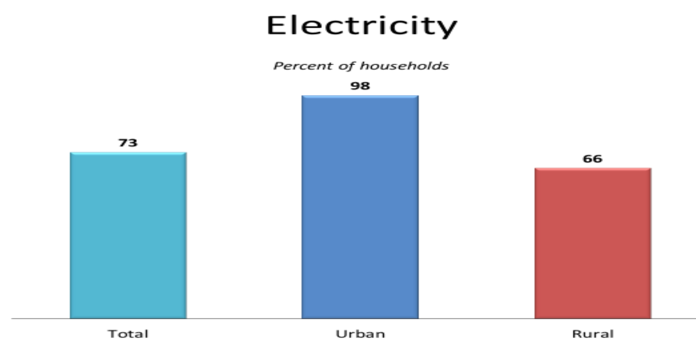


Figure 1: Access to Water and Sanitation in Timor-Leste, Census 2015

The 2015 Census register 79% of the population with access to safe drinking water and 50% with access to basic sanitation. The situation has significantly improved over the past five years, particularly in rural areas where only 26% of the population lack safe drinking water and 35% lack improved latrines, compared with 8% and 3% of urban areas respectively.



Source: Census 2015, TL National Statistic Directorate

Figure 2: Access to Electricity in Timor-Leste, Census 2015

2016 Demographic and Health Survey[4] highlighted the differences in the use of health services: the degree of utilization increases with the increase in the educational level of the patient, particularly with regard to family planning and reproductive health.

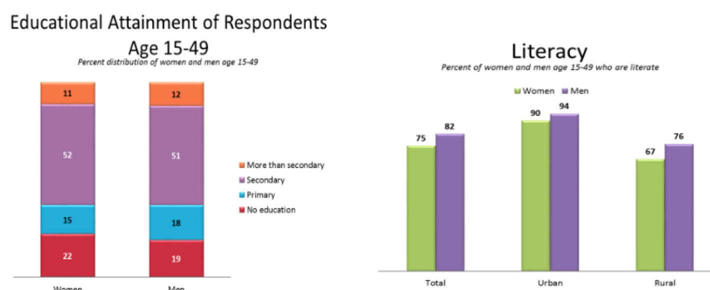


Figure 3: Access to Education in Timor-Leste, Demographic Health Survey 2016

[4] Timor-Leste Demographic and Health Survey 2016

Similarly, differences in gender-based and culturally constructed social relationships can be exerted in various ways: exposure, risk and vulnerability; nature, severity or frequency of health problems; how symptoms are perceived; behaviors in seeking services; access to health services; ability to follow treatment; long-term social and health consequences, etc.

2.2 HEALTH FILE

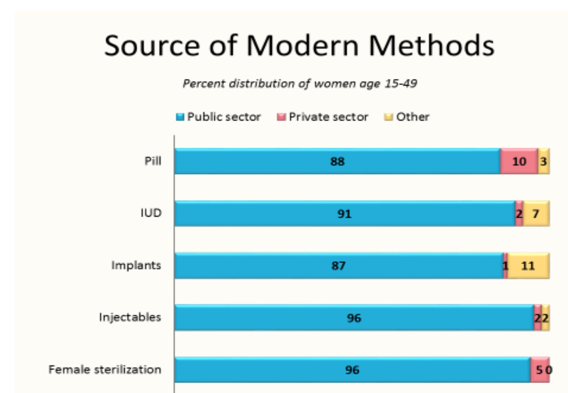
Changes in health indicators over the past eight years after independence shows that Timor-Leste is progressing fast in its efforts to tackle major health challenges characterized by significantly high maternal and child mortality rates, coupled by high incidence of communicable diseases.

a) Maternal Health

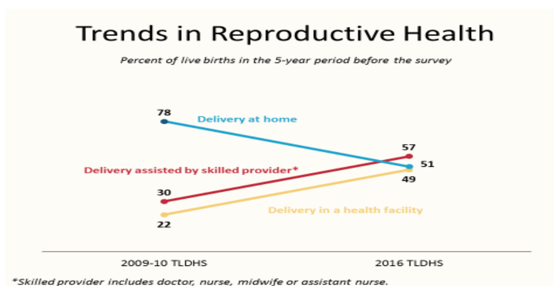
Maternal and newborn health in Timor-Leste has improved since independence in 2002, but much remains to be done to reduce the continuing high rates of maternal and newborn mortality.

With regards to family planning situation in Timor-Leste, the latest Survey also reported the following:

- The modern contraceptive prevalence rate among married women is 24% and 2% use a traditional method;
- The most commonly used modern methods are injectable (12%);
- The majority of injectable, implants, IUD, and pills are obtained from the public sector;
- 25% have an unmet need for family planning;
- 47% is satisfied by modern methods.



The 2016 TLDHS shows that 84% of women age 15-49 received at least one ANC visit with skilled providers during the pregnancy for their most recent birth.



- **84%** of women received **antenatal care** for a skilled provider at least once.
- **49%** of births are **delivered in a health facility**.
- **57%** of births are **assisted by a skilled provider**.
- **35%** of women and **31%** of newborns receive a **postnatal check within 2 days of birth**.
- **60%** of women report **at least 1 problem in accessing health care** for themselves when sick.

Figure 4: Trends in Reproductive Health in Timor-Leste, 2009-10 to 2016

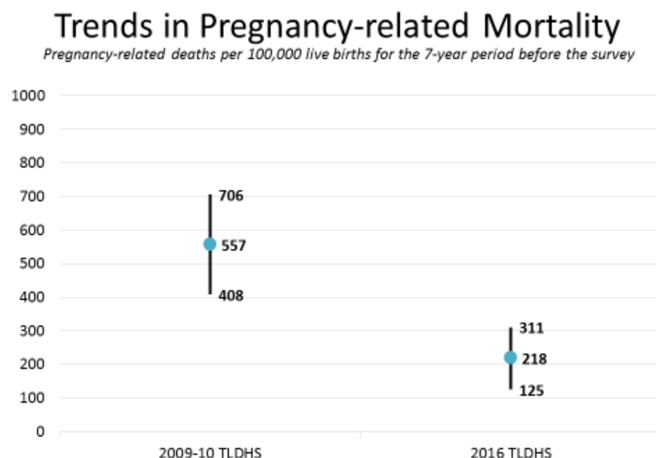


Figure 5: Trends in Pregnancy-related Mortality in Timor-Leste, 2009-10 to 2016

Maternal mortality ratio is 195 deaths per 100,000 live births. Pregnancy-related mortality ratio is 218 deaths per 100,000 live births.

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

Most of the ANC is provided by nurses/midwives (70%), with the Survey indicates a stable decrease on maternal and child mortality, as indicated below:

- Current infant mortality rate is 30 deaths per 1,000 live births
- Under-5 mortality is 41 deaths per 1,000 live births. Childhood mortality is generally higher among children of less educated mothers and those from poorer households

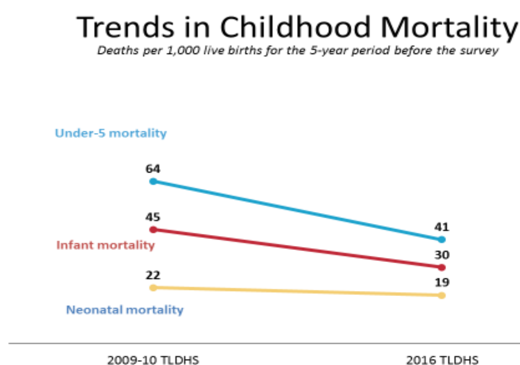


Figure 6: Trends in Childhood Mortality in Timor-Leste, 2009-10 to 2016

b) Nutrition

The nutritional status of both children and adults in Timor-Leste remains significantly below acceptable world standards. As the National Nutritional Strategy notes, under-nutrition is brought about by a combination of broad economic, political, educational and cultural features of a society.

Findings of the Timor-Leste DHS 2016 and highlight the enormity of the problem of malnutrition in young children and women in particular.

For Children:

- 50% of children under 6 months are exclusively breastfed;
- 40% of children age 6-59 months and 24% of women
- age 15-49 are anemic;
- 46% of children under 5 are stunted and 23% are severely stunted;
- 24% are wasted and 10% are severely wasted;
- 40% of children are underweight;
- 6% of children are overweight.

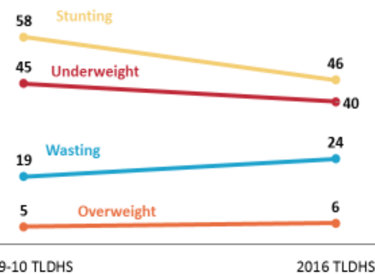


Figure 7: Trends in Nutrition Status of Children in Timor-Leste, 2009-10 to 2016

Overall adult nutritional status is also a concern, especially for women, whereby 10% of women age 15-49 are of short stature (below 145 cm), 27% are underweight, 8% are overweight and 2% are obese. However, the prevalence of women who are underweight ranges from a low of 19% in Viqueque to a high of 37% in Oecusse, and the prevalence of women who are overweight or obese ranges from a low of 3% in Ermera to a high of 15% in Dili.

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.

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.

c) Control of Communicable Diseases

i. 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 and dengue) second only to respiratory illnesses in terms of national morbidity and mortality.

One of the big successes in the history of Ministry of Health Timor-Leste is the massive reduction of malaria incidence rate. Figure below shows the incidence rate of malaria which declined sharply from 104.2 /1000 population in 2010 to 5.3 in 2012 and gradually reduced to below than 1/1000 population for three years before it reached 0.03 /1000 population in 2017.

Despite a nationwide incidence rate reduction, there were still few cases detected in six municipalities, including Dili, Special Administrative Region of Oecusse-Ambeno, Bobonaro, Covalima, Manufahe and Liquiça with 10, 10, 6, 2, 1 and 1 respectively - with 13 cases imported and 17 indigenous cases.

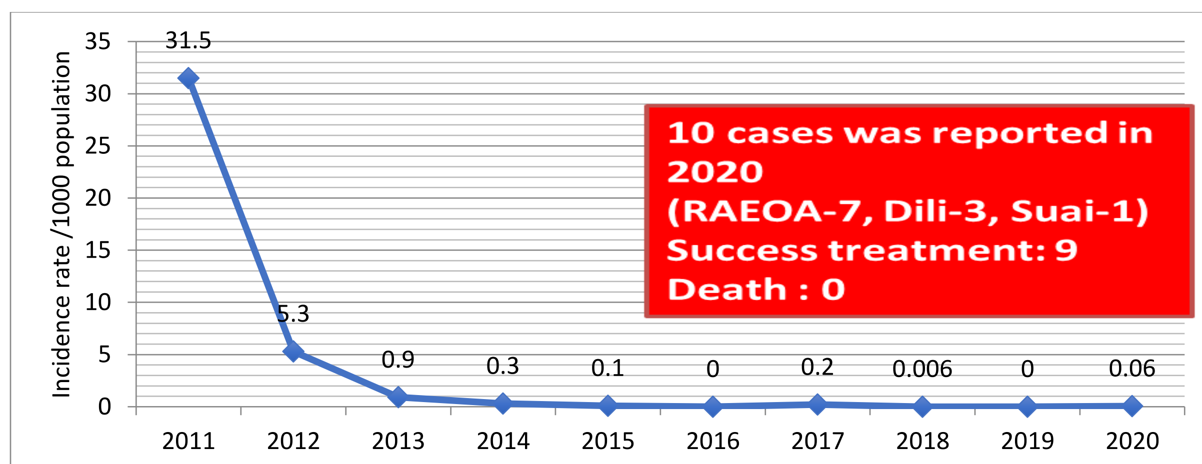


Figure 8: Malaria Incidence in Timor-Leste, 2011-2020

Moreover, in 2020 there were 10 imported cases of malaria with no more death cases reported over the past ten years. Hence, with the current status of eradication under control, Timor-Leste is now entering the preparation of elimination phase of malaria before declared of free malaria.

ii. Tuberculosis

The World Health Organization set strategy with objectives to end the global TB epidemic, with targets to reduce TB deaths by 95% and to cut new cases by 90% between 2015 and 2035, and to guarantee that no family is burdened with appalling expenses due to TB.

The MoH also recognized the challenges in combating TB in Timor-Leste as the country is considered a TB “high burden” nation with an estimated incidence rate in 2019 of over 400 cases per 100,000 people.

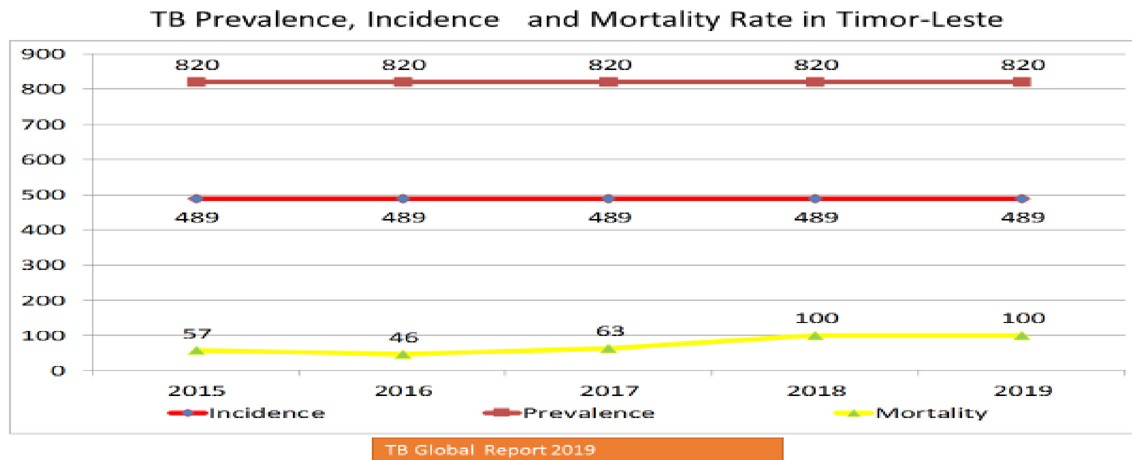


Figure 9: TB Rates in Timor-Leste, 2015-2019

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.

iii. HIV-AIDS & Sexually Transmitted Diseases

The first HIV/AIDS case in Timor-Leste was confirmed in 2001. However, 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.

DHS 2016 report on "Reproductive Health and Family Planning" show details on the low level of awareness in Timor-Leste of matters relating to STIs overall and the concept of safe sex practice.

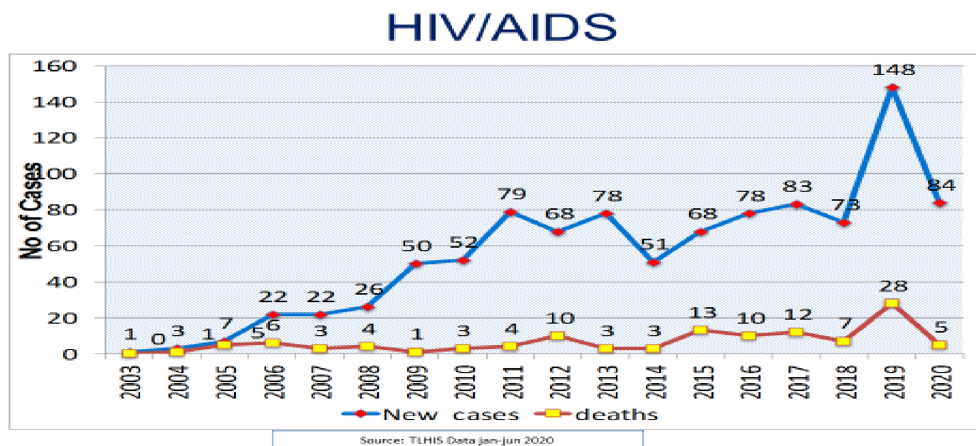


Figure 10: Trends of HIV-AIDS Cases in Timor-Leste, 2003-2020

HIV new cases have been increasing gradually since 2003 with the highest peaked in 2019 with 148 new cases of a cumulative total of 1110 cases over the years. Conversely, the number of deaths also increased significantly and reached a total 138 deaths in 2019.

d) Control of Other Communicable Diseases

Diarrhoeal Diseases: Although eminently preventable, diarrhoea ranks as one of the four major child health problems in Timor-Leste along with acute respiratory infections, skin infection and malnutrition. One fifth of all deaths of Timorese children under five years are attributable directly to diarrhoea.

Leprosy PB and MB cases by municipalities is shown in only three municipalities having a total of 11 PB cases, whereas the MB cases appeared to be present in 10 municipalities with total cases of 137. Dili, Baucau and Oecusse have higher number of MB cases with 51, 42 and 22 respectively and all the other municipalities have MB cases ranging from 1 to 9 cases.

Lymphatic filariasis is caused by three filarial species, namely, Wuchereria bancrofti, Brugia malayi and Brugia timori, of which two species, W. bancrofti and B. malayi, are widespread across the South-East Asia region. By contrast, B. timori is localized to only a few islands in the eastern part of the Indonesian archipelago, which includes Timor-Leste. B. timori has previously been reported as the most prevalent species in Timor-Leste (95%), with approximately 5% being due to B. malayi and W. bancrofti. The 2012 National Parasite Survey found that 17.5% of the Timorese population was found to be seropositive for Brugian antibody, indicating that a large percentage of the population had been infected with filariasis at some time in their life. The results of this study prompted the Ministry of Health to re-initiate the Mass Drug Administration (MDA) program in 2015 as part of the MOH's Integrated NTD Control Plan 2015–2020, with the aim of LF elimination. Along with a successful MDA implementation with high drug coverage, the country is on the right track to eliminate LF by 2024.

Soil Transmitted Helminths (STH) are a group of NTDs that are also endemic in Timor-Leste. The 2012 National Parasite Survey found an overall national prevalence of any STH at 29.1% among school-aged children. For STH control, additional mass deworming for 1-15 years has been implemented in Dili where the baseline prevalence is over 50% since 2017.

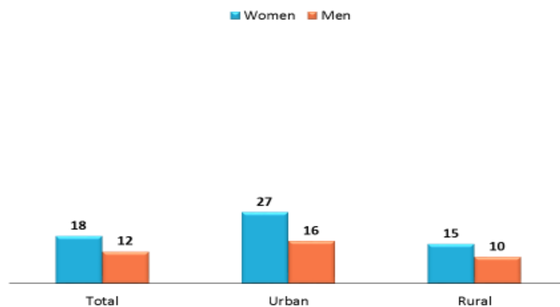
Health Emergencies: In 2007 the WHO successfully advocated for the implementation of the International Health Regulation 2005 (IHR 2005) which are designed to provide a legal framework to protect all nations from acute public health risks that have the potential to spread internationally and impact negatively on health, trade and travel. Timor-Leste is bound by these regulations.

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, the occurrence of Severe Acute Respiratory Syndrome (SARS) infections, Ebola and Zika viruses.

e) Control of Non-Communicable Diseases

i. Chronic Diseases

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 emerging among younger age groups.



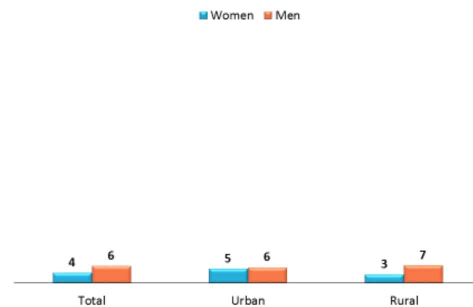


Figure 11: Self-Reported High Blood Pressure and Heart Disease in Timor-Leste, DHS 2016

In 2018, chronic diseases were among the top ten causes of death for all ages in Timor-Leste, including overseas referrals for the following diseases presented below:

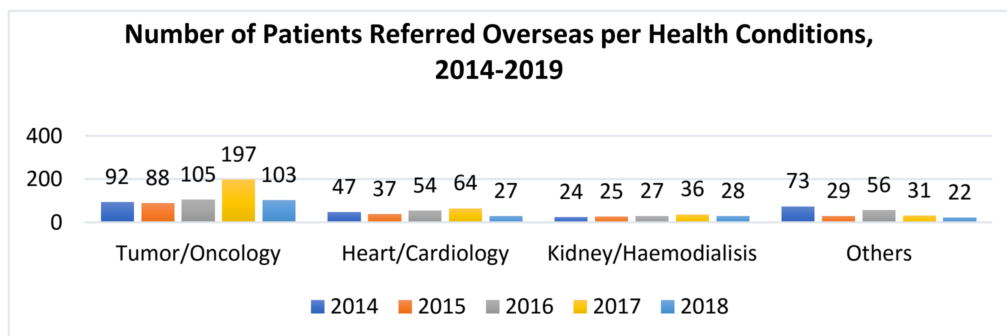


Figure 12: Number of Patients Referred Overseas Per Health Conditions, 2017-2018

Based on NCD risk factor survey using the WHO STEP wise approach to NCD Surveillance (STEPS) conducted in October–November 2014 there is a high prevalence of NCD risk factors. About half (56%) of the adults used some form of tobacco product (70% of adult men use tobacco in any form). The prevalence of current alcohol consumption was 42.8% in men. The prevalence of raised blood pressure (BP), raised total cholesterol and raised fasting blood glucose were 39.3%, 21% and 1.5%, respectively.

The proportion of households using solid fuel for cooking was estimated at 87% in the Country as per the Demographic and Health Survey (DHS), 2016. The results of the STEPS survey also suggest a low coverage of NCD interventions and high treatment gaps.

For example, among women aged 30–49 years, only 1.1% had ever had a screening test for cervical cancer and 97.3% with raised blood pressure were not on medications.

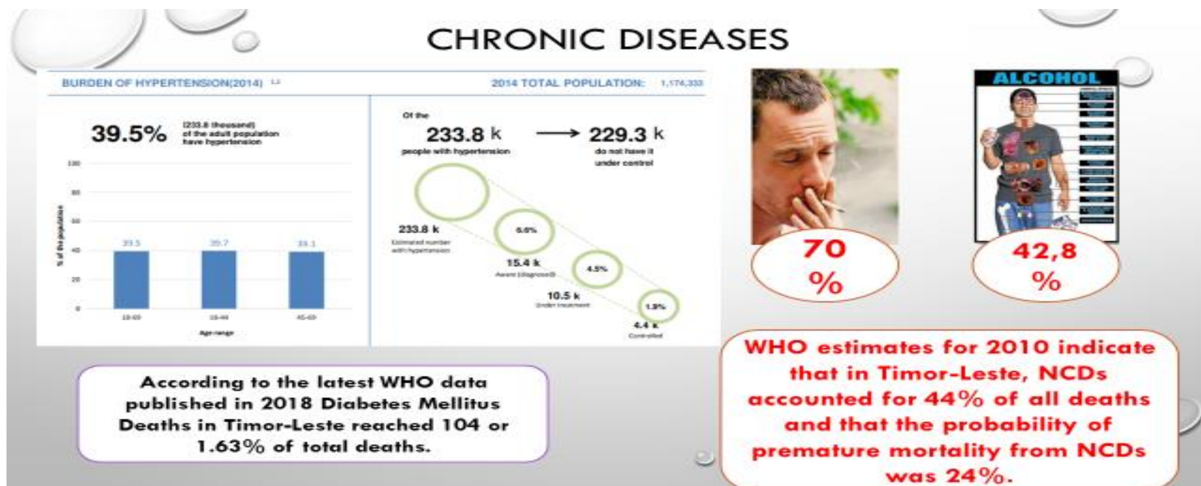
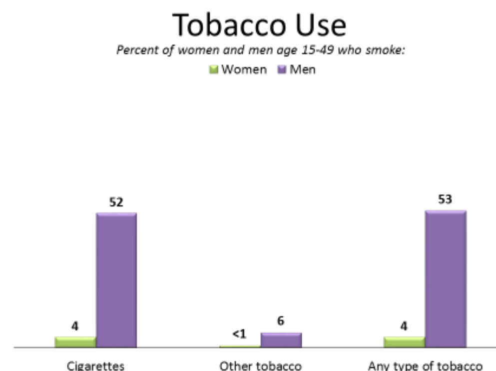


Figure 13: Burden of Chronic Diseases in Timor-Leste, 2014

Among prevention of risk factors, tobacco control is leading with a law in place. However, mechanisms for implementing this law still need to be fully established. Alcohol prevention and control are lagging behind with no regulatory framework to address these. While food based dietary guidelines have been issued, a comprehensive approach to modifying the diet is not in place. This includes increasing awareness, establishing an enabling environment and regulatory approaches.



ii. Mental Health

The Department of Mental Health is responsible for the coordinating management of comprehensive care of mental disorders, substance abuse, and people with neurological disorders such as epilepsy.

There are limited number of mental health specialists working for the public health sector (1 in each municipality, 2 in Dili and Oecusse), as well as trained general nurses (in 25% of CHCs), adopt a bio-psycho-social-cultural-spiritual model for both aetiology and management.

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

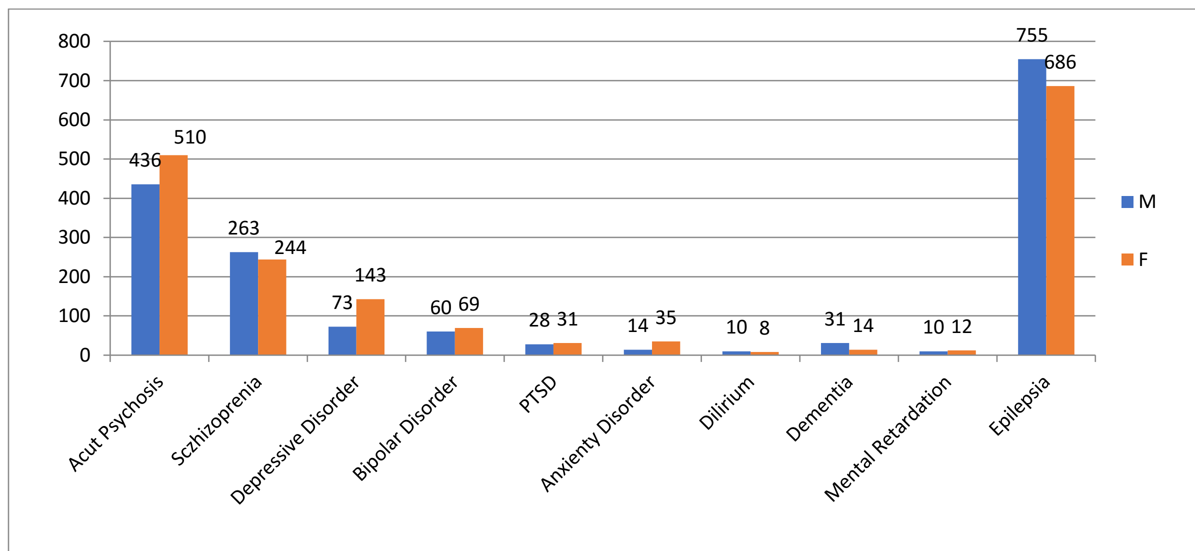


Figure 14: Number of Mental Health Cases in Timor-Leste, 2019

Main constrains are:

a. Shortages in human resources for mental health pose significant challenges for service delivery and psychosocial services are primarily delivered through NGOs. Available financial and community resources, including social networks, are not mobilized to their

full potential to scale up mental health promotion, prevention of mental illnesses, and mental health services.

b. The lack of inpatient services has been a significant gap in the country including psychosocial service that currently still requiring.
c. The lack of research evidence to inform mental health policy and practice is a significant impediment for mental health policy and planning.
d. Social inclusion policy implementations is still not have a proper approach to People with mental disabilities.

iii. Oral Health

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

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

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

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

Currently there are 104 dedicated health professionals in national health system to deliver oral health services in different level of point of care constituted by 1 specialist orthodontist, 1 odonatologist, 5 General Dentist, 2 bachelor degree, 52 Dental Nurses, 43 Dental technicians.

iv. Eye Health

Recent Rapid Assessment of Avoidable Blindness (RAAB) surveys indicate that one-in-eight Timorese have either blindness or moderate-to-severe visual impairment, with one-in-35 Timorese being blind. These rates equate to 157,000 Timorese having significant ocular impairment, of whom 36,000 are estimated to be blind (2016).

Cataract accounts for an estimated 84% of blindness and severe visual impairment and 64.4% of moderate visual impairment.

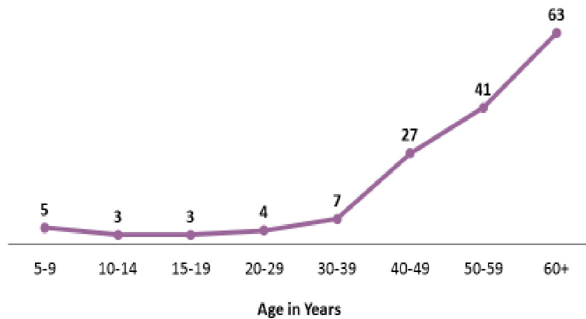
Uncorrected refractive error accounts for one-in-three case of moderate visual impairment, <5% of severe visual impairment, and <1% of blindness. Additional causes of visual impairment identified in the 2016 RAAB survey include trachomatous and non-trachomatous corneal opacities, and glaucoma, each accounting for <5% of all-cause visual impairment.

Emerging causes of ocular impairment in Timor-Leste mirror the increasing burden of non-communicable disease and increasing age of the Timorese Population, and include glaucoma and diabetic retinopathy. A 2013-4 estimate of diabetic retinopathy suggested a 15% point-prevalence of diabetes mellitus in an unselected ocular outpatient population, of who 18.6% had evidence of diabetic retinopathy, an aggressive degenerative disease of the retina.

v. Other Non-communicable Diseases

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.

According to Timor-Leste Demographic Health Survey (TLDHS) 2016, 15% of the population age 5+ years was reported to have some level of difficulty in at least one domain of functioning, 2% percent of the population was reported to have either a lot of difficulty functioning in at least one domain, or could not function in one of the domains at all, The most commonly reported difficulty is the ability to see – reported for 16% of both women and men age 15+, 6% of people age 15+ with no education have a many challenges or cannot function at all in at least 1 domain.



Living with a disability poses many complex challenges, including the difficult access to health services available in the country. As Timor Leste has the universal practice of health, the right to health includes access to basic health services, as well as specialized rehabilitation services.

It is important that the services be provided individually or "person-centered," with due consideration to the range of support services required (for example, support devices, rehabilitation, home visits to provide basic medical care).

Figure 15: Disability by Age in Timor-Leste, 2016

On the other hand, 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.

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.

2.3 NATIONAL HEALTH SERVICES

The MOH has two roles - stewardship and service/programme provision. Stewardship refers to the central service functions of (public and private) sector-wide policy direction, regulation, organisational monitoring and surveillance, inter-sectoral 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.

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

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

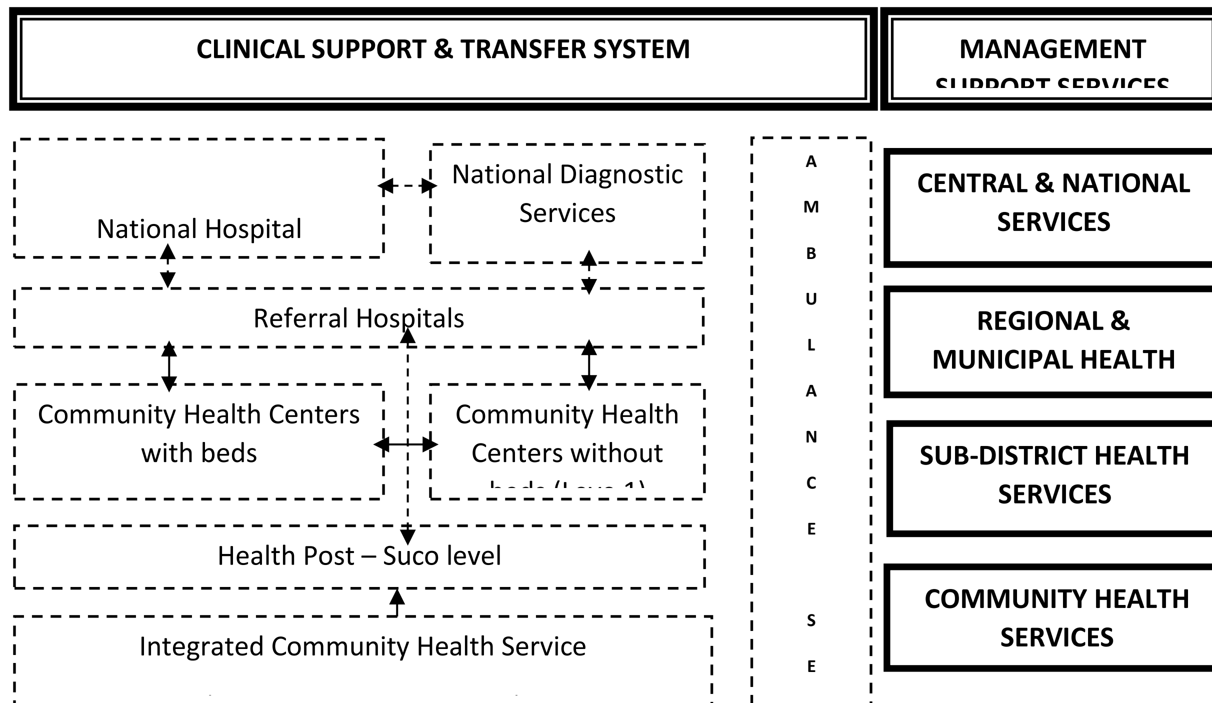
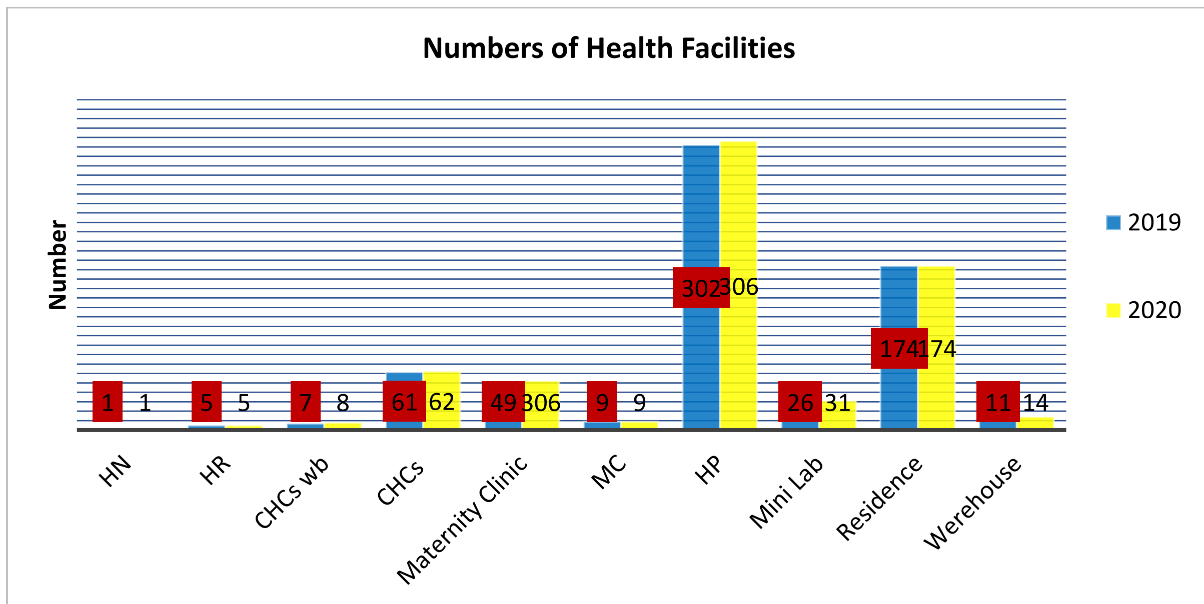


Figure 16: Current Health Service Configuration in Timor-Leste



PENSS 2011-30: Target for 2016 is 313 Health Posts, 70 CHCs (page 135)

Figure 17: Number of Public Health Facilities, 2019-2020

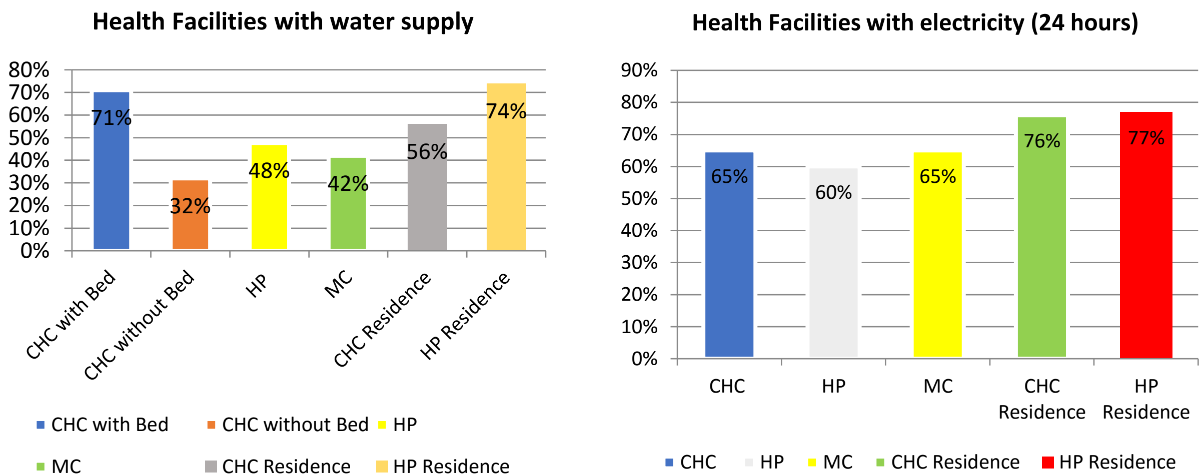


Figure 18: Number of Public Health Facilities with Access to Water supply and Electricity, 2019

Over the past ten years, health infrastructure has been focusing on rehabilitation and construction of health facilities, management offices and training centers, resourcing these facilities with basic equipment, ambulances and multifunctional vehicles, access to electricity and water supply. However, from a total of 306 Health Posts fully functioning, 109 is without water supply, and 56 Health Posts have no access to electricity.

2.3.1 Primary Health Care Services

Primary health care services are provided through the Municipal Health Service structure, with Community Health Centres, Health Posts and outreach activities servicing geographically defined populations within a framework of the BSP while incorporating an integrated community health service or SISCa.

Devolution of management authority and responsibility to district health teams has been a cornerstone of the MOH during its formative years. The community-based activities consist of Domiciliary Visits, SISCA in all villages, mobile services conducted at other sites e.g. schools, markets, community structures and "mop up" services regularly conducted according to programmatic needs.

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

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

Level 3 CHCs provide inpatient and outpatient services, with a staff component of 10-14 including a physician (the "Municipal Medical Officer"), and radio communications with direct access to ambulance services. Depending on the vicinity of referral hospitals, inpatients are admitted to an observation unit with two to four beds for pre-referral stabilization of severe cases, or to a ward of 10-20 beds with a set of diagnosis support equipment including laboratory with capacity for essential tests. Where there is no health post available in remote communities, CHCs provide basic outreach services on a regular basis by motorbike on a twice-per-week basis.

2.3.2 Hospital Services

There are two levels of hospitals providing secondary care in Timor-Leste, Municipal Hospitals and Regional Hospitals. Tertiary health care services are provided by the National Hospital, with some specialized services provided overseas as a result of limited technology and human resources required to perform complex interventions.

Referral hospitals are located in five strategic regions and they all have out-patient, emergency and in-patient departments, staffed with general practitioners and specialists in four clinical areas such as surgery, pediatrics, gynecology-obstetrics and internal medicine.

The national hospital is the top tier referral health facility for specialized services and has linkages for tertiary care with other specialized health facilities overseas. Both national and referral hospitals provide practical tutorials and skills enhancement to primary health care workers, while also accommodating internship opportunities to new graduates.

Referral arrangements between the three levels of services are linked with ambulance services, with ambulances based in hospitals and district ambulance stations. Services at the secondary and tertiary levels shall be oriented to support service quality in the health facilities and to improve the performance of the referral chain and level of excellence that is expected from both secondary and tertiary health care services.

2.3.3 The Private Health Sector

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

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

While public health services are delivered through a network of facilities distributed across the country, from an integrated community health services to Health Posts, Community Health Centre, Municipal, Regional and the National Hospital, the organizational structure of the private health sector, on the other hand, does not follow any specified rules or regulations to comply with national health services configuration, thus, leaving the sector to develop independently with no boundaries in terms of provision of services accredited to primary, secondary or tertiary levels of health care.

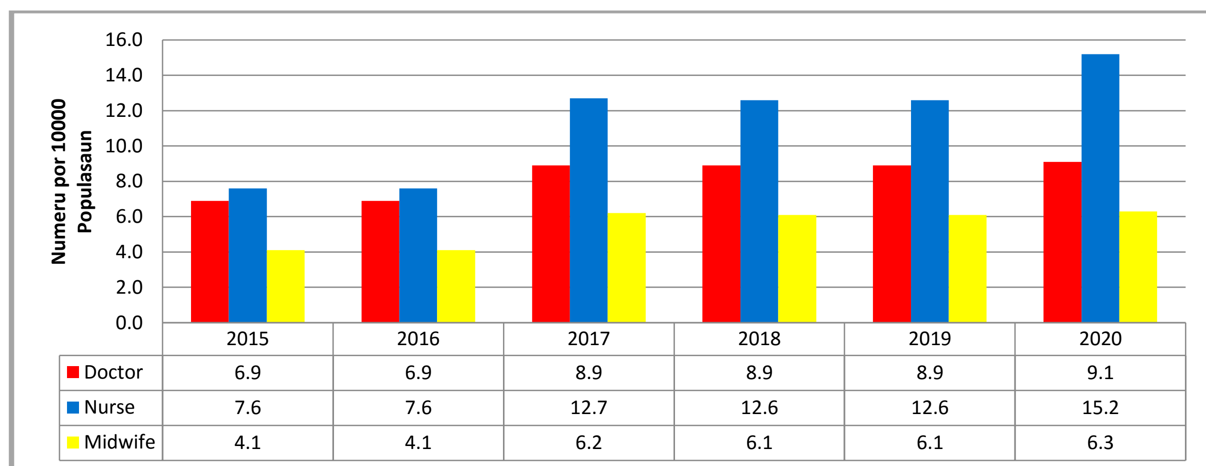
The profit-making private sector is developing gradually, especially in the large cities, as current health policy recognizes the role of the private sector in providing health care services. Policy declarations concerning the promotion of public-private partnerships have not been explored sufficiently and management models should be combined for this type of partnerships, as long as they do not prejudice routine service provision and access for citizens with limited purchasing power.

Health care in the non-profit-making private sector is essentially provided by foreign Non-Governmental Organizations (NGOs) and some religious groups, with few NGOs and private clinics partnering with the Government to implement essential community health care programs in the areas of prevention, disease control, health education and information.

In the pharmaceutical area, the number of private operators is growing throughout the country, particularly in the urban areas. There are accounts of exorbitant price systems practiced by private pharmacies. Inspection activities are presently ineffective largely due to the shortage of inspectors and the absence of specific programs in this area.

2.4 HUMAN RESOURCES FOR HEALTH

In Timor-Leste, Human Resources for Health (HRH) has been a long-term priority in the health care planning process, given its centrality in sector performance.



	2015	2016	2017	2018	2019	2020
Doctor	6.9	6.9	8.9	8.9	8.9	9.1
Nurse	7.6	7.6	12.7	12.6	12.6	15.2
Midwife	4.1	4.1	6.2	6.1	6.1	6.3

Figure 19: Health Professional per Population Ratio, 2015-2020

In 2010, the Ministry of Health had a total of 30 General Doctors hired to work in several health facilities[5] , rising to 889 in 2019, and an increase of doctor-population ratio from 4 doctor per 10,000 inhabitants to 8.9 ratio. Figure 3 highlights a significant increase in the overall

[5] NHSSP 2011-2030

combination ratio of 24 health workforce per 10,000 populations, despite of WHO recommended global standard of 44.5/10,000.

The NHSSP 2011-2030 defines continuing education as for HRH a key element quality. Despite the efforts made by the National Health Institute to offer continuing training to health professional, it is clear that there are still areas not sufficiently covered and insufficient coordination, planning, monitoring and evaluation of training conducted. In addition to the acknowledged gains in the development of Health Human Resources, identified constraints persist that need to be mitigated, namely:

- Inequalities in the distribution of HRH both at the health pyramid and geographical level, as well as at the care facilities;
- Insufficient allocation of HRH;
- Insufficient availability of multidisciplinary care teams;
- Inadequacy of the performance appraisal system;
- Inadequacy between the profile required by the post and vocational training;
- Insufficient policy of motivation, retention and retention of technicians;
- Failure to timely schedule the replacement of professionals on leave and in retirement.

Table 2: HRH distribution by cadre, gender and institution, 2019

		MoH (central)	Referral Hospitals	HNGV, INS, NL & SAMES	Municipal Health Services	Total	TOTAL
Specialist doctor	**F**	1	0	9	2	12	**35**
	M	0	2	20	1	23	
	ALL	**1**	**2**	**29**	**3**	**35**	
General doctor	**F**	18	33	47	342	440	**889**
	M	17	31	40	361	449	
	ALL	**35**	**64**	**87**	**703**	**889**	
Nurse (all)	**F**	4	82	163	244	493	**1,268**
	M	15	125	131	504	775	
	ALL	**19**	**207**	**294**	**748**	**1,268**	
Auxiliary nurse	**F**	0	13	11	42	66	**231**
	M	11	20	11	123	165	
	ALL	**11**	**33**	**22**	**165**	**231**	
Midwives	**F**	**3**	**69**	**71**	**475**	**618**	**618**
Allied HPs	**F**	10	45	79	185	319	**647**
	M	12	61	62	193	328	
	ALL	**22**	**106**	**141**	**378**	**647**	
Total	**F**	**36**	**242**	**380**	**1290**	**1,948**	**3,688**
	M	**55**	**239**	**264**	**1182**	**1,740**	

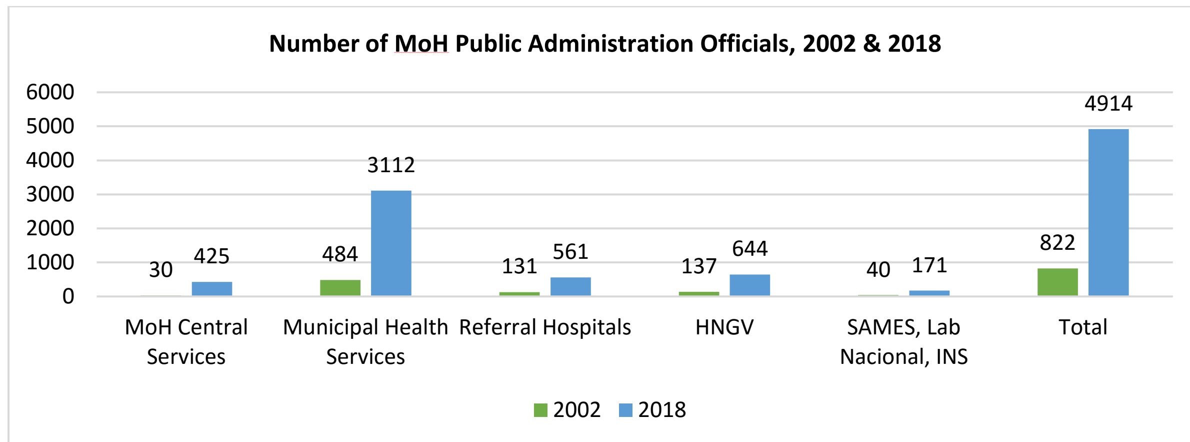


Figure 20: Total Number of MOH Civil Service recruitment, 2018

With regards to professional training and health education in the country, important progress has been made in the last decade, with several higher education institutions created, namely the Timor Lorosa'e National University and other private higher education institutions, under the strategic coordination of the Ministry of Education. Among the main courses of interest to the health sector, there are degrees in public health, nursing, midwifery, laboratory technician and pharmacy.

The Cuban Medical Brigade has been playing a determinant role in the education of general doctors that are currently placed at several Community Health Centers and Health Posts across the country, whilst also inspiring the adoption of a new approach to Primary Health Care services, *Saúde na Família*, as to ensure "health for all".

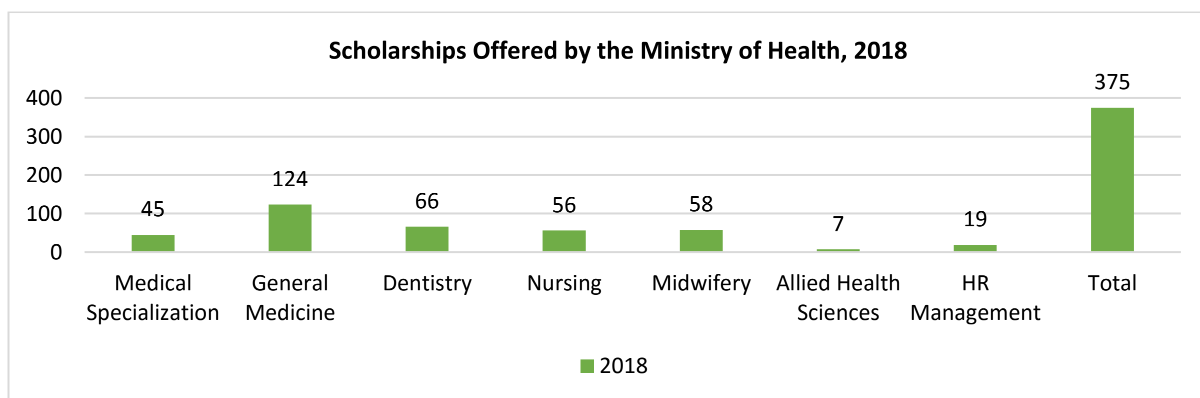


Figure 21: Total Number of Scholarships offered by the MOH, 2018

The positive evolution of the HRH overview within the framework of the NHSSP should not preclude the analysis of the remaining constraints, namely the lack of in-house capacity for basic and specialized training of physicians. This is a serious handicap to the aspirations of the SDP as part of its vision for health development in the year 2030.

At the micro level, the lack of incentive mechanisms, motivation, health staff fixation and the fight against a phenomenon, until recently, unknown in the Ministry of Health, but which is threatening to be affirmed, is staff emigration - the so-called brain drain or talent drain - to the private sector and/or international organizations.

2.5 FINANCING THE NATIONAL HEALTH SERVICES

In Timor-Leste, government budget and donor assistance are the largest sources of revenue for the public health sector, while private, out-of-pocket expenditure remain well below of 10% of Total Health Expenditure. Health Expenditure as percentage of both GDP (1.4%) and total government expenditure (5%). It is characterized by strong reliance on public expenditure (2/3 of which from domestic sources). Most expenditure is devoted to curative care, while 2/3 of private expenditure (which is 6% of all health expenditure) is spent on drugs dispensed at private outlets.

Health Financing Country Diagnosis 2017 identified the following areas of concern:

- Projection of a steep reduction of government revenues as well as donor assistance where budget allocations could take place in restricted environment and return on investments (value for money) is a critical negotiation tool;
- The pooling function is increasingly fragmented with increasing number of decentralized units, limiting the sector from building a common strategy for health funds;
- There is no strategic purchasing of health services with budget allocations following an incremental approach;
- Coverage and utilization of health services is still low, and substantial inefficiencies and inequities have been identified, some of which may be partially caused by the current implementation of the health financing functions;
- Decentralization may make health services more responsive to the people’s needs and expectations, but it also involves risks, such as the exacerbation of territorial inequities and the incapacity to ensure continuity of care across territory and levels.

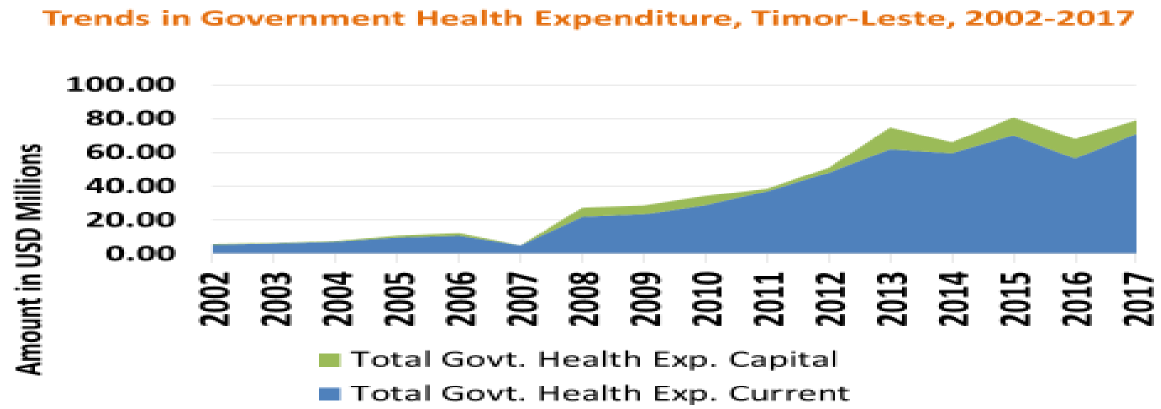


Figure 22: Trends in Government Health Expenditure in Timor-Leste, 2002-2017

VISION 2030: Where do we want to go?

3. VISION 2030

3.1 VISION

Vision 2030 puts Timor-Leste on a path that will lead to sustainable prosperity. The 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 multi-sectoral 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.

3.2 MISSION

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

- Increase equitable access to health services
- Improve the quality and responsiveness of health services
- Enhance the regulatory capacity of the MOH
- Foster partnerships in improving health delivering services
- Improve the financing of the health sector

3.3 CORE VALUES & PRINCIPLES

- Right to health
- Equity
- Cultural sensitivity and awareness
- Professional Ethics and Integrity
- Participation
- Accountability

3.4 OVERARCHING GOALS

- Safe motherhood leading to healthy start for new-born and infants
- Healthy children and adolescents
- Mental health and wellbeing
- Healthy ageing
- Reduce mortality, morbidity and disability related to NCDS and their risk factors
- Reduce mortality, mortality, morbidity and disability due to communicable diseases
- Eliminate Neglected Tropical Diseases (NTDs) as public health problems

- Reduce the number of cases of death, disability, and illness, with emphasis on protection of the poor and vulnerable populations affected by emergencies and disasters

Figure 23: Linkages of priority areas to the NHSSP Goals and objectives

Overall Strategic Development Goals (SDP 2011-2030):
Timor-Leste to be an Upper-middle Income Country with Educated and Healthy Population in 2030

Phase I: 2011-2015

- Human Resource Development
- Infrastructure Development
- Stengthen Institutions

Phase II: 2016-2020

- Strengthen Human Resources
- Strengthen Infrastructure
- Develop Strategic Industries

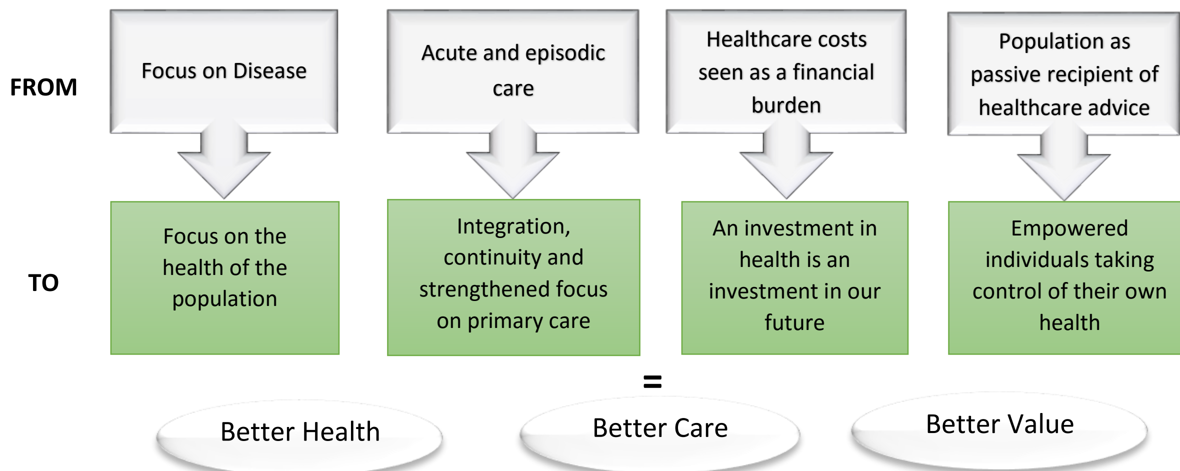
Phase III: 2021-2030

- Eradicate Extreme Poverty
- Modernize and strengthen Private Sector
- Diversification of Economy

NHSSP 2011-2030 Priority Directions

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

CHANGING PARADIGM TO PATIENT-CENTERED APPROACH TO HEALTH CARE



Strategies to get where we want to go:

Good Governance

Health Services Delivery

Support Systems & Services

Essential Resources

4. Governing the National Health System

OVERARCHING STRATEGIC GOALS: To stewardship capacity of the MOH is strengthen to achieve universal access to health services and health care coverage		
OUTCOMES		**STRATEGIC ACTIONS**
4.1	**Effective Stewardship and Governance of the Health Sector at all levels**	Improve the capacity to implement essential functions of the National Health Services
		Implement an effective and sustainable mechanism for the systematic review and updating of health policies, laws and regulations
		Enhance institutional regulatory mechanism for registration and licencing of health professionals and health services providers
		Implement Monitoring and Evaluation Framework through the MOH, Municipal Health Services, Hospitals and Autonomous health institutions
		Within the framework of the Health in All Policies (One Health) approach, improve partnerships with other government ministries, communities, non-governmental organizations, civil society and international community.
		Institutionalised results-based planning and budgeting and align to MOH strategic goals with formalised mechanism for prioritization during the ten-year execution of NHSSSP II 2030
4.2	**Efficient and Effective organizational and management structure of the public health system**	Modernize and restructure the Ministry of Health through public administration reform programme
		Implement an effective and sustainable mechanism for the systemic strengthening of management and leadership capacity in the MOH and introduction of programmes for the continuous development of new technical competences
		Develop and implement a Customer Service Improvement Plan through the public health sector
		Establish effective service level agreements and ensure that they are systematically monitored to drive accountability, quality and performance
		Develop and implement a Public Private Partnership Strategy throughout the MOH, its departments and agencies
		Systemic publication on the performance of health system
4.3	**Strengthened National Health Information System and full compliance with the legal requirements for reporting to the notification system**	Effective implementation of the MOH Health Management Information System to ensure the availability of accurate data
		Strengthen Surveillance
		Full implementation of the eight core capacities of the International Health Regulations

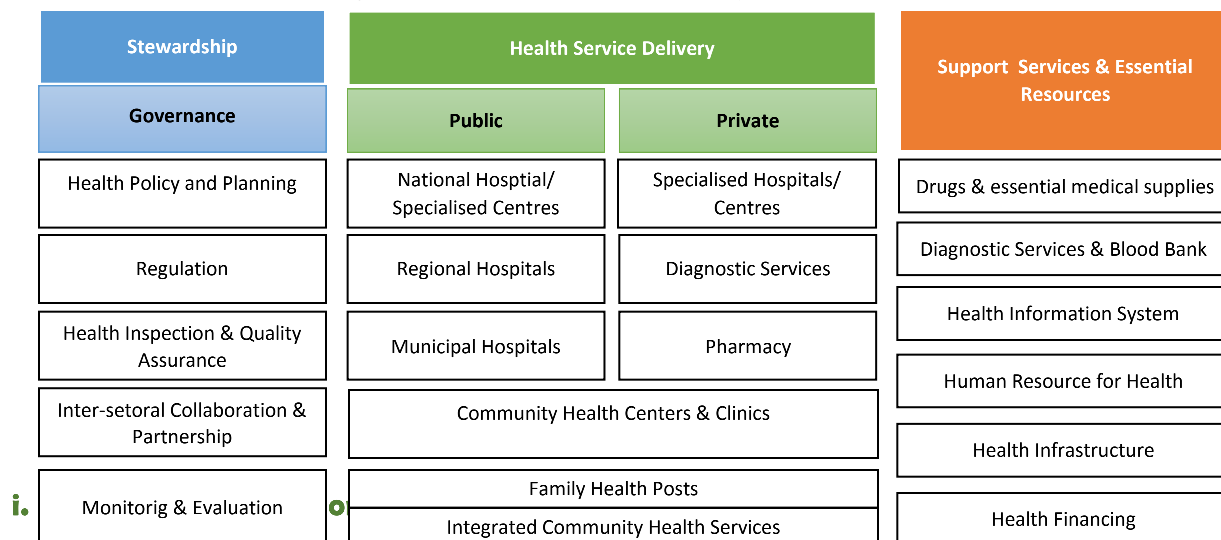
4.1 STEWARDSHIP ROLE OF THE MINISTRY OF HEALTH

The stewardship and governance of health systems, also called leadership, is arguably the most complex but critical building block of any health system. It is about the role of the government in health and its relation to other actors whose activities impact on health to oversee and guide the whole health system, private as well as public, in order to protect to public interest.

Stewardship and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability[6] . Accordingly, the National Constitution of RDTL[7] states that “all Timorese citizens are entitle to health care and the State has a duty to promote and protect this right free of charge, in accordance with its capabilities and in conformity with the law”. The Constitution further states that health services shall, as far as possible, be run within a decentralized participatory management setting.

Similarly, the National Health System Law[8] embraces the principles of a health system universally adopted by the World Health Organization (WHO), thus, defining Timor-Leste health system as harmonic and structured health system, which includes “all the organizations, institutions, and resources that are devoted to producing health actions” and will allow for exercise of the right to health protection. This definition includes the full range of players engaged in the provision and financing of health services including the public, private sector for-profit and non-profit, as well as international and bilateral donors, foundations, and voluntary organizations involved in funding or implementing health activities.

Figure 24: Revised National Health System Framework



[6] WHO (World Health Organization). Everybody’s business: Strengthening health systems to improve health outcomes, WHO’s framework for action. Geneva: World Health Organization; 2007.
[7] Article 57, Constitution of Democratic Republic of Timor-Leste, 2002.
[8] Health System Law No. 10/2004, of November 24th

The government has expressed, at the highest level, its commitment to Sustainable Development Goals (SDG) and Universal health Coverage (UHC). Pursuant to this commitment, the Strategic Development Plan 2011-2030 (SDP) provides the overall policy framework within which the Ministry of Health must assume its stewardship role. Strengthening health policy and regulation is essential to creating an enabling policy and legal environment for health system development.

The challenges ahead are for the MOH to enhance capacities for policy analysis and formulation, as well as develop appropriate mechanisms to support policy and legal implementation.

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

Strategies:

1. Institutionalise results-based planning and budgeting, and align to Government priority goals with formalised mechanisms for prioritization during the remaining timeframe of execution of NHSSP;
2. Update health policies, legislations and regulations
3. Strengthen institutional regulatory capacity for the enforcement of health policies and laws
4. Enhance institutional regulatory mechanism for the registration and licensing of health professionals and health services providers
5. Legislative, organisational and administrative reform of management structures, systems and procedures in the MOH to respond effectively to the change agenda;
6. Disseminate all legislation and policies applicable to the health sector to all levels of the health service delivery system, community representatives and the private sector;
7. Develop a system of coordination and monitoring implementation of health sector policies and legislations; and
8. Strengthen capacity of MOH for health sector policy formulation, analysis and implementation.

Expected Results:

1. Health policy direction and standard procedures regulated;
2. Obligations under law are met;
3. Improved supervision and regulation of private services;
4. Increased public participation in decisions about health;
5. Improved accountability and effectiveness of the health system
6. Improved stewardship of the sector by the MOH.

ii. Health System Responsiveness & Quality Improvement

Improved health outcomes are closely linked to health system responsiveness and accountability. Performance of health services on the supply side, and public awareness of patient rights on the demand side puts high pressure onto the system to acknowledge ensuring that all quality functions are met through different institutions within the system.

Quality improvement presents a huge challenge to all stakeholders in the health sector and beyond. It is pivotal to health services delivery and behavioral change/health promotion for it is concerned with issues such as equity, accessibility, effectiveness, efficiency, appropriateness and responsiveness.

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

Goal:

- Provide evidence based for planning and implementation in order to improve responsiveness to population health needs; and
- Strengthen leadership, management for quality improvement and organizational capacity within the health sector.

Strategies:

1. Strengthen the capacity of health personnel to ensure accountability and responsiveness to their assigned tasks;
2. Strengthen the HMIS capacity to monitor health sector performance, particularly at the district level, through intensive training skills development, upgrading manuals and through making ICT linked by internet to a central data warehouse;
3. Improve research capacity in the MOH and mandate for National Health Research Advisory Committee in an effort to institutionalize health research at various levels of health care;
4. Establishment of a National Public Health Regulatory Authority Body which includes the Pharmaceutical Regulatory Authority, Food Safety and Quality Control Services;
5. Develop guidelines for mainstreaming gender issues in health sector planning, in line with the National Gender Policy;
6. Strengthening mechanism for coordination and harmonization of various information through epidemiological surveillance media and communication techniques;

7. Establish National Health Council that will have a quasi-judicial mandate to protect the right to health, while at the same time ensure appropriate Licensing, Registration, and Professional Ethics within the National Health System;
8. Institute an Internal Audit program under the Office of Health Inspectorate that will provide a comprehensive, internationally recognized system of financial audit and inspection of MoH operational activities.

Expected Results:

1. Institutionalised capacity in the health sector for quality improvement and assurance;
2. Culture of quality management in the health sector is developed;
3. Health Professional Competency Tests institutionalised a pre-requisite for professional practice;
4. Improved quality of health services sector-wide;
5. 90% of service recipients satisfied with the care provided;
6. Health Professional Council established to contribute towards improved professionalism and ethics, as well as the enforcement of standard competencies and health practice regulations.

iii. Gender Equity

The concept of gender equity recognizes that women and men have different needs, power and access to resources, and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.

International and national data show that men experience higher mortality and lower life expectancy than women around the world, while women tend to experience better healthy life expectancy but years living with ill health than men, although this varies across the lifespan and in relation to specific conditions.

Women and men also use health care differently, with the former consulting more often than the latter, particularly in Primary Health Care, Men's underuse of some services also needs to be recognized and addressed.

Awareness of gender mainstreaming and affirmative action for women is low within the MoH. Surprisingly, the National Health System Act 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.

The health sector in Timor-Leste is atypical internationally in that there are far more men working in the system than women. 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.

Goal: ensure fairness and justice in the provision of health care services and well as in the distribution of power, resources and responsibilities between women and men.

Strategies:

1. Promote gender mainstreaming in the MOH;
2. Improve awareness of gender issues throughout all health programmes and the health workforce;
3. Provide affirmative action techniques to the appointment of women to management and senior clinical posts in the MOH;
4. Strengthen the role of male health professional in sexual reproductive health;
5. Monitor and evaluate violence against girl's women impact on policies, services and programmes.

Expected Results:

1. Improved access to quality health services for women, children and adolescents;
2. Appropriate representation (on the basis of gender proportionality) of women in decision making posts at the different tiers of the health system;
3. System in place at Hospitals and Community Health Centres to confidentially deal with cases of physical and sexual violence;
4. Improved collaboration with community leaders (men and women) and with women's organization that caters for rights, health and wellbeing of women and girls;
5. Gender-disaggregated data becomes routinely available and captured by the Health Management Information System (HMIS).

iv. Inter-Sector Collaboration and Partnership

The vision statement of the MOH acknowledges the multi-dimensional nature of health and the wide range of determinants influencing health status.

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.

Similarly, the MOH has sought to adopt an inter-sectoral approach to strategic planning. With the production of the Inter-sectorial Action Framework document and the formation of Inter-

sectoral Working Group (comprised of several ministries), 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.

The main **goal** is to build consensus among different sectors and partners to develop a culture of quality in public and private health service delivery and management through the use of MOH quality practice and professional standards.

The imperative to act intersectorally remains urgent. For meaningful implementation of the NHSSP, it is vital that the MOH embraces the following **Strategies**:

1. Mapping all health stakeholders;
2. Strengthen partnership and sector's cooperation department through capacity building and training;
3. Re-energises the Inter-sectoral Working Group through the scheduling, chairing and agenda setting of regular (quarterly) meetings as stipulated in the Framework;
4. Organises meetings with individual ministries to mutually determine action plans to foster collaboration and coordination;
5. Promote collaboration for integrated community development through joint planning, monitoring and evaluation;
6. To nurture public-private partnership for the provision of quality services in a harmonized and complementary manner;
7. Develop and implement a system for collecting accurate information about the capabilities of the private health care providers and their activities, in order to assess and channel their contribution to national health priorities; and
8. Review and strengthen financial reporting, transparency, accountability, monitoring and evaluation of inter-sectoral programs and activities.

Expected Results:

1. Health stakeholders and partners listed as per the areas and programs of intervention;
2. Regular (three monthly) liaison meetings are held between the MOH, Development Partners and the NGO sector to foster common interests and share information;
3. A more constructive mechanism in place to activate and energise sector-wide thinking between external partners and the Ministry;
4. Standard Memorandum of Understanding that articulates the basis for exchange between the Ministry and all its development partners developed (including broad goals of collaboration, a code of conduct) and an agreed mechanism and process for conducting joint technical sector-wide reviews;

5. Qualified personnel trained to manage external aid and partnership agreements in the health sector.

4.2 DECENTRALIZATION

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

The role and functions of the central level are to develop health policies and regulations, establishing standard for health services, setting priorities, national planning and budgeting, donors' coordination, management of national programs, monitoring and evaluation of the health system and safeguarding equity through resource allocation mechanisms such as cross subsidy.

On the other hand, the Municipal Health Services are gradually takin on more role in developing and implementing their own "…plan, supervise, coordinate, monitor and evaluate all health activities at the local level.

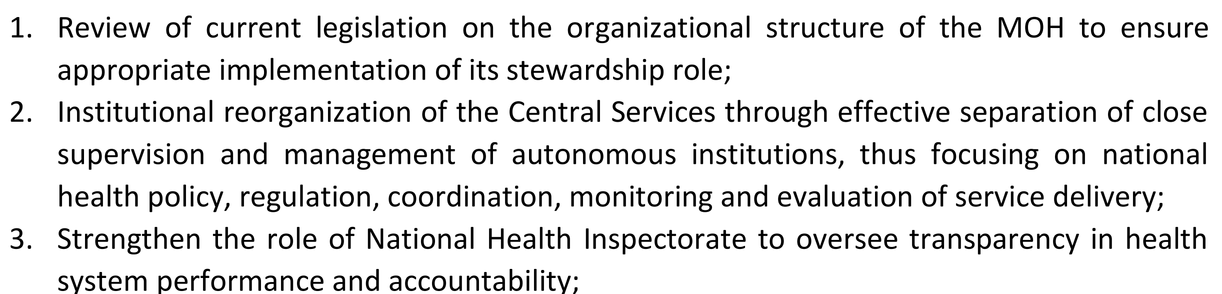
The journey towards institutional maturity of the MOH will require strengthening the organizational and management capacity at all levels, with clearly defined roles and responsibilities and appropriate balance between central governance functions and local service delivery functions.

The **goal** is to:

a) Ensure the full implementation of the stewardship role of the MOH as a policy-maker and regulator of the health system, provision of all the support services to the sector, while ensuring its appropriate financing system; and
b) Efficient and effective organization and management of health service delivery at Municipalities, following national priority for improving access to quality health care.

Strategies for goal a):

1. Review of current legislation on the organizational structure of the MOH to ensure appropriate implementation of its stewardship role;
2. Institutional reorganization of the Central Services through effective separation of close supervision and management of autonomous institutions, thus focusing on national health policy, regulation, coordination, monitoring and evaluation of service delivery;
3. Strengthen the role of National Health Inspectorate to oversee transparency in health system performance and accountability;



4. Introduce new management arrangements for the General Directorate of Health, focusing on corporate thinking and organizational values in promoting and institutionalizing behavior change for result-oriented actions across the central services;
5. Extend the role of Protocol and Communication Office at central and district health services for improve marketing and advocacy of health related issues and practices.
6. Strategies for goal b):
7. Development of Health Sector Decentralization Framework to include the following aspects: the operational objectives of decentralization; the resources, functions and authority that are to be transferred, and to which levels; the authority relationships between the various levels; adapting the organizational structure to the changes; strengthening the decentralized units; inter-sectoral collaboration and community participation;
8. Build appropriate management capacity at district level, especially the District Health Management Teams and Committees with consultative roles to the Government on health related development issues, health planning and program oversight;
9. Establish community health committees to voice community interests and health issues in the wider district health management networks.

Expected Results:

1. Restructuring of the health sector completed by 2022;
2. Municipal Health Committees all established, with clearly defined roles and responsibilities by 2023;
3. Autonomous status of Personalized Health Services reinforced and strengthen by 2024;
4. Marketing and communication of major health policies and programs strengthened;
5. Corporate management culture and practices gradually introduced and strengthened at central level;
6. Health Sector Decentralization Framework fully operational by 2024;
7. Municipal health management capacity strengthened and fully responsive to their roles and responsibilities by 2024;
8. Lines of communication and coordination between the Municipal Authorities and different levels of health services clearly defined and strengthened.

4.3 HEALTHCARE SERVICES' CONFIGURATION

The Government is determined to improve the access to and equity of essential health care services and to ensure that health sector plays its essential role in the realization of SDP 2030 goals. As a signatory of the Agenda 2030 with its internationally defined Sustainable Development Goals (SDGs), Timor-Leste has expressed its commitment to reach these targets in the remaining ten years by incorporating these and other national targets into the annual operational plans to inform and guide priority interventions and resource allocation.

However, the Health care delivery services in Timor-Leste is disease centric with inefficiencies produced as hospitals engage in providing services to patients that can be more effectively provided at Municipal Health Services. Although there is a wide network of health centres categorised according to geo-demographic characteristics of the population they serve, they are underutilised due to issues with service availability and accessibility as well as a decided preference amongst the populace to use hospitals as the first point of care.

There is a need for greater coordination between the levels of care as the referral system is not effectively utilized leading to inefficient use of resources and an added burden to secondary and tertiary health care facilities. Currently Guido Valadares National Hospital is overcrowded with patients who could be more cheaply treated in other referral hospitals and Community Health Centres. Thus, efficiency gains and improved access to care will be enhanced through a well-functioned referral system.

Worldwide, hospitals are undergoing essential changes in the way they are organised, managed and the services they provide. Parallel to new investments in hospital infrastructure and equipment, there is urgent need to re-orient the role of hospitals and modernise their management to improve response capacity, efficiency and health outcomes while increasing quality and patient safety.

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

- Ensuring a services package that is responsive to each level' needs
- Improving coverage and utilization of services
- Integrating national programs at central, municipal 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.

Figure 25 illustrates the current NHS configuration pyramid, with PHC as the foundation of health care service delivery.

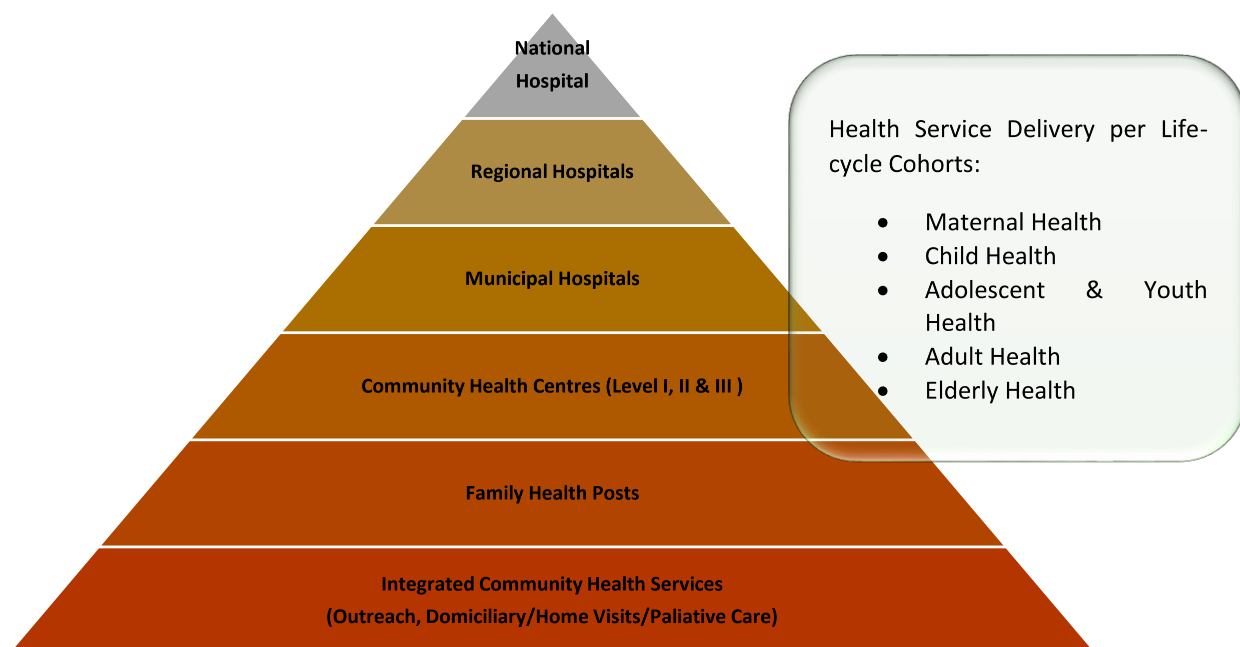


Figure 25: Health Service Delivery Pyramid

Improving efficiency in the utilization of services by strengthening the referral system is key to improving the quality and credibility of the health services at all levels. By ensuring the timely access to the appropriate level of services in case of life-threatening complications will result in more individuals/patients making more use of lower level facilities as opposed to higher level facilities and in the reduction of self-referrals.

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).

To complete the referral 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.

As such, national health services configuration encompass the following health units:

a) *Family Health Posts* are the interface between the community and the Community Health Centres. They are expected to organize and coordinate structured, permanent dialogue and interaction with families and individuals within a community, by undertaking:
    - Curative activities
    - Rehabilitative activities

- Preventive activities
- Promotive activities
- Electronic health registration (health profile) of the population in the catchment area
- Records-keeping and reporting on activities
- Micro-planning to ensure all communities in the catchment area are receiving essential package of PHC services

The Structure of the Services	Current situation	By the	2020-2024					Years 2011/2030
Years	**FY2019**	**2024**	**20**	**21**	**22**	**23**	**24**	**Years 2030**
Health Post	306	427	327	352	357	402	427	
Construction Plan		125	25	25	25	25	25	452

Existing Specifications	Additional requirement (expansion)
▪ 3 Consultation rooms ▪ 1 Emergency room ▪ Maternity Unit with 4 observations bed ▪ Laboratory room ▪ 2 Toilets ▪ 2 Waiting areas ▪ Drug dispensary ▪ Reception room ▪ Staff room	▪ Ramp for disability ▪ External toilets for (M, F and disability) ▪ Counselling room ▪ Emergency room

Figure 26: Investment Plan for the Family Health Posts, 2020-2024

b) *Community Health Centres* provides the services listed above for the population in their immediate catchment areas, and extends additional support services to Family Health Posts. This entails:

- Clinical supportive supervision of lower level facilities
- Adequate management of referred patients
- Providing logistical support to Family Health Posts in their catchment areas (e.g., medicines e consumables, EPI cold chain with the fridge and vaccines that are kept there to cover immunization needs)

- Coordinating information flow from facilities in catchment area
- Recognition and facilitation of referral to and from appropriate levels.

The Structure of the Services	Current situation	By the	2020-2024	Years 2011/2030

Years	FY2019	2024	20	21	22	23	24	Years 2030
Community Health Centre	65	70	67	67	68	69	70	
Construction Plan			5	5	5	5	5	70

Existing Specification	**Expansion of the existing**
▪ General Consultation room ▪ Paediatric Consultation room ▪ Internal Consultation room ▪ Treatment room (Injection) ▪ Observation room ▪ Delivery room ▪ Midwife room ▪ Nurse room ▪ Reception room ▪ Meeting room ▪ Manager room ▪ Doctor room ▪ Inpatient ward with 10 beds ▪ Medicine room ▪ Pharmacy room ▪ Laboratory room ▪ X-Ray room ▪ Kitchen ▪ Toilets for staff & public	▪ Emergency unit room with 4 observation beds ▪ Maternity unit with birthing rooms and 4 observation beds ▪ Dental Unit ▪ Ophthalmology unit ▪ Mental unit with emergency care ▪ VCT unit with HIV treatment room ▪ Public health unit ▪ Drug dispensary unit ▪ Laboratory unit ▪ Waiting area ▪ Inpatient ward with 10 beds ▪ Toilets for staffs and public ▪ Waste management area ▪ Administration unit ▪ Counselling room ▪ Ramp for disability ▪ External toilets for (M, F and disability)

Figure 27: Investment Plan for the Community Health Centres, 2020-2024

c) Municipal and Regional Hospitals are marked by a broader spectrum of specialized referral curative services aimed at ensuring that a wide scope of potential health needs of the

communities is solved at a point where they have access. These facilities also serve as internship centres for all cadres of health workers who function at the primary care level.

These referral hospitals will ensure that the following outputs are delivered during this NHSSP II:

- Specialized medical care is provided as defined in the comprehensive package of essential secondary health care services
- Outreach activities and clinical supportive supervision of lower level facilities
- Training facilities for cadres of health workers is carried out based on the requirements
- Internship capacity strengthening for health workers is provided
- Health sector activities in the respective Municipality and Regions are coordinated through the identified stakeholder forum.

The Structure of the Services	**Current situation**	**By the**	**2020-2024**					**Years 2011/2030**
Municipal Hospital	**FY2019**	**2024**	**20**	**21**	**22**	**23**	**24**	**2030**
FS&DED ▪ Viqueque ▪ Lospalos ▪ Manufahi	0	1	1	0	0	0	0	
Construction Plan ▪ Viqueque ▪ Lospalos ▪ Manufahi	0	3	0	1	2	3	3	13

Current Specification	**Ongoing Draft Terms of Reference (TOR) for Feasibility Study & Detail Engineering Design (DED)**
▪ Referral Emergency and ambulances unit ▪ Policlinic for specialized services unit ▪ Waiting areas ▪ Internal medicine services unit ▪ Paediatrician unit ▪ Obstetrician/Gynaecology unit ▪ Medical rehabilitation unit ▪ Radiology unit ▪ Laboratory unit ▪ Pharmacy and dispensary unit; ▪ Warehouse for logistics ▪ Laundry and dining lounge ▪ Kitchen ▪ ICT and medical record unit ▪ Waste management ▪ Biomedical unit	

Regional Hospital	FY2019	2024	20	21	22	23	24	2030
▪ General administration unit ▪ Parking unit.								
Feasibility Study & DED ▪ Ermera ▪ Natarbora ▪ Covalima ▪ Maliana	0	2	1	1	0	0	0	2
Construction Plan ▪ Ermera ▪ Maubisse ▪ Natarbora	2	1	0	0	1	1	1	5

Existing Specification	Expansion Plan
▪ Emergency unit ▪ Ambulance unit ▪ Obstetrician services ▪ Paediatrician services ▪ Internist Services ▪ Surgeon services ▪ Anaesthetist services ▪ Psychiatrist services ▪ Dermatologist services ▪ Ophthalmologist services ▪ ENT specialist services ▪ Orthopaedist services ▪ Urologist services ▪ Cardiologist services ▪ Neonatologist services	▪ Pulmonologist services ▪ Rehab-medic services ▪ Forensic-specialist services ▪ Dental specialist services ▪ Radiologist services unit ▪ Laboratory services unit ▪ Pharmacy and dispensary unit ▪ Laundry unit ▪ Kitchen & dining launch ▪ ICT and medical record ▪ Waste management ▪ Biomedical unit ▪ Administration ▪ Parking area

Figure 28: Investment Plan for Municipal and Regional Hospitals, 2020-2024

d) National Hospital completes the spectrum of specialised referral curative services as well as the scope of expected services to cater for the potential health needs of the population. It contains all the remaining specialised services that most efficiently provided at a national level, including training facilities for cadres of specialised health workers who function at the secondary and tertiary levels of health care.

National Hospital also serve as internship centre for all other staff not served at the referral hospitals, in addition to clinical research.

<table>
<tr><th>The Structure of The Services</th><th>Current situation</th><th>By the</th><th colspan="5">2020 - 2024</th><th>Years 2011 / 2030</th></tr>
<tr><th>National Hospital</th><th>FY2019</th><th>2024</th><th>20</th><th>21</th><th>22</th><th>23</th><th>24</th><th>2030</th></tr>
<tr><td>Feasibility Study & Master Plan GVNH</td><td>1</td><td>1</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td colspan="4">Existing Specification</td><td colspan="5">Terms Of References (TOR)
Target “Teaching Hospital” 600 beds</td></tr>
<tr><td colspan="4">▪ Emergency unit
▪ Ambulance unit
▪ Specialized policlinics
▪ Obstetrician unit
▪ Paediatrician unit
▪ Internist unit
▪ Surgeon unit
▪ Anaesthetist unit
▪ Psychiatrist & Emergency unit
▪ Dermatologist unit
▪ Ophthalmologist unit
▪ ENT specialist unit
▪ Orthopaedist Unit
▪ Urologist unit
▪ Cardiologist unit
▪ Neonatologist unit
▪ Pulmonologist unit
▪ Rehab-medic unit
▪ Forensic-specialist unit
▪ Dental specialist unit
▪ Radiologist unit
▪ Plastic surgery unit
▪ Pathology clinic unit
▪ Paediatric pulmonologist unit
▪ Endocrinologist unit
▪ Pathology anatomy unit
▪ Paediatric surgery unit
▪ Head-neck surgery
▪ Infertility treatment unit
▪ Paediatric neurologist unit
▪ Oncologist unit
▪ Geriatric unit
▪ Cardiovascular surgery unit
▪ Haematologist clinical/Pathologist unit</td><td colspan="5">A. MEDICAL PROGRAM
▪ Ambulatory department
▪ Emergency department
▪ Inpatient department
▪ Paediatric & Maternity
▪ Central Operation Theatre
▪ Orthopaedic department
▪ Medical-rehabilitation
B. SERVICES
▪ Administration
▪ Back of house
▪ Clinical support services
▪ Clinical file & coding
▪ Central sterilization
▪ Medical gas
C. ACTIVITIES
▪ Auditorium & Education
▪ Mall & Cafeteria
▪ Green space
▪ Parking area
▪ Residential & Apartment</td></tr>
</table>

▪ Laboratory services unit ▪ Pharmacy & Dispensary unit ▪ Laundry unit ▪ Kitchen & dining lounge ▪ ICT and medical record ▪ Waste Management ▪ Biomedical unit ▪ Administration ▪ Parking area	

Figure 29: Investment Plan for the National Hospital, 2020-2024

Overall, the **goal 1** for National Health Services Configuration is to:

- Strengthen Primary Health Care facilities through implementation of the standard Comprehensive Essential Package in a revised and renewed organizational structure of Municipal Health Services
- All Hospitals, specialized health care facilities and support services are modernized to provide efficient and quality service in a safe and aesthetically pleasant environment

Strategies:

1. Develop and essential health package that meets the needs of the population based on epidemiological and environmental profiles and in line with the social and economic forecast;
2. Reorganize community health centres to a three-tier system (level 1, level 2 and level 3) with strengthened and streamlined referral and linkage systems that offers a more equitable and a higher level of care/services based on demographic and health needs;
3. Upgrade and improve key infrastructure in hospitals and support facilities to improve efficiency and meet the demands of the population including the establishment of Centres of Excellence for mental health, cardiology, oncology, neurology and nephrology;
4. Mid-term strategic plans prepared by all Municipal Health Services, referral hospitals and the national referral hospital in consultation with the MOH and other stakeholders (including consumer representatives);
5. Provide the necessary resources required to ensure health facility readiness throughout the NHS;
6. Develop and implement a quality assurance program to assess and support clinical standards for all hospital-based specialty and sub-specialty areas as identified in the

hospital package of services established and used as the basis of monitoring quality of care;

7. 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;

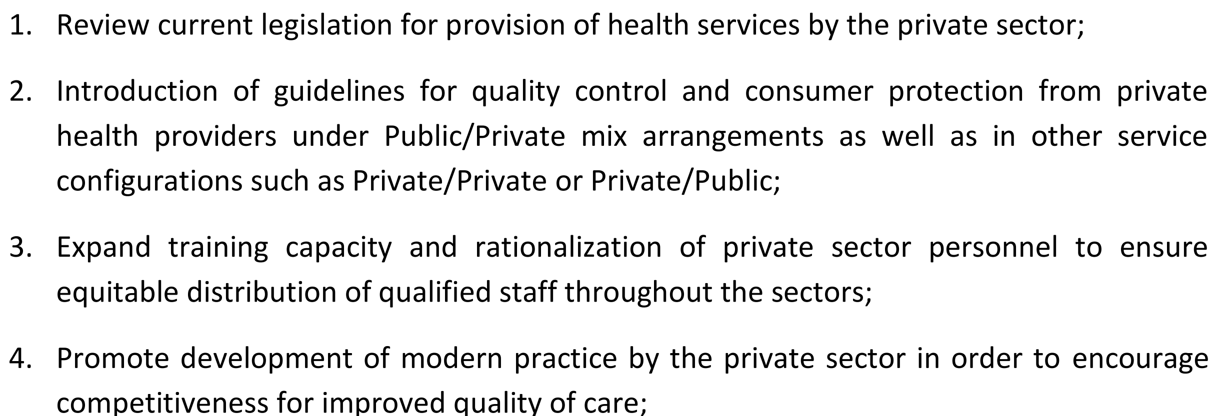
Expected Results:

1. Mid-term strategic plans produced and socialised;
2. Strategic plans identify priority specialty/sub-specialty areas in keeping with the health services directives and protocols;
3. Referral policies produced and socialised;
4. Operationalisation of human, financial and other resource needs through annual activity plans to ensure facility readiness;
5. Operationalisation of information management needs through facility annual activity plans;
6. Agreed systems of clinical triage, diagnosis, treatment and auditing implemented;
7. Clinical skills profile applied for use in determining capacity development needs;
8. At least 60% of all CHCs and Health Posts fill minimum requirements of health-facility readiness.

Goal 2: to increase coverage and consumer choice to efficient and quality health care services through participation of the private sector in health service provision.

Strategies:

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



5. Develop criteria for contracting-out services to the private sector strengthened through clear guidelines and enabling environment.

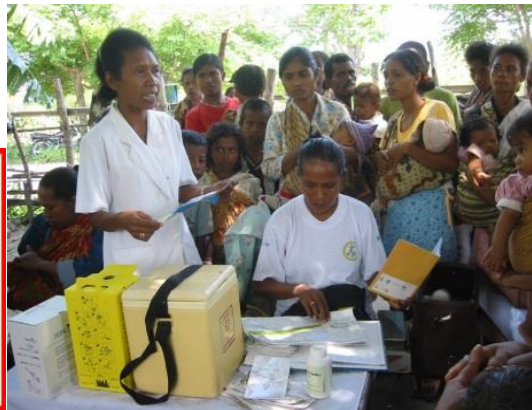
Expected Results:

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

OPTIONS FOR PRIVATE SECTOR PARTICIPATION IN NATIONAL HEALTH SECTOR	
OPTIONS	***RESPONSIBILITY***
Outsourcing nonclinical support services	Provides nonclinical services (cleaning, catering, laundry, security, building maintenance) and employs staff for these services
Outsourcing clinical support services	Provides clinical support services such as radiology and laboratory services
Outsourcing specialized clinical services	Provide specialized clinical services such as oncology, nephrology, cardiology and neurology
Private management of public health facilities	Manages public health facilities under contract with government and provides clinical and nonclinical services. May employ all staff and be responsible for new capital investment, depending on the terms of the contract.
Private financing, construction and operation of new public health facility	Finances, construct and operates new public health facility, and provides nonclinical or clinical services or both.

Table 3: Options for Private Sector Participation in the National Health Sector

SAÚDE
MATERNO
INFANTIL



SAÚDE DA CRIANÇA

PROTEGER E CUIDAR DE
ADOLESCENTES

Saúde
MENTAL

SAÚDE DO IDOSO

SAÚDE DO ADULTO

5. Health Service Delivery

<table>
<tr><td colspan="3">OVERARCHING STRATEGIC GOALS:
• Safe motherhood leading to healthy start for new-born and infants
• Healthy children and adolescents
• Mental health and wellbeing
• Healthy ageing
• Reduce mortality, morbidity and disability related to NCDS and their risk factors
• Reduce mortality, mortality, morbidity and disability due to communicable diseases
• Eliminate Neglected Tropical Diseases (NTDs) as public health problems
• Reduce the number of cases of death, disability, and illness, with emphasis on protection of the poor and vulnerable populations affected by emergencies and disasters</td></tr>
<tr><td colspan="2">STRATEGIC OUTCOMES</td><td>STRATEGIC ACTIONS</td></tr>
<tr><td rowspan="4">5.1</td><td rowspan="4">Strengthening Primary Health Care Facilities through implementation of the Comprehensive Essential Package in a revised and renewed primary care model of Saúde na Família in all Health Care facilities by 2030</td><td>Develop an essential benefit package that meets the identified needs of the population based on epidemiological and environmental profiles and in line with the social and economic forecast.</td></tr>
<tr><td>Transform structures and functions of health centres and health departments to effectively serve as the gateway to modern health services, procure the necessary equipment and new technologies, including green technologies and safe health facilities standards, and increasing their capacities to respond to population needs and demands.</td></tr>
<tr><td>Reorganize primary health care centres to a three-tiered system (Family Health Posts at Community/Level 1; CHC Level 2 at Administrative Post and comprehensive CHC at Municipal Level 3) – see annex 1 for proposed structure.</td></tr>
<tr><td>Create new and expand existing national health programmes that encourage community based involvement in health care provision.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="6">5.2</td><td rowspan="6">All hospitals, specialised care centres and support services are modernised to provide efficient and quality services in an aesthetically pleasant environment</td><td>Define and implement a comprehensive package of essential secondary and tertiary health care services, and support services in line with scientific/technology advancement and standards.</td></tr>
<tr><td>Identify, upgrade and improve key infrastructure in hospitals and support facilities to improve efficiency and meet the demands of the population including the establishment of Centres of Excellence for mental health, cardiology, neurology, oncology and nephrology)</td></tr>
<tr><td>Establish new facilities to increase capacity and meet new demands of the population. This includes the building of General Municipal Hospitals</td></tr>
<tr><td>Implement telemedicine to improve access to health care</td></tr>
<tr><td>Implement quality assurance and safety standards to assess and support delivery of health services in all public facilities</td></tr>
<tr><td>Strengthen management competences and the adoption of modern tools for management of hospitals and allied services</td></tr>
</table>

5.1 SAÚDE NA FAMÍLIA

To respond to current health challenges, Timor-Leste's health service delivery will need to improve and sustainably ensure access to comprehensive, quality, first level of care services with strong competencies for promoting healthy lifestyles and prevention, early detection, management and controlling chronic conditions, and the prevention of complex complications that lead to premature deaths.

Saúde na Família is a collective and integrated model of providing PHC services with activities focusing essentially on periodic home visits and the holistic monitoring of individuals and their families located within a defined geographic area, involving health professionals and, when necessary, professionals from other socio-economic sectors and determinants of health.

The implementation of health care services delivery, under *Saúde na Família* approach is based on the life cycle approach, following internationally recognized best practices.

Embedded within the Integrated Community Health Services approach or Serviço Integrado de Saúde Comunitária (SISCa), Saúde na Família strives towards the attainment of Universal Health Coverage as to ensure that *no one is left behind*.

Goal:

- To ensure access to quality and equitable Primary Health Care throughout the country;
- To be able to solve 80% of families and communities' health problems and needs;
- To ensure continuous, global and integral health care provision between and among different levels (primary, secondary and tertiary) following the widespread use of EHR throughout the national health system.

Strategies:

1. Establish Family Health Teams, at the level of Community Health Centers and Health Posts, dedicated to regular home visits to families in the respective geographic area and to organize adequate responses to the health problems and needs of the population, at home and in the different levels of health care provision;

2. Carry out actions to dispense households and integrate health information systems, including clinical, pharmaceutical and service performance monitoring applications, with the Electronic Health Registry;
3. Integration of preventive, curative and rehabilitation care, with education and health promotion actions, with special attention to the factors underlying the main chronic diseases and the protection of individual and collective health;
4. Adequacy of demand for hospital emergency services, through integrated care processes for acute and non-urgent diseases that can be treated at the level of provision of primary health care;
5. Inter-sectoral, individual and community involvement that promote participation in relation to socio-economic factors and health determinants;
6. Specialized and continuous training in Family Medicine for doctors, nurses, midwives, allied technicians and public health agents;
7. Institutionalization of the Electronic Health Record (EHR) system throughout the National Health Service, recognizing the different subsystems for the collection, analysis and processing of health statistics, including the regular publication of the health diagnosis of a given community, municipality or region and reports on the country's health profile.

Expected Results:

1. 100% of families visited and stratified according to pre-defined group BY 2024;
2. At least 50% of Head of Sucos involved in participatory diagnostic sessions alongside their communities;
3. Saúde na Família key indicators defined and disseminated in unison with comprehensive PHC package, including demographic indicators, process indicators, input, output and outcome indicators;
4. Teams of *Saúde na Família* formed and deployed by 2021;
5. Curriculum developed and post-graduate curse conducted on Family Health Program instituted.

a) Maternal Health

The WHO/ UNFPA/ UNICEF guidelines provide guidance for the integrated management of pregnancy and child birth: “Managing complications in Pregnancy and Childbirth, A Guide for Midwives and Doctors.” In support of the Safe Motherhood Initiative, the WHO “Making

Pregnancy Safer Strategy" focuses on the Health Sector's contribution to reducing maternal and newborn deaths. In addition, the Integrated Management of Pregnancy and Childbirth (IMPACT) is the technical component of the aforementioned strategy and mainly addresses the following:

1. Improving the skills of health workers through locally adapted guidelines and standards for the management of pregnancy and childbirth at different levels of the health care system;
2. Interventions to improve the health care system's response to the needs of pregnant women and their newborns, and to improve the district level management of health services, including the provision of adequate staffing, logistics, supplies and equipment;
3. Health education and promotion of activities that improve family and community attitudes and practices in relation to pregnancy and childbirth.

The **goal** is to ensure that the people of Timor-Leste can:

SDG 3.7

"By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes"

- Experience healthy reproductive development
- 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.

Strategies:

1. 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;
2. Increase the level of awareness in the population about matters relating to pregnancy and childbirth;

3. 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 Comprehensive Package of Essential PHC);
4. Conduct maternal death and perinatal audits to all maternal deaths in all facilities;
5. 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;
6. Provide confidential, sensitive and culturally and religiously appropriate health care services and counselling responses to victims of gender-related and sexual violence.

Expected Results:

SDG 3.1

"By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births"

1. Revised Reproductive Health and Family Planning policy document available and implemented;
2. Integration of STIs and HIV/AIDS services and programmes supported and sustained;
3. Programmes of community engagement on matters of gender-related and sexual violence developed and implemented;
4. All CHCs providing BEOC and all hospitals providing CEOC Services with appropriate personnel and equipment in place;
5. Mothers kept healthy during pregnancy and are able to have normal deliveries;
6. 85% of pregnant women recurring to ANC and post-natal care at least four times by 2024;
7. More than 80% of deliveries assisted at a health facility by 2024;
8. Normal deliveries at CHC and upwards only;
9. All newborns (up to 2 weeks) receive protection against preventable conditions;
10. By 2030, reduce maternal mortality ratio to less than 70 per 100,000 live births and halve neonatal mortality rate.

b) Child Health

WHO and UNICEF guidelines for Integrated Management of Childhood Illness (IMCI) offer simple and effective methods to prevent and manage the leading causes of serious illness and mortality in young child. The clinical guidelines promote evidence-based assessment and treatment, using a syndrome approach that supports the rational, effective and affordable use of drugs. The guidelines include methods for checking a child's immunization and nutrition status; teaching parents how to provide treatments at home; assessing a child's feeding and counselling to solve feeding problems; and advising parents about when to return to a health facility. The approach is designed for use in outpatient clinical settings with limited diagnostic tools, limited medications and limited opportunities to produce complicated clinical procedures. In each country, the IMCI clinical guidelines are adapted:

1. To cover the most serious childhood illnesses typically seen at first-level or primary health care facilities;
2. To make the guidelines consistent with national treatment guidelines and other policies; a
3. To make the guidelines feasible to implement through the health system and by families caring for their children at home.

SDG 3.2

"By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under -5 mortality to at least as low as 25 per 1,000 live births "

Goal: To scale up high-impact child survival interventions.

Strategies:

1. Revise and update the current Child Health Policy document to provide additional guidance on identified priority areas, to accommodate the service and programme directives of the Comprehensive Package of Essential PHC services and to better integrate community engagement within the core strategic areas;
2. Improve and consolidate child-specific case management knowledge and skills of all health practitioners;

3. Improve family engagement and community practices to ensure an integrated approach to IMCI throughout Timor-Leste;
4. Increase access in Timor-Leste to immunisation services to all especially those from vulnerable population sub-groups living in the remote and "hard to reach" areas;
5. Collaborate with all major stakeholders in operationalising immunisation strategic priorities.

Expected Results:

1. Adequate IMCI support systems in place and being utilised;
2. Improve and consolidate child-specific case management knowledge and skills of all health practitioners;
3. Approved referral system in place and being utilised appropriately for IMCI patients;
4. New vaccines and technologies adopted appropriately;
5. 100% of all hospitals provides quality pediatric services;
6. Training centres for obstetric-nurses and midwives expanded for in-service programs to specifically identified regions, with 70% of work placement of required midwives;
7. 95% of immunization coverage maintained for BCG-POLIO-DPTHep B-Measles by 2024;
8. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least 12 per 1,000 live births under-5 mortality to at least as low as 25 per 1,000 births.

c) Adolescent Health

Technical guidelines are provided in the "Global Accelerated Action for the Health of Adolescents (AA-HA!)" to support country implementation for coming of age of adolescent health within global health. More than 3000 adolescents die every day from largely preventable causes such as unintentional injuries; violence; sexual and reproductive health problems, including HIV; communicable diseases; non-communicable chronic diseases, mental health problems, poor nutrition, substance use, alcohol and tobacco. Although much research is still needed, effective interventions are available for countries such as Timor-Leste to act now.

The goal is to improve the health status of adolescents.

Strategies:

1. Prioritize the delivery of comprehensive and integrated adolescent-responsive health services at all levels of service delivery (prioritize allocation of physical space/room and commodities);
2. Scale up in-service adolescent health training of health professionals and workers;
3. Strengthen the policy and regulatory framework for provision and access of adolescent health services, including clear policies and guidelines on age of consent to Reproductive Health (SRH) and HIV services;
4. Increase demand and utilization of relevant health services through peer education, school health programs and outreach or domiciliary visits;
5. Design and implement targeted innovative Social and Behavioral Change Communication (SBCC) campaigns with adolescents to promote the use of preventive health services;
6. Promote changes in social norms and behaviors that affect the health and wellbeing of adolescents, such as Sexual Gender Based Violence (SGBV), child marriage, alcohol, tobacco and substance abuse, etc.

Expected Results:

1. National Adolescent and Youth Health Strategic Plan developed;
2. Behaviour change is promoted amongst adolescents that leads to a healthy lifestyle;
3. Adolescents are able to survive common health conditions affecting them;
4. Youth friendly environment is available at all health facilities;
5. Reduced teenage pregnancies among girls;
6. Adolescents are protected against sexual exploitation and abuse.

d) Adult and Elderly Health

Healthy adults are an asset to the country and are essential for societal productivity and economic development. Therefore, in order to optimise Timor-Leste's continued and sustained economic growth to successfully achieve SDP vision 2030, it is imperative to value the health and wellness of the adults.

Similarly, effective community-based primary health care is essential in order to support healthy ageing. Many of the priorities for adults remains in this cycle, with particular emphasis on the prevention and care of chronic diseases. Expenditure on health increases significantly in this stage, and it is therefore imperative that health is addressed in conjunction with social care.

Physically and mentally healthy adults can be more focused at workplace, can contribute to the prevention of many chronic diseases, have more energy and confidence, and are able to be more productive, thereby supporting healthy communities and societies.

Mental health is of equal priority for the elderly. There are three subsets to healthy ageing that must be provided for to ensure comprehensive health of the elderly. These subsets are: healthy biological ageing, defined as the "maintenance, post maturity, of optimal physical and cognitive functioning for as long as possible, delaying the onset and rate of functional decline". Functional ageing is the cognitive and physical capabilities to carry out essential tasks on a daily basis, and wellbeing can be viewed as positive emotional health, engaging in meaningful societal relationships, leading a meaningful life and maintaining independence.

The **goal** is to improve the health status of the adult population while also improving access to quality health care services for elderly population.

Strategies:

1. Conduct C-DOTS activities and defaulter tracing;
2. Raise awareness of non-communicable disease control;
3. Care for chronically ill through palliative care at home or adequate facilities;
4. Equip adults and the elderly population with knowledge and skills for health and key health messages to promote adoption of a healthy lifestyle and care seeking;
5. Assist with ensuring integrated family health services delivery;
6. Promote participation in actions for health education and promotion.

Expected Results:

1. Adults and Elderly persons are practicing a healthy lifestyle;
2. Adults and Elderly persons are able to survive common health conditions affecting them;
3. Elderly persons are protected against exploitation and abuse;
4. Elderly friendly environment is available at all health facilities.

e) People with Special Health Needs

All citizens and residents who meet the WHO definition of disability as "an umbrella term for impairments, activity limitations, and participation restrictions" (World Health Organization, 2017). The term 'special needs' as used in this document is interchangeable with 'disability' and

is meant to include any physical, developmental, sensory, behavioural, cognitive or emotional impairment that may limit a person's ability to perform daily self-maintenance or social and life activities.

Goal: Improve access to quality health care services for people with disability as well as management of early treatment of trauma and substance miss-use in Timor-Leste.

Strategy:

a. Strengthen outreach activities and increase community participation in the health care program to people with special needs in order to improve early detection of disability;

b. Promote research and development to better understand the epidemiology of children and adults with special needs in Timor-Leste;

c. 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;

d. 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; and

e. Strengthen inter-sector coordination to promote awareness of people with special needs and increase greater access to health care, education and employment.

Expected Results:

a. 40% of health facilities have access for people with disability by 2024;

b. Injury/trauma prevention and control strategy document prepared and used;

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

d. Substance abuse strategies produced and disseminated across the MOH and partnership sectors;

e. Coordination forum established between the health sector, social solidarity, education, labor and public works to improve the lives and wellbeing of people with special needs.

5.2 CONTROL OF COMMUNICABLE DISEASES

Overall Goal: 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.

SDG 3.3

"By 2030, end epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases"

a) Mosquitoes Born Disease (Malaria & Dengue)

Goal:

- To prevent the re-introduction of malaria transmission in Timor-Leste
- To receive malaria elimination certificate from WHO

Strategies:

1. Strengthen malaria surveillance of indigenous and imported cases;
2. Build on the strategic foundations established through the production of the National Mosquito-Borne Disease Control Strategy for Timor-Leste;
3. Enhance case management through early case detection and delivery of effective antimalarial therapies;
4. Selective application of vector control measures based on the principles of Integrated Vector management;
5. Prevention measures to include bed net distribution, fogging and elimination of breeding sites, as well as improved rapid outbreak response;
6. Enable and promote research for improved policy formulation.

Expected Results:

1. Reduced cases of malaria to less than 10;
2. To maintain 0% of mortality rate due to local transmission;
3. 100% of all analysts and clinicians trained;
4. 80% of LLINs distributed to people who live-in high-risk areas;

5. % of LLINs distributed to pregnant mothers;
6. Vector control education and promotion activities conducted nationally every quarter;
7. 100% of outbreaks controlled.

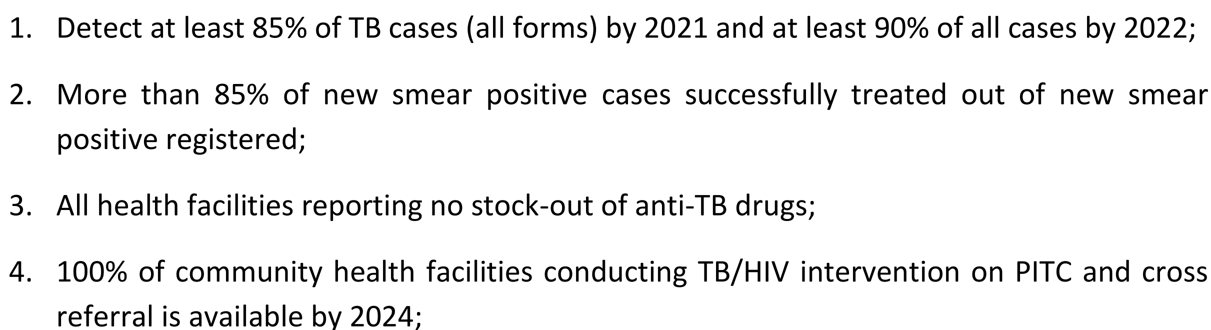
b) Tuberculosis

Goal: To achieve a rapid decline in incidence, mortality and morbidity due to TB while moving along the path towards ending TB by achieving a reduction in the incidence of all forms of TB.

Strategies:

1. Build on the strategic foundations established through the production of the National Tuberculosis Strategy, while integrating ongoing on-going strategic activities to the role and functional delineations of the comprehensive package of health care services;
2. Enhancing access to TB diagnostic and treatment services that are accountable to clients and based on human rights approach;
3. Scale-up of response to emerging challenges of HIV-TB and MDR-TB;
4. Strengthening system to effectively deliver quality services to all TB patients with complementation from NGOs/ CBOs/ FBOs;
5. Promoting adoption of international best practices amongst all care providers;
6. Innovative community lead initiatives for delivering care and support for TB patients;
7. Research to collect relevant baseline data and monitoring efficacy of interventions in local context;
8. Adopting partnership approach to involve all national and international stakeholders working with the national TB program.

Expected Results:



1. Detect at least 85% of TB cases (all forms) by 2021 and at least 90% of all cases by 2022;
2. More than 85% of new smear positive cases successfully treated out of new smear positive registered;
3. All health facilities reporting no stock-out of anti-TB drugs;
4. 100% of community health facilities conducting TB/HIV intervention on PITC and cross referral is available by 2024;

5. All training institutions incorporate DOTS and DOTS Plus in pre-service training curriculum of medicine, nursing and pharmacy;

6. More than 65% of private health providers are involved in community and patient groups to ensure appropriate implementation of TB program;

7. Significant reduction of TB Incidence and prevalence rates reported every four years.

c) Sexual Transmissible Infections & HIV-AIDS

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

Strategies:

1. Prevention of HIV and Sexual Transmissible Infections (STI) through awareness, enabling environment and promoting behavior change communication;

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

3. Strengthening monitoring and evaluation and capacity building of human resources;

4. Support community-based organizations and inter-sector engagement in behavior change communication and prevention initiatives;

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

6. Treatment and care to all HIV infected and affected individuals;

7. Information management to better understand the HIV and STI situation.

Expected Results:

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

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

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

4. Community based palliative care protocol developed and implemented with 25% of AIDS patients receiving continuous care;
5. 90% of key population and vulnerable groups in Timor-Leste will be reached with information and have knowledge about HIV and how to prevent it;
6. HIV testing provided to 100% of people seeking STI treatment services and 100% of people with TB;
7. 90% of all people living with HIV will receive antiretroviral treatment.

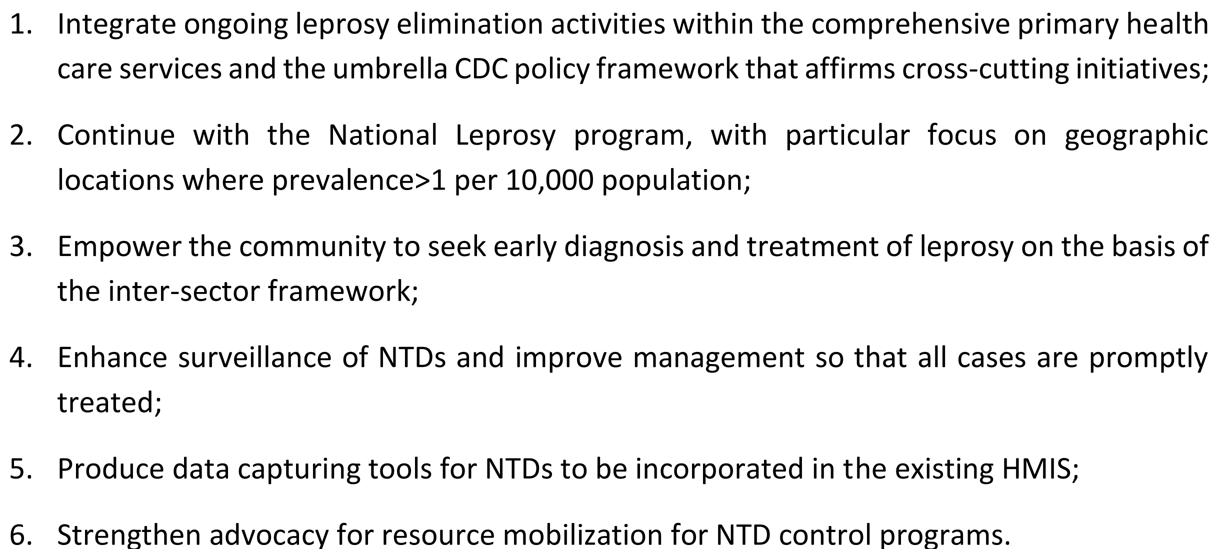
d) Neglected Tropical Diseases

Neglected Tropical Diseases (NTDs) area a group of infectious diseases that affect people in the tropics, and they present one of the largest economic and health burdens on the affected population due to their debilitating nature.

The endemic NTDs include lymphatic filariasis (elephantiasis), schistosomiasis (bilharziasis), soil-transmitted helminthiasis, trachoma, trypanosomiasis, leprosy, and taeniais. Timor-Leste is committed to control and eliminate these diseases, in line with the WHO resolution on NTDs as agreed during the 2012 World Health Assembly, and successful Mass Drug Administrations were scaled up in the country since then.

Goal: to eliminate leprosy at a sub national (municipal) level and have Timor-Leste free of NTDs.

Strategy:



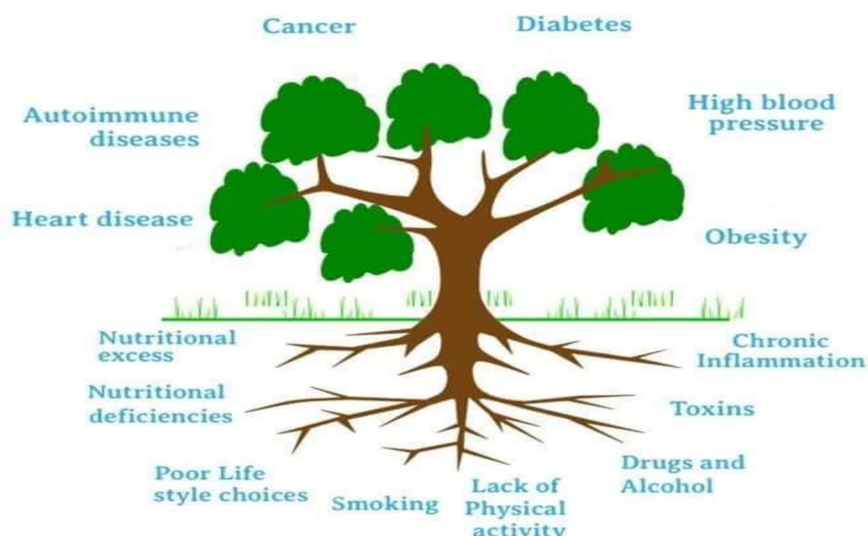
1. Integrate ongoing leprosy elimination activities within the comprehensive primary health care services and the umbrella CDC policy framework that affirms cross-cutting initiatives;
2. Continue with the National Leprosy program, with particular focus on geographic locations where prevalence>1 per 10,000 population;
3. Empower the community to seek early diagnosis and treatment of leprosy on the basis of the inter-sector framework;
4. Enhance surveillance of NTDs and improve management so that all cases are promptly treated;
5. Produce data capturing tools for NTDs to be incorporated in the existing HMIS;
6. Strengthen advocacy for resource mobilization for NTD control programs.

Expected Results:

1. 100% of community health care activities delivering education on leprosy;
2. Registration of cases of endemic lymphatic filariasis within the health information systems;
3. Prophylactic treatment against trachoma and schistomiasis fully reported;
4. All patients requiring rehabilitation services will be appropriately referred as needed;
5. Elimination of Leprosy and other NDTs by 2030.

5.3 CONTROL OF NON-COMMUNICABLE DISEASES

The term "non-communicable" diseases (NCDs) 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. In Timor-Leste, 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.



The WHO Package of Essential Non-Communicable Chronic Disease (NCCD) interventions for primary care in low-resource settings is an innovative and action-oriented response to health challenges faced by the adolescents. Efficient use of limited health resources, sustainable health financing mechanisms, access to basic diagnostics and essential medicines and organised medical information and referral systems are imperative for provision of equitable care for people with and risk of NCCD.

SDG 3.4

"By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being"

The WHO package is the minimum standard for NCCD to strengthen national capacity to integrate and scale up care of heart disease, stroke, cardiovascular risk, diabetes, cancer, asthma and chronic obstructive pulmonary disease in primary health care in low-resource settings.

a) Chronic Diseases

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

Strategies:

1. Produce a mid-term diabetes, Cardio Vascular Disease and Cancer prevention and control strategic plan for Timor-Leste that is integrated within the comprehensive and cross-cutting umbrella NCD framework;
2. Increase access and quality of age-friendly and old-age specific health services, with a focus on improving the skills of primary health care providers and introducing strengthening community models, such as home care programs;
3. Advocacy, partnership and leadership for a multi-sector response for prevention and control of NCD risk factors;
4. Improve health system response to early detection and management of NCDs at primary, secondary and tertiary levels of care;
5. Increase skills of health staff and equip all of health facility at different level to manage Chronic Diseases;
6. Continuous training of specialists in Internal Medicine, Cardiac Surgery, Intensive Care, Physiotherapists, Neurosurgery, Endocrinology, Oncology, Radiotherapist, Pathology, Urology, Otorhinolaryngology, Nephrology, Gastroenterology, Angiology, Orthopaedics;

7. Promote research studies and surveys on NCDs to inform development and implementation of policy interventions;

8. National campaigns on prevention and control of NCD, including promotion of healthy diet and physical activities;

9. Increase resources for screening, management and follow-up of NCDs patients;

10. Establishment of NCD Registry, including stroke, cancer and diabetes register.

Expected Results:

1. National and municipality level multisetoral committees constituted and functional for prevention and control of NCDs;

2. National policies and legislations developed and regulations enforced for prevention and control alcohol, tobacco and betel nut use;

3. Cardiac, Renal and Cancer centre, with palliative care units established and fully operational at HNGV;

4. Integrated addiction services for substance misuse and abuse (drug, tobacco and alcohol);

5. In-service training in diabetes, CVD and Cancer prevention, management and control for all health workers developed and included in IHS calendar;

6. National NCD and risk factor surveys such as STEPS, GYTS, GSHS and GATS among adult and adolescent population conducted at predefined intervals;

7. 70% of health facilities fully equipped and staffed for management of chronic diseases, following a comprehensive package of health care services.

b) Mental Health

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

Key strategies:

1. Scale up human resources for mental health by building the knowledge and skills for general and specialized health workers to deliver evidence-based, culturally appropriate and human rights-oriented mental health and social care services to identify, refer, assess, and provide treatment and support to people with mental disorders across all levels and disciplines of care;

2. Strengthen leadership and governance for a multi-sectoral response to mental health by engage stakeholders from all relevant sectors and establish mechanisms to empower people with mental disorders and psychosocial disabilities to have a formal role and authority to influence the process of designing, planning and implementing policy, law, and services;
3. Increase promotion and prevention strategies for mental health to create a more supportive and less stigmatized environment for people with mental disorders and psychosocial disabilities and encourage early assistance seeking behaviour without fear of discrimination or social alienation;
4. Ensure access to necessary infrastructure and equipment for service delivery including, the regular supplies of drugs and other consumables;
5. Improve the capacity of the human resource in the area of mental health by offering the scholarship for the training of psychiatrists, psychiatric nurses, psychologists, and technical professionals in mental health.

Expected Results:

1. Number of human resource for mental health produced (psychiatrist, nurse psychiatrist, psychologists) and integrated into the National health system;
2. Increase % of mental disorders and epilepsy treatments, monitoring and evaluation at municipals and hospital services;
3. Acute Care Facility established at National Hospital and at least two established at referral and district hospitals by 2024;
4. 75% of health facilities have access to mental health education and promotion materials;
5. A standard operational procedure (SOP) established to facilitate the recovery and social reintegration of patients with mental problems.

c) Oral Health

Goal: to improve oral health status of the Timorese People through evidence bases, integrated, multi-sectoral approach to oral disease prevention and control, oral health promotion, health systems development and enabling policies.

Strategies:

1. Build on the strategic foundations established through the production of the National Oral Health Strategic Plan while linking ongoing oral health strategic activities to the umbrella NCD policy framework that affirms integrated and cross-cutting initiatives;
2. To ensure access to appropriate oral health services to the population at all facility levels.
3. To reorient clinical service delivery from a curative model of care to a blend of promotive, preventive and curative interventions.
4. To promote community awareness and participation in priority target groups who are at risk of critical oral conditions.

Expected Results:

1. Integrated and coordinated approach to oral health illness management developed and implemented;
2. Priority focus on child and adolescent oral health and oral health as part of primary care
3. Increased number of scholarship opportunities to oral health professionals such as Dentists, Dental Nurses and Dental Technicians;
4. 75% of health centres implements oral health programs;
5. Baseline data on periodontal diseases and oral cancer in Timor-Leste registered and targets set by 2024;
6. At least 40% of primary and secondary schools participate in oral health promotion and education activities.

d) Eye Health

Goal: to reduce the prevalence of eye health problems in Timor-Leste.

Strategies:

1. 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 umbrella NCD policy framework that affirms integrated and cross-cutting initiatives;
2. Increase access to comprehensive high-quality eye care services;

3. To strengthen outreach activities and increase community participation in the eye care program at SISCa level;

4. Increase capacity of health staff to deliver eye care services at all levels;

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

Expected Results:

1. Development of eye care medium-term strategic plan;
2. 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;
3. Subspecialized eye health care services available at National Hospital;
4. Specialized eye care services is delivered at all referral hospitals;
5. Health facilities fully equipped and appropriately staffed to implement eye care programme.

e) Other Non-Communicable Diseases

Goal: Improve access to quality health care services for people with disability as well as management of early treatment of trauma and substance miss-use in Timor-Leste.

Strategy:

1. To strengthen outreach activities and increase community participation in the health care program to people with disability at SISCa level;

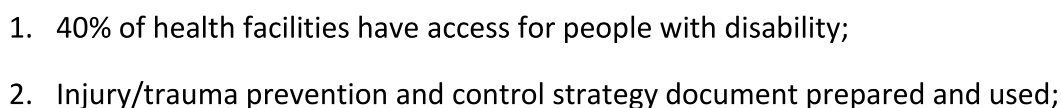
2. Produce a mid-term injury/trauma prevention and control strategic plan for Timor-Leste that is integrated within the comprehensive and cross-cutting umbrella NCD framework; and

3. 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

Expected Results:

1. 40% of health facilities have access for people with disability;

2. Injury/trauma prevention and control strategy document prepared and used;



3. Integrated and coordinated approach to injury/ trauma management includes data collection and analysis;
4. Substance abuse strategies produced and disseminated across the MOH and partnership sectors.

5.4 OTHER PRIORITY PUBLIC HEALTH PROGRAMS

a) Nutrition

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

Strategies:

1. Improve access and quality of nutrition services at facility and community levels for all live cohorts;
2. 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;
3. Promote diversity and consumption of locally produced food;
4. 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;
5. Strengthen nutrition information management system and surveillance.

Expected Results:

1. National programme of nutrient supplementation operational and functioning well;
2. Nutrient supplementation statistics utilised in decision-making locally and centrally;
3. Inter-government cooperation on nutrition issues working effectively;
4. Local home food gardens being monitored;
5. 60% of children under 6 months old are exclusively breastfed and at least 50% of under 1 year old receives appropriate complementary foods in addition to breastfeeding;

6. At least 50% of schools are implementing recommended feeding programs.

b) Health Education and Promotion

In 1986, the Ottawa charter redefined health promotion as "the process of enabling people to control over, and improve their health." Thus, 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.

Timor-Leste Behavior Change Communication (BCC) Framework for health promotion, guides the health promotion department of the MOH to "a set of integrated interpersonal, community-based and mass communication strategies, working along with community members and organizations, local institutions, research groups, national and community radio stations, national television and newspapers, health personnel and other stakeholders at district and national levels."[9]

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

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

Strategies:

1. Revise and update the current National Strategy for Health Promotion (NSHP).
2. Empower the community, by placing the people as partners and actors able to help each other in solving their own health problems and adopt healthy behaviors.
3. Reorient Family 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:
    a. healing environments for patients and their families

[9] Ministry of Health, 2007 BCC Framework for HP.

b. healthy workplaces for staff

c. leadership in environmentally sound practices

4. Strengthen partnerships to create a supportive environment for behavior change.
5. Integrate the health promotion approach into health programs.
6. Build the capacity of all health promotion personnel at all levels.

Expected Results:

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

c) Public Health Emergencies

Timor-Leste, like other countries, is challenged by recurrent disease outbreaks and other health emergencies of novel influenza strains in animals such as birds and pigs, such as H5N1, H1N1 and H7N9. Although most of these outbreaks and health emergencies area preventable, they result in unacceptably high morbidity, mortality, disability, and socio-economic disruptions.

The WHO has guided member states to use of the ‘all-hazards approach’, defined as ‘integrated hazard management strategy that incorporates planning for and consideration of all potential natural and technological ‘hazards’. In Timor-Leste, The Ministry of Health has developed, with technical support from WHO, the National Policy on Health Security, alongside an Action Plan in order to strengthen national capacity response to emerging and re-emerging diseases that can pose a very high risk to public health in the country.

In addition, the presence of antimicrobial resistance (AMR) in the country threatens the effective prevention and treatment of an increased range of infections caused by bacteria, parasites, viruses, and fungi.

The strategic **goals** across all stages and activities proposed in this plan will be to prevent the onset of emerging and re-emerging neglected tropical diseases, as well as to prevent, protect, control and provide public health response to the international spread of diseases by:

SDG 3.d

"Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks"

- Strengthening and sustaining the capacity to prepare for and prevent health emergencies;
- Minimizing transmissibility, morbidity and mortality through early detection, reporting and management of confirm outbreaks.

Strategies:

1. Review national legislation and policies to prioritise disaster risk management, health security, and international health regulation (IHR 2005);
2. Regulate the national list of diseases that require mandatory notification;
3. Develop mechanism for monitoring AMR;
4. Establish multisetoral operational framework for zoonotic diseases, emerging and re-emerging infectious diseases, and environmental risk factors using the 'One Health' approach;
5. Strengthen capacity of national health staff at Point of Entries (PoEs) on implementing the International Health Regulation (IHR 2005);
6. Develop of guideline and mechanism of Outbreak Response for other acute and viral infection diseases;
7. Strengthen public health emergency operations centre and partnership arrangements with both public and private actors, with standard operating procedures and trained staff;
8. Strengthen Monitoring & Evaluation.

Expected Results:

1. 100% of outbreaks reported within 48 hours of its occurrence;
2. Emergency Operation Centre in place at all Municipalities;
3. National Health Security Action Plan developed and disseminated;

4. National Authority on Health Regulation, Pharmacovigilance and Epidemiology Surveillance established;
5. All laboratory technicians and clinicians are trained on detection and treatment of suspected cases of major emergency disease outbreaks;
6. Training of multidisciplinary staff on IHR minimum core capacities;
7. Integrated emerging and re-emerging diseases Information System alert developed.

d) Environmental Health and Sanitation

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.

The Government of Timor-Leste is committed, through the promotion of cooperative inter-ministerial and development partner activity and through community engagement at central and local levels, 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 conditions, 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.

SDG 3.9

"By 2030, substantially reduce the number of deaths and illness from hazardous chemicals and air, water and soil pollution and contamination"

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.

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

Strategies:

Environmental Health Generally:	Establish a shared platform for environmental health practice across government and within population sub-groups in Timor-Leste;
Water:	Improve access to safe water in Timor-Leste in order to reduce waterborne disease;
Sanitation:	Improve sanitation and hygiene practices in Timor-Leste in order to reduce the incidence of faecal-oral transmitted diseases;
Food:	Reduce the risk of food-borne disease in Timor-Leste by ensuring adequate safeguards in food preparation, processing, transportation and storage
Vector Control:	Reduce illness and death in Timor-Leste from vector-borne diseases, especially mosquito-borne disease;
Waste Management:	Minimise the impact in Timor-Leste of human generated waste on the environment and on health;
Occupational Health And Safety:	Minimise occupational health risks and promote a healthy workforce in Timor-Leste;
Housing:	Strengthen health through the promotion of building and housing standards in Timor-Leste;
Air:	Improve indoor and outdoor air quality to minimise illness and death from respiratory and other air-pollution related diseases in Timor-Leste.

Expected Results:

1. Inter-sectoral environmental health guidelines and protocols prepared and publicised;
2. MOH water quality standards publicised;
3. MOH follow-up of sanitary inspection, source protection, disinfection at production points and disinfection at the point of use (household level) implemented;
4. Development of a comprehensive hygiene promotion approach to sanitation services;

5. 50% schools adopting MOH hygiene promotion approach to sanitation services and protocols;
6. Integrated vector control management systems in place;
7. Guidelines to support legislation on waste management developed and approved;
8. Comprehensive set of workplace standards and guidelines developed;
9. 40% of household reach category B of healthy house standard (based on KUBASA) by 2024;
10. 60% of public facilities, particularly schools, Health facilities and Public Offices have access to water, improved hygiene conditions and waste management system by 2024.

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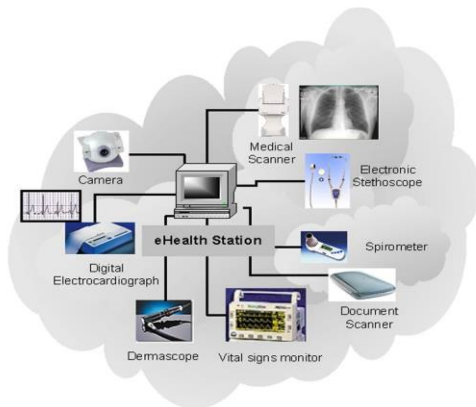
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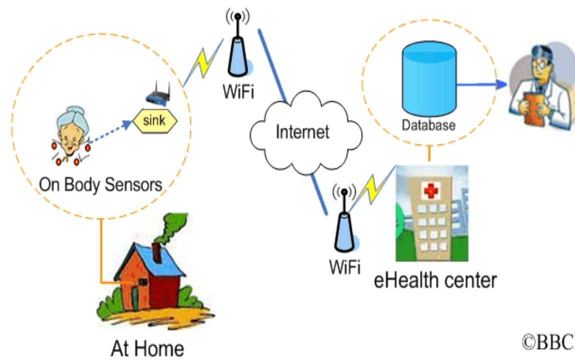
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6. Support System & Services

6.1 MEDICINES & ESSENTIAL MEDICAL SUPPLIES

Access to essential medicines and supplies is fundamental to the good performance of the health care delivery system. In Timor-Leste, 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.

Despite the approval of a new National Medicines Policy in 2018, the procurement, distribution and rational use of pharmaceuticals require a complex system of institutional, legal and policy related matters that together frustrate attempts to respond to the original aims of the Autonomous Medical Services (or SAMES I.P.).

Therefore, Legislation to enhance the commercial autonomy and administrative responsiveness of SAMES I.P. is yet to result in major advance and there are persistent problems in quality control, monitoring the presence of fake and substandard medicines on the market, growing drug resistance problems due to irrational use and self-medication in lieu of seeking qualified health care.

The **Goal** is to ensure timely and affordable access to safe, quality, effective medicines, vaccines and consumables.

SDG 3.8

"Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"

Strategies:

1. Revise and regulate National Medicines Policy, National Standard Treatment Guidelines and the National Essential Medicines List;

2. Strengthen mechanism for enforcing regulations to ensure compliance to the set standards for manufacture, importation, storage, distribution, sale, and use of medicines and allied substances;

3. Promote partnership arrangements for research and development on the use of traditional or alternative medicines in the country;

4. Undertake a thorough assessment of the supply chain comprising from SAMES I.P. to the lowest level (HPs) and develop supply chain strategy including SOPs for all and each level;
5. Develop SOPs to ensure efficient, cost-effective and ethical procurement, storage and distribution of essential drugs and medical supplies;
6. Develop and implement policy and protocols for equipment including standards for each level (revise current figures according to PHC ESP 2020) and SOPs for use, maintenance, repairs, etc.; Include plan to re-equip all facilities (in coordination with management strengthening programme9;
7. Strengthen pharmacovigilance activities and promote rational use of medicine in the country;
8. Strengthen management of medicines and pharmaceutical information system to facilitate effective monitoring of the supply chain, while ensuring adequate storage of pharmaceutical and medical supplies at all health facilities;
9. Undertake periodic baseline surveys on the use of medicines and medical supplies;
10. Build human resource capacity in pharmacy through pre-service training, in-service training and technical assistance.

Expected Results:

1. Approved Essential Medicines List updated is in line with the Standard Treatment Guidelines;
2. Have in place an independent National Regulatory Authority for Medicines and Pharmaceutical Products;
3. Improve the capacity of the country to obtain more affordable and equitable prices for medicines and other consumables;
4. Capitalization of SAMES I.P. realized by 2024;
5. Less than 10% of stock-out of essential medicines and consumables at all public health facilities;
6. Develop and implement M&E tools for supply chain management
7. Availability of well-trained and adequate pharmaceutical personnel.

6.2 HEALTH DIAGNOSTIC SERVICES

Appropriate laboratory and imaging support services are a critical factor in the diagnosis and delivery of quality health care services, as diagnostic tests can improve patient care, contribute to protecting consumer health and health limit healthcare spending.

While in theory about half of Timor-Leste's population has some access to these services, in practice this is much lower due to substantial equipment down time resulting from poor maintenance, lack of basic supplies and a shortage of trained technicians. Similarly, blood blank services are mandated to ensure nationwide, equitable and affordable access to blood and blood products, ethically collected and rationally used.

Therefore, it is imperative to address the establishment of a quality control structure within the MOH for central coordination and supervision of quality diagnostic and blood bank services in the country.

The main **goal** is to enhance access and quality of diagnostic services in Timor-Leste through a safe, efficient and cost-effective laboratory and imaging services to meet the needs of the health care system.

Strategies:

1. Strengthen National Health Laboratory management capacity in order to increase institutional effectiveness;
2. Develop and review relevant policy and legal framework in order to guide the provisional of diagnostic laboratories and imaging services in Timor-Leste, following national and international standards;
3. Develop action plan for the implementation of PPP for Diagnostic Services at Community Health Centres level II & III and Hospitals;
4. Build capacity for quality laboratory reagents, blood and imaging quantification, procurement and management;
5. Train and build capacity in all medical imaging categories;
6. Establish a Laboratory Management Information System, both electronic and paper based;
7. Strengthen coordination of Quality Assurance activities (clinical and equipment) among end users, biomedical engineers and health professionals;

8. Support implementation of QA committees for diagnostic health services and the establishment of National Diagnostic Regulatory Authority.

Expected Results:

1. Comprehensive package of diagnostic services developed and implemented;
2. Diagnostic Services Protocols and SOPs updated;
3. Quality assurance guidelines developed and implemented by 2024;
4. Planned preventive maintenance system developed and implemented every year;
5. Laboratory monitoring and evaluation system developed and implemented by 2022;
6. 100% of diagnostic equipment fully operational;
7. 90% of laboratory and imaging services providing accurate diagnostic results;
8. All hospitals have their imaging department implementing QI/QA activities towards accreditation standards.
9. National Diagnostic Regulatory Authority established.

6.3 HEALTH RESEARCH & DEVELOPMENT

Integration and institutionalization of research as an integral routine component of the health policy development and program implementation process is of critical importance, alongside the mobilization of resources for conducting relevant health 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. The National Health Institute is responsible for overseeing research and development programs in the health sector. However, the development of effective mechanisms and systems in setting out MOH and national program health research priorities is almost non-existent.

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

Strategies:

1. 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;
2. Facilitate dissemination of research results to all relevant stakeholders in order to maximize utilization of research outcomes;
3. Strengthening capacity to conduct applied health research in the National Hospital, and other statutory health bodies and training institutions.

Expected Results:

1. Health Research Centre established within the auspices of a new National Public Health Institute;
2. National Health Research Agenda priorities identified and published annually;
3. Grants/contracts for health system research annually provided;
4. Link between health research, health policy and programmes strengthened.

6.4 HEALTH MANAGEMENT INFORMATION SYSTEM

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

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

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

Strategies:

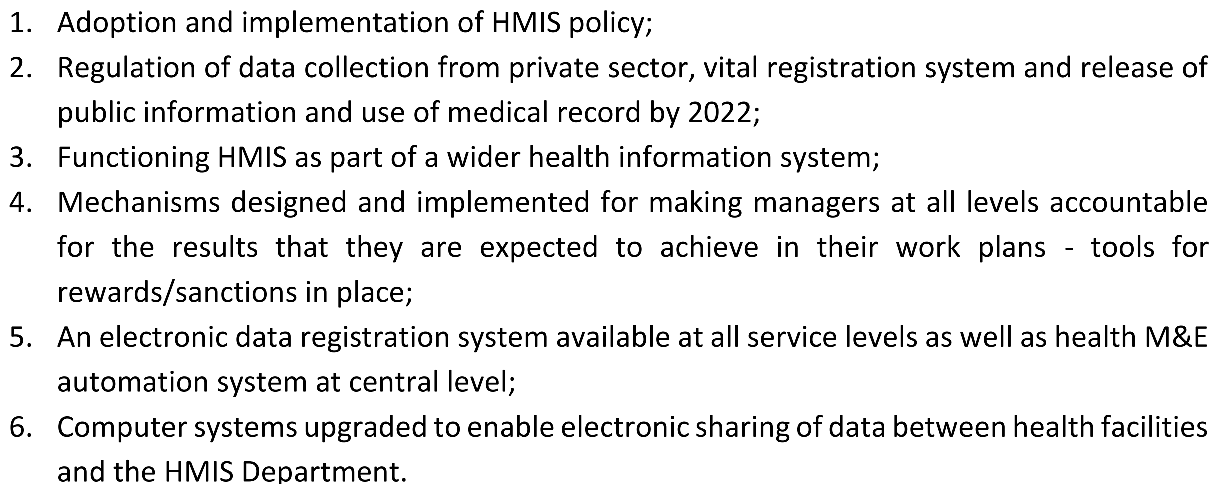
1. Definition and endorsement of national policy and legislation on HIS-related issues such as confidentiality of medical records, data collection from private sector, vital registration system, release of public information and use of electronic medical record;

2. Begin software development in 2021 after the HMIS, disease surveillance and hospital information systems have been fine-tuned, to ensure that they interface easily and smoothly with each other;

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

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

Expected Results:



1. Adoption and implementation of HMIS policy;
2. Regulation of data collection from private sector, vital registration system and release of public information and use of medical record by 2022;
3. Functioning HMIS as part of a wider health information system;
4. Mechanisms designed and implemented for making managers at all levels accountable for the results that they are expected to achieve in their work plans - tools for rewards/sanctions in place;
5. An electronic data registration system available at all service levels as well as health M&E automation system at central level;
6. Computer systems upgraded to enable electronic sharing of data between health facilities and the HMIS Department.

7. Essential Resources

SDG 3.c

"Substantially increase health financing and the recruitment, development, training and detection of the health workforce in developing countries, especially in least developed countries and Small Island developing States"

7.1 HUMAN RESOURCES FOR HEALTH

Health professionals and workers are the backbone of health systems. As such, they are central to the achievement of health outcomes.

A recent analysis conducted by the WHO and the MOH in the have recognized that staffing the health system is the rate limiting step to all the key reform objectives. Any expansion and scale-up operation for addressing equity of access requires adequate personnel, as does the move towards universal health coverage. Human resources are key to improving the quality and effectiveness of health services.

However, health workers are unevenly distributed – between urban and rural areas, and between the public and private sectors. The working environment, with deficient equipment, lack of drugs and irregular supervision, saps morale and effectiveness. There is, as well, a weak knowledge base in skills and competencies. These problems are interrelated and hamper planning and service delivery.

The Ministry of Health is committed to developing its human resource base through effective policy and making strategic choices in the area of human resource management (HRM) and human resource development (HRD). A comprehensive and balanced workforce strategic plan is expected to support the intended improvement of health system performance. In this regard, the MOH will work in close collaboration with the Civil Service Commission and the Public

Administration Reform Secretariat, which is spearheading the introduction of results-based management in the public sector.

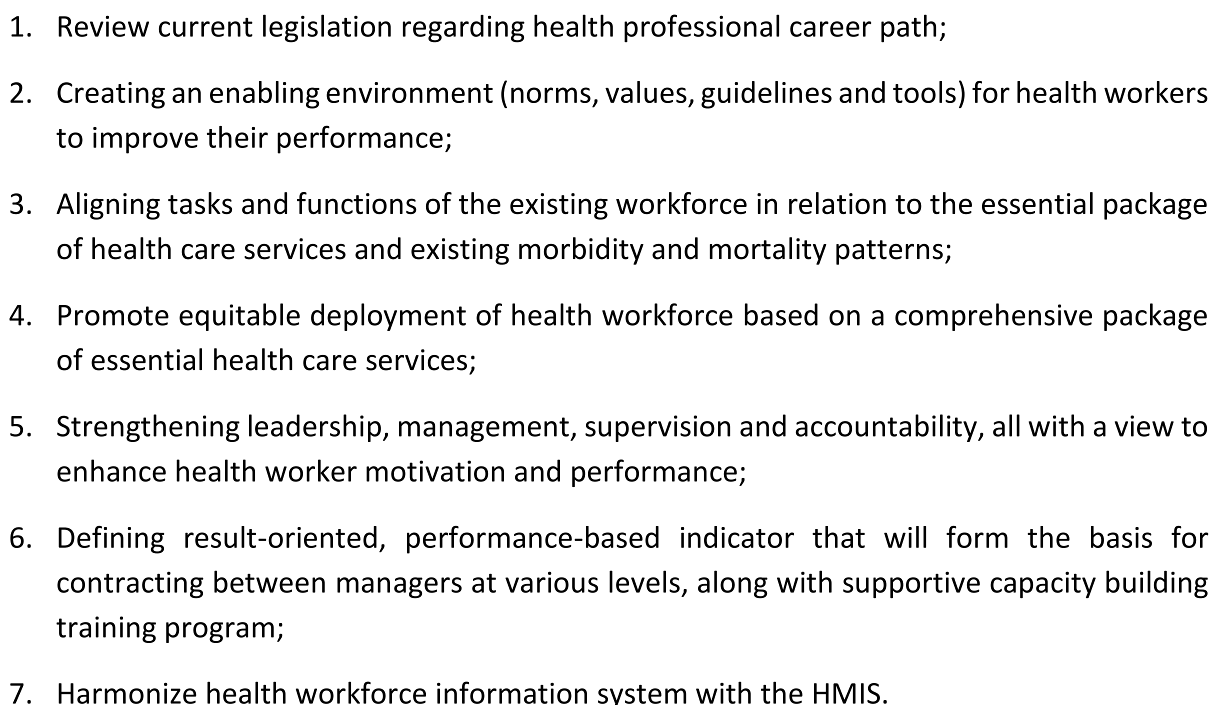
To arrive at such a situation, substantial preparatory work is needed to put the systems in place that will allow for this condition to be fulfilled, therefore, address the following NHSSP II **goals:**

- Develop the capacity for training and education institutions in Timor-Leste
- Strengthen health workforce management, including equitable distribution of health professionals, the availability of timely, reliable and relevant information required improve performance and motivation, as well as HR planning, monitoring and performance evaluation.

Strategies for Human Resource Development:

1. Review standards for minimum staffing needs;
2. Align health workforce scholarships and training programs based on health sector need assessment and gaps identified;
3. Promote the adoption and oversight of an independent accreditation authority for all health training institutions;
4. Strengthen the institutional capacity of the National Health Institute;

Strategies for Human Resource Management:



1. Review current legislation regarding health professional career path;
2. Creating an enabling environment (norms, values, guidelines and tools) for health workers to improve their performance;
3. Aligning tasks and functions of the existing workforce in relation to the essential package of health care services and existing morbidity and mortality patterns;
4. Promote equitable deployment of health workforce based on a comprehensive package of essential health care services;
5. Strengthening leadership, management, supervision and accountability, all with a view to enhance health worker motivation and performance;
6. Defining result-oriented, performance-based indicator that will form the basis for contracting between managers at various levels, along with supportive capacity building training program;
7. Harmonize health workforce information system with the HMIS.

Expected Results:

1. Numbers of various categories of staff to be recruited and deployed based on staffing needs assessment;
2. Training needs assessment elaborated to establish training requirements (and identify the gaps within the current training capacity) in the light of NHSSP II (by end of 2021) and relevant curricula developed;
3. % of junior and senior managers trained on leadership and management;
4. Redeployment of staff (over- and understaffing) addressed, in particular redeployment of nurses and midwives to accelerate the implementation of essential package of health care services at Community Health Centers and redeployment of doctors to poorly staffed referral hospitals;
5. Comprehensive human resource management guidelines elaborated, regulated and adopted - These guidelines will include revised/rationalized staffing norms (based on workload); transparent criteria for redeployment of staff; harmonization of employment schemes between various categories of employers (MoH, NGOs, FBOs); policies to enhance staff motivation and welfare and improve staff retention; the introduction of annual staff performance appraisals; and suggestions for the introduction of a functional performance-based remuneration system with incentives and/or promotion;
6. Results-oriented performance management introduced and operational among managers at all levels; performance standards and expected outputs defined and a supportive training program is in place;
7. Electronic staff tracking system in place and maintained by central MOH on the basis of regular reporting by all health institutions.

7.2 HEALTH INFRASTRUCTURE

The public health sector has been engaged in a program of rehabilitation and development of its physical infrastructure for several years. Notwithstanding the improvements that have been achieved, much of the health infrastructure, particularly the health centres, remains below acceptable standards.

Thus, a well maintained, modern and appropriate infrastructure will help to ensure that delivery of health services is efficient and cost effective.

A common definition of this work area has been developed as part of the norms and standards. Infrastructure in the health sector refers to four main components:

- Buildings: Medical and non-medical nature (health facilities, offices, storages and professional accommodations)
- Equipment: Medical and hospital
- Transport services of various types and categories

To achieve the objectives of NHSSP II, these four components of the health infrastructure must be integrated into a harmonious whole, together with other required inputs (especially human resources) to avoid mismatches in their development and ensure that health services are delivered efficiently, equitably, effectively and in a sustainable manner. This integration is embodied in the principles that underlie appropriate planning and management for health infrastructure.

The overall **goal** of the health sector in the area of health infrastructure will be to provide a functional, efficient and sustainable health infrastructure network to bring effective health care service delivery closer to the people.

Strategic interventions will focus on:

1. Develop standards for secondary and tertiary health care facilities in keeping with international best practice;
2. Advocate for the fiscal space for capital investment in order to retool the public health sector;
3. Improving health facility readiness and availability of quality of health services;
4. Establish a functional referral system by providing:
    - Communication equipment for consultation, referral and strengthening management;
    - Means of transport to facilitate referral;
    - A sustainable maintenance programme;
5. Designing the improvement plan activities in a manner that ensures infrastructure investment is always in sync with investments in other inputs and services, so that outputs from the resources invested are maximized;
6. Training of logistic and asset management personnel;
7. Setting up contract performance rating system for suppliers and infrastructure services providers;

8. Developing a procurement management information system (PMIS) for health infrastructure.

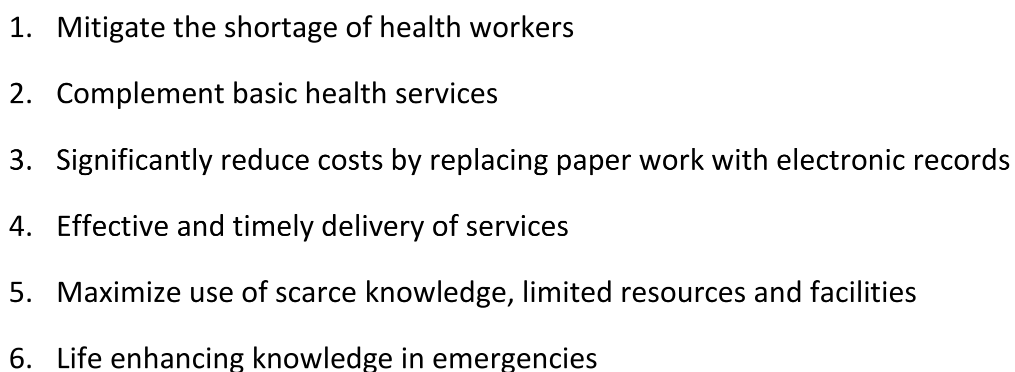
Expected Results:

1. Standard procedures for fixed assets management are in place;
2. Procurement management information system (PMIS) implemented;
3. Compliance to maintenance policy and guidelines available at all levels of health care services provision;
4. New Health Posts, 5 New CHCs and 3 Municipal Referral Hospitals build by 2024;
5. 60% of Primary Health Care facilities feel the minimum criteria for readiness;
6. 90% of equipment is repaired;
7. Transport inventory ready in 50% of the central and municipal health services and 100% hospitals, together with a maintenance plan for the fleet and capacity building for the drivers.

7.3 INFORMATION & COMMUNICATION TECHNOLOGY

Communication within the health sector has different meanings. In the NHSSP II it will relate to the range of communication channels that exist between the various levels of administrative responsibility (lines of reporting, horizontal and vertical) and medical care (communications needed for referral of emergencies). It will also refer to the information and communication technologies (ICTs) that are becoming increasingly essential to improve and facilitate such communication. The role of Information Communication Technologies (ICT) can no longer be ignored in health services. The health sector's relationship with information is distinct from that of other development sectors. Various reports underline its usefulness in health related efforts, especially when shortage of required Human Resources and other barriers limit the effective and efficient delivery of services.

Advantages of ICT implementation include:



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

Computers available at the existing health care facilities (hospitals and a number of community health centers) are limited to the rudimentary local function of data input storage (many times unreliable) and basic word and spread sheet processing.

Radio communication network set-up at the first years after independence are practically not functioning now, the clinical communication being done exclusively by the use of expensive and inefficient mobile telephony or paper work.

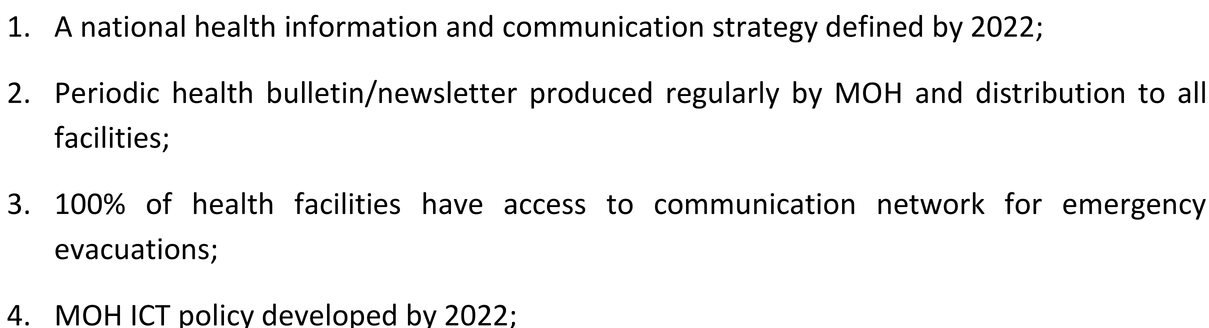
By looking at communication as a system, its imperfections and bottlenecks become clearer. In fact, much of the frustration and misunderstanding that have affected the sector could have been avoided if clear and appropriate guidelines had been in place to define how to conduct communication with the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

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

Strategies:

1. Development of a Health Communication Strategy;
2. Install communication lines linking health facilities between HPs, CHCs and Hospitals located within their catchment areas;
3. To develop ICT policy for the national health services and ensure that appropriate tools and mechanism are in place;
4. Adequately train staff using ICT equipment as well as ensure availability of qualified technicians.

Expected Results:



1. A national health information and communication strategy defined by 2022;
2. Periodic health bulletin/newsletter produced regularly by MOH and distribution to all facilities;
3. 100% of health facilities have access to communication network for emergency evacuations;
4. MOH ICT policy developed by 2022;

5. ICT network established and expanded to all health service levels, with all Municipal Health Services management teams and hospitals having access to official email address and internet.

7.4 HEALTH FINANCING

Health financing as a core function of a health system includes decisions on sources of revenues for the health sector, pooling arrangements and how to allocate those resources to pay for health services that should be guaranteed to the population. Addressing all three, health financing functions comprehensively and in alignment with the other health systems functions is a necessary condition for moving towards Universal Health.

Goal: Increase and strengthen public finance for health to address unmet needs of health services, reduce inequities in resource availability and improve health system allocative and technical efficiency.

Strategy:

1. Ensure sufficient and sustainable public financing for health;
2. Harness reforms in program budgeting, performance-based resource allocation and essential service package;
3. Strengthen capacity in health financing analytics including national health accounts, auditing and financial protection monitoring;
4. Introduce a performance-based contract signed annually between the central MoH and the Municipal Health Services, linking resources allocation with realistic targets set for health services delivery;
5. Develop a performance-based financial management information system that captures both levels of health care activities in budgeting and expenditure reporting.

Expected Results:

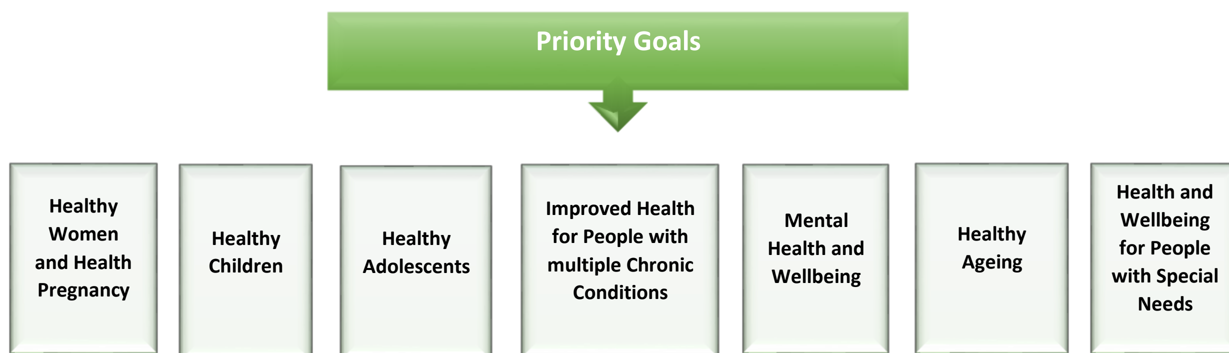
1. Computerized financial management information system developed and functional for budget preparation, implementation, reporting and, ultimately, transactions accounting;
2. Performance-based budgeting process strengthened, linking budgets to inputs and linking outputs to expenditures with workable monitoring and accounting mechanisms;
3. < 15% of household with OOP health expenditure;
4. < 2% of population with large household expenditure on health as a share of total household expenditure;
5. >10% of government budget allocated for health.

8. Implementation Arrangements

8.1 PRIOTITY SETTINGS

At the heart of the NHSSP II lies the ambition that the health system will make investments in new strategic approach to service delivery and support around population groups, thus, creating the platform for much greater innovation in health and healthcare.

Addressing population groups allows for new designs to better identify problems and solutions to those problems that lie outside of the acute health care setting. This will allow more preventive, less complex, better coordinated, and more cost-effective approaches to care to flourish in the future. Saúde na Família approach focuses on the life course of an individual and also take into account significance to future society, vulnerability and service demand.



The attainment of key priority goals will be a major undertaking, requiring the efforts of large numbers of people working towards common outcomes. In this regard, planning and budgeting process, across the whole system will include the following:

1. At the national level, (a) introduction of sector Annual Implementation Plan (AIP)s (b) national monitoring and evaluation frameworks and HMIS reforms (c) public financial management reforms including consideration of establishment of MTEF;
2. At the District level, strengthening of program-based planning and M & E systems;
3. At the sub District level, installation of integrated micro-planning systems for CHCs;
4. At the Suco level, installation of Suco Development Planning with funding through the Ministry of State Administration;
5. At the institutional level, overall budget-planning process integrated to a digital system to allow for timely communication and response between the different layers of health care service delivery.

In terms of the planning and budgeting system, the main **decision making bodies** are as follows:

- ***The Council of Directors***, chaired by the Minister for Health, is the executive authority of the Ministry of Health with the responsibility to lead development of plans and provide final approval of plans and budgets.
- ***National Departments*** including the Departments of Policy, Planning and Cooperation, the Department of Finance and National programs have the critical role of plan appraisal and of ensuring District plans are linked to national and sector programs and strategies and guidelines.
- ***The Municipal Health* Council,** is responsible for leading plan development at Municipal level and is responsible for recommending Municipal Health Plans and Budgets for approval.
- ***The Suco Council*** is responsible for identifying community health needs, mobilizing local resources, and for integrating health into the Suco Development Plan.

The main **coordination and technical support bodies** are:

- ***The Health Sector Coordination Committee*** is the forum for the Ministry of Health, and development partners to review health policies and challenges in the health sector and to oversee projects and programs guided by the National Health Sector Strategic Plan 2011-2030. The HSCC should be involved at the partner's consultation and planning appraisal planning steps, and should supports monitoring of progress against the National M & E framework.
- ***The Municipal and sub District Technical Working Groups are involved at all stages of the planning process***, and coordinates health activities with local authorities and partners. It also ensures development of sub district Annual Implementation Plans (harmonized into one action plan). It monitors progress of sub district coverage and agree on corrective actions. This group also technically supports the development and implementation of the health component of the suco development plans.
- ***The Village Health Committee and Suco Council*** has a role in health education and in informing and mobilizing the population for health activities and campaigns. The Suco Council has a role in assessing community needs, Suco development planning and in monitoring of health care access and outcomes through the activities of the PSF and EsF.

8.2 IMPLEMENTATION APPROACH

The definition of planning "*The process by which health managers, providers and communities work together as a team to organize their present and future resources to provide and improve*

health services and health outcomes"[10] describes many of the concepts that will be explained in this overview of planning. These include: team work, community involvement, mobilizing resources, setting priorities and making choices and achieving better health outcomes.

If the MOH is to meet its SDG targets (and adopting the strategic directives of the Government Program is designed to achieve SDP vision) 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.

These approaches are all intended to support the **goal** of "*One Plan, One Budget, One Monitoring and Evaluation Framework.*"

Given the scope and scale of system and service improvement presented in the NHSSP II, a high degree of program leadership and coordination will be required across the entire national health system toward achieving the ambitious goals.

Multiple strategies, action plans and committees were developed during the implementation of first edition of NHSSP 2011-2030, all of which are intrinsically linked to the MOH organizational structure. Moving forward, existing structures will be used when applicable, to support the implementation of the initiatives identified in the NHSSP II.

A cohesive approach will be adopted to bringing together different strategies and action plans already in place, to ensure that there is no duplication of efforts.

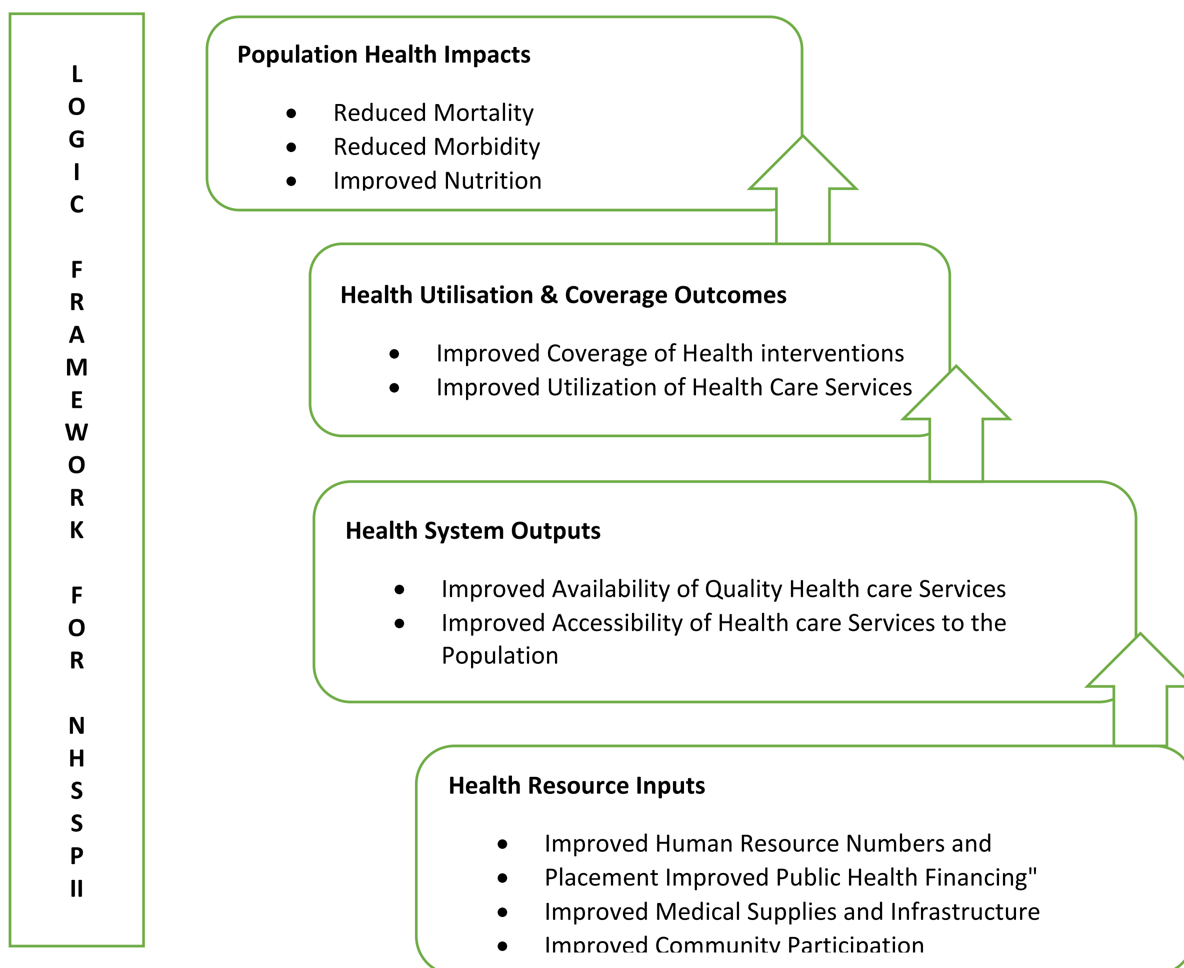
The planning levels are linked into a single operating system by the following **strategies:**

1. Reference to the overall health sector objectives and strategy which provides the overall direction for the health sector in terms of outcomes;
2. Reference to a National M&E framework which provides the agreed roadmap for measuring progress and evaluating outcomes;
3. Reference to consistent planning and budgeting cycle and steps inside these guidelines so that all actors work towards one plan, one budget and one M & E in their jurisdiction;
4. Reference to a single management, partnership and coordination framework that provides oversight for plan and budget development and implementation at each level of the system.

[10] Health Planning and Budgeting Guidelines, MoH 2014

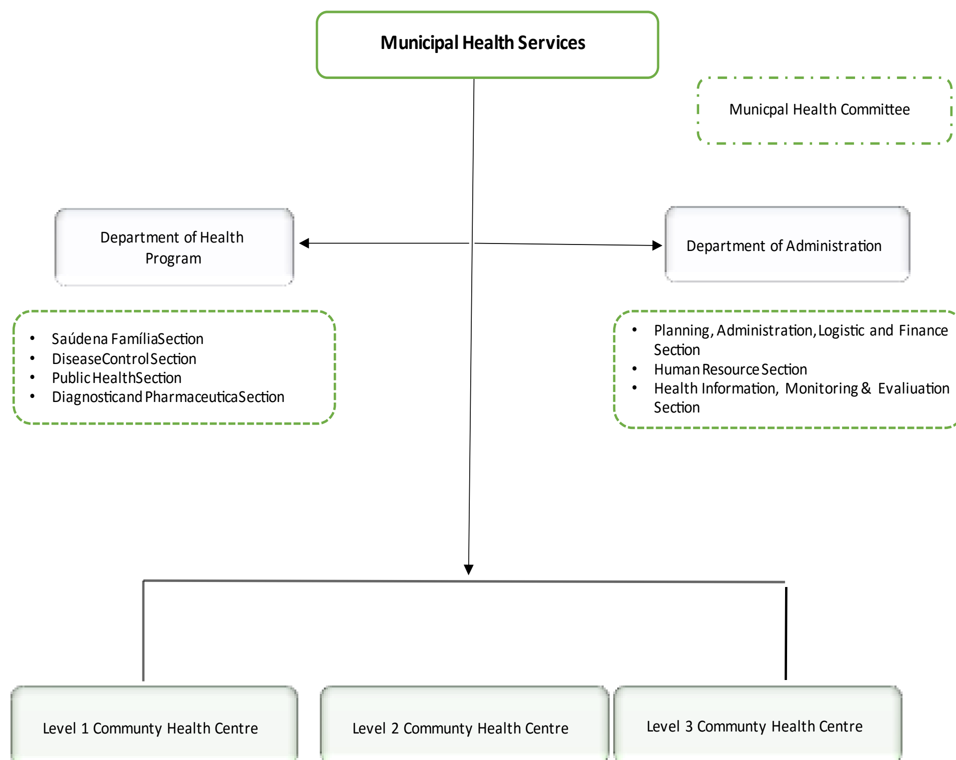
Expected Results:

1. Health system functions in a more coordinated and efficient and equitable manner in order to achieve the objectives of the NHSSP 2011-2020;
2. Short-term strategic plans for public Health programs and Disease control developed and updated;
3. Regional hospital development plans and municipal health Plans developed, following local situation and national health targets;
4. Business plans developed for autonomous health institutions;
5. Supporting supervision activities conducted following a bottom-up approach to health M&E;
6. Results-based plans are informed by the "dashboard" indicators reflected in the National Monitoring and Evaluation Framework;
7. Joint Annual Health Sector Review and the Joint Annual Health Sector Planning Summit conducted.



ANNEXES

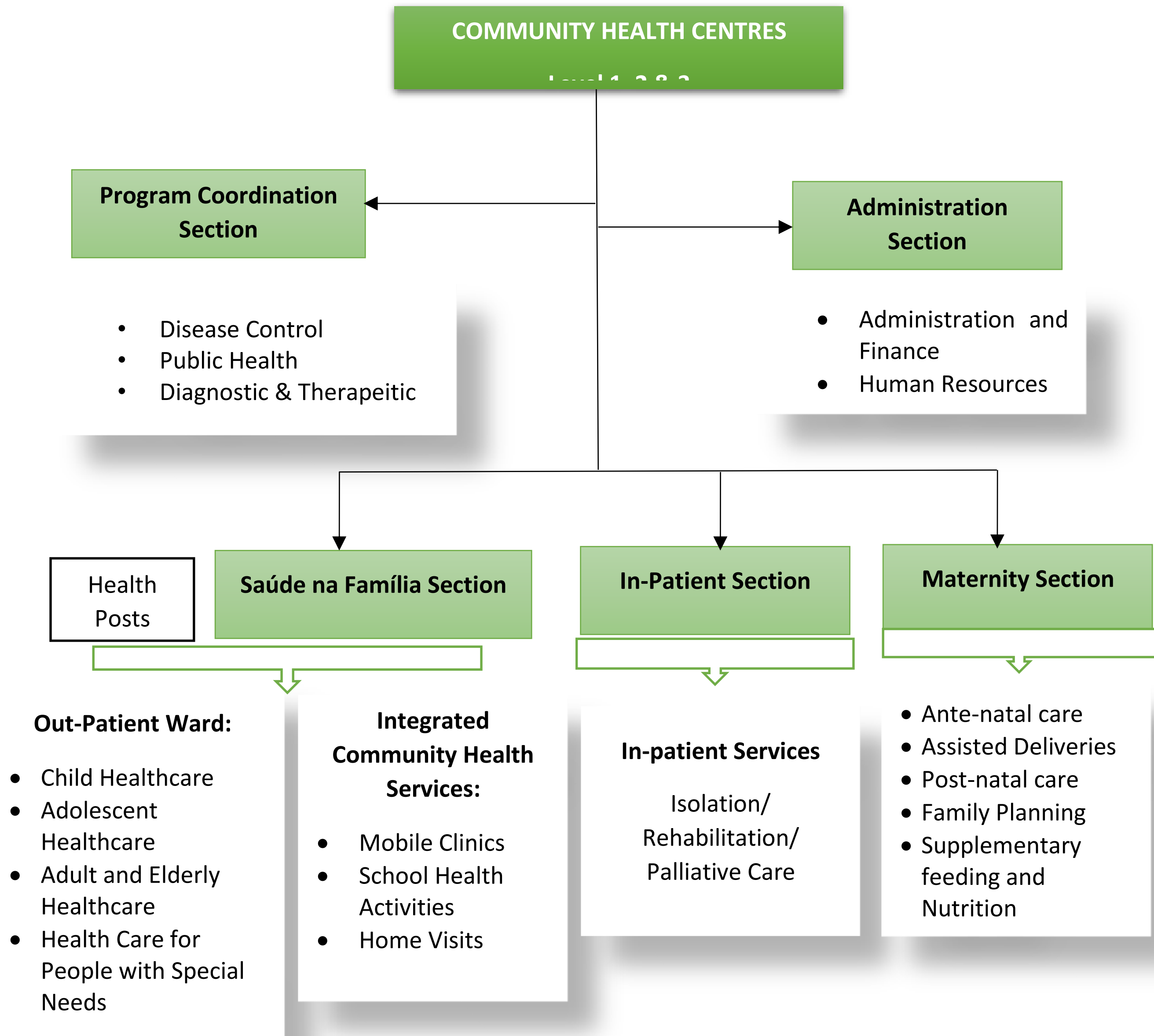
Annex I: The Structure of Municipal Health Services



The Structure of Community Health Centres

As per the Joint Ministerial Diploma No. 6/2018, of 21 march, that approves the organic structure of Municipal Health Services does provide a comprehensive configuration of the national health care services provision located at each administrative authority.

- Community Health Centres level 1 (CHC-1) located in most administrative posts ("Posto administrativo") of the country, provide ambulatory health services to a population of between 7,500 and 12,000 in rural areas and to around 15,000 in urban settings.
- Community Health Centres level 2 (CHC-2) are located in some administrative posts covering populations of around 20,000. These CHCs offer the same services than CHC-Level 1 but have an inpatient department with up to 20 beds.
- Community Health Centres level 3 (CHC-3) are health facilities located in the municipal capital, or big urban concentrations which provide general ambulatory and inpatient services covering a population of around 50,000.


COMMUNITY HEALTH CENTRES
Program Coordination Section
Administration Section
Disease Control
Public Health
Diagnostic & Therapeitic
Administration and Finance
Human Resources
Health Posts
Saúde na Família Section
In-Patient Section
Maternity Section
Out-Patient Ward:
Child Healthcare
Adolescent Healthcare
Adult and Elderly Healthcare
Health Care for People with Special Needs
Integrated Community Health Services:
Mobile Clinics
School Health Activities
Home Visits
In-patient Services
Isolation/ Rehabilitation/ Palliative Care
Ante-natal care
Assisted Deliveries
Post-natal care
Family Planning
Supplementary feeding and Nutrition

Annex II: Comprehensive Primary Health Care Essential Services Package [11]

A. Health services linked to the life course

HEALTH SERVICES LINKED TO THE LIFE COURSE								
MATERNAL HEALTH								
PRE-CONCEPTION CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Mobilize population for promotion of institutional delivery	yes	yes	yes	yes	yes	yes	yes	
Support PSFs for health promotion activities on safe motherhood	yes							
Early identification of pre-pregnancy obstetric risks and health education and information about recommended healthcare seeking behaviour	yes	yes	yes	yes	yes	yes	yes	
Promotion of family planning among newly married couples	yes	yes	yes	yes	yes	yes	yes	
ANTENATAL CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Diagnosis of pregnancy	yes/refer	yes/refer	yes	yes	yes	yes	yes	yes
Registration of pregnancy and opening of LISIO booklet	yes	yes	yes	yes	yes	yes	yes	
Health education about healthy eating and physical activity during pregnancy	yes	yes	yes	yes	yes	yes	yes	

[11] Version approved by MOH Board of Directors on June 4th, 2019

Birth preparedness plan (BPP) according to expected delivery date (e.g. money, means of communication, transport, blood donors, etc.)	yes	yes	yes	yes	yes	yes	yes	
Health education about normal signs of labour	yes	yes	yes	yes	yes	yes	yes	
Health education about pregnancy warning signs (e.g. bleeding, nausea/vomits, decline in foetal movements, pre-term contractions, pre-term waters break, headache, abdominal pain, swelling, etc.)	yes	yes	yes	yes	yes	yes	yes	
Obstetric monitoring according to ANC protocol: height, weight, blood pressure, fundal height, foetal heartbeat, tetanus immunisation, laboratory tests, folic acid and ferro sulphate supplementation, deworming, MUAC, etc.	yes	yes	yes	yes	yes	yes	yes	
Laboratory examinations according to protocol (e.g. urine, Hb, group and Rh, glucose, VDRL, HIV, HbSAg)	Refer	Refer	no/refer	no/refer	yes/refer	yes/refer	yes/refer	yes
Screening of pregnancy complications (e.g. anaemia, malaria, UTIs, hypertension, diabetes, STIs, HIV/AIDS, etc.)	yes	yes	yes	yes	yes	yes	yes	

Early identification, referral and treatment of obstetric complications (e.g. pre-eclampsia, ante- partum haemorrhage, abdominal pain, premature Rupture of membranes, etc.)	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	yes
Management of late pregnancy complications (e.g. premature rupture of membranes, preterm labour, mal presentations, etc.)	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	yes
HIV Prophylaxis (ARV) for seropositive mothers according to policy	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	yes	yes	Yes
Malaria screening using RDT and provision of LLINs for pregnant women	yes	yes	yes	yes	yes	yes	yes	
DELIVERY CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Assist birth in the health facility for normal deliveries using partogram from admission and refer complicated cases	Refer	Refer	Yes/refer	Yes/refer	Yes/refer	Yes/refer	Yes/refer	Yes/refer
NEWBORN CARE (MOTHER AND NEWBORN)	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Immediate post-partum care for mother and newborn (e.g. blood pressure, bleeding check-up, etc.)			yes	yes	yes	yes	yes	yes
Initiate breastfeeding in the first hour after delivery			yes	yes	yes	yes	yes	yes

Promote skin to skin for all new-borns with emphasis on low weight newborns/premature babies			yes	yes	yes	yes	yes	yes
Prophylaxis for neonatal conjunctivitis			yes	yes	yes	yes	yes	yes
Postnatal check-up mother (e.g. breastfeeding, infection, haemorrhage, etc.) and newborn (e.g. umbilical cord, etc.) as per protocol before discharge	yes	yes	yes	yes	yes	yes	yes	yes
Postpartum family planning counselling	yes	yes	yes	yes	yes	yes	yes	yes
POSTNATAL CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Promotion and education about early and exclusive breastfeeding (first 6 months) and weaning plan	yes	yes	yes	yes	yes	yes	yes	
Home visit for postnatal care (baby and mother)			yes	yes	yes	yes	yes	
Identification/care/referral of preterm childbirths weight less than 2500gr and born with malformation or some illness during perinatal period	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer
Education about essential newborn care including how to manage common newborn ailments and identification of danger signs	yes	yes	yes	yes	yes	yes	yes	

OBSTETRIC AND NEONATAL EMERGENCIES	SISCa/PT/MC	SnF	HP1	HP2	CHC-1	CHC-2	CHC-3	RH
BEmONC Administer antibiotics (parenteral)	no/refer	no/refer	Ampi/refer	Ampi/refer	Ampi-Genta/refer	Ampi-Genta/refer	Ampi-Genta/refer	yes
BEmONC Administer uterotonics drugs (oxytocin) as per protocol	no	no	yes	yes	yes	yes	yes	yes
BEmONC Administer anticonvulsants (Mg. Sulph.)	no	no	no/refer	no/refer	Yes/refer	Yes/refer	Yes/refer	yes
BEmONC Manual removal of placenta	only if skills/ref	only if skills/ref	only if skills/ref	only if skills/ref	only if skills/ref	only if skills/ref	only if skills/ref	yes
BEmONC Removal of retained products following miscarriage or abortion	no/refer	no/refer	no/refer	no/refer	BEmONC facilities/ref	BEmONC facilities/ref	BEmONC facilities/ref	yes
BEmONC Assisted vaginal delivery, preferably with vacuum extractor (abnormal presentation)	no/refer	no/refer	no/refer	no/refer	no/refer	BEmONC facilities/ref	BEmONC facilities/ref	yes
BEmONC Basic neonatal resuscitation care			Yes/refer	Yes/refer	Yes/refer	Yes/refer	Yes/refer	yes
CEmONC Caesarean section	no/refer	no/refer	no/refer	no/refer	no/refer	no/refer	no/refer	yes
CEmONC Safe blood transfusion	no/refer	no/refer	no/refer	no/refer	no/refer	no/refer	no/refer	yes
CEmONC Provision of care to low birthweight, including resuscitation (promote skin to skin)			no/refer	no/refer	no/refer	no/refer	no/refer	yes

FAMILY PLANNING	SISCa/PT/MC	SnF	HP1	HP2	CHC-1	CHC-2	CHC-3	RH
Health education and promotion of FP	yes	yes	yes	yes	yes	yes	yes	yes
Provision of FP services: condom, oral and injections			yes	yes	yes	yes	yes	yes
Provision of FP services: implant and IUDs					yes/refer	yes/refer	yes	yes
Provision of FP services: tubectomy								yes
Treatment for infertility								yes
CHILD HEALTH								
DEVELOPMENTAL CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Health education to mothers and families on child care including home-treatment of common illnesses	yes	yes	yes	yes	yes	yes	yes	
Growth monitoring and child care visits as per protocol	yes	yes	yes	yes	yes	yes	yes	
Treatment for children with severe acute malnutrition without complications	yes	yes	yes	yes	yes	yes	yes	
Refer children with severe acute malnutrition with any complications which need secondary care	yes	yes	yes	yes	yes	yes	yes	
Support and follow up lactating mothers including nutritional advise for children 6-23 months	yes	yes	yes	yes	yes	yes	yes	

Deworming with albendazole and administration of Vit. A every 6 months for children aged 6-59 months	yes	yes	yes	yes	yes	yes	yes	
IMMUNIZATION (EPI)	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Screening of all children for immunisation status	yes	yes	yes	yes	yes	yes	yes	yes
Daily Immunization Service (facility)			yes	yes	yes	yes	yes	yes
Outreach for immunisation (SISCa/mobile clinics/domiciliary visit)	yes	yes						
IMCI	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Assessment, classification and treatment of common childhood illnesses using the IMCI protocol	yes	yes	yes	yes	yes	yes	yes	yes
NUTRITION	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Promote healthy food and nutrition in family particularly child and infant feeding	yes	yes	yes	yes	yes	yes	yes	yes
Practical demonstrations on how to use local food	yes					yes	yes	
Promote breastfeeding and healthy complementary feeding (mother support groups)	yes	yes	yes	yes	yes	yes	yes	
MUAC screening and growth monitoring and Refer of malnourished cases to	yes	yes	yes	yes	yes	yes	yes	yes

relevant level								
Supplement Vit. A, albendazole, micronutrients (MNP)	yes	yes	yes	yes	yes	yes	yes	yes
Support and supervise community-based management of severe malnutrition	yes	yes	yes	yes	yes	yes	yes	yes
Screening all children under five for malnutrition and start treatment of malnourished as per protocol	Yes/refer	Yes/refer	yes	yes	yes	yes	yes	yes
Treatment of with severe acute malnutrition with any complicated illness which need secondary care	Yes/refer	Yes/refer	Yes/refer	Yes/refer	Yes/refer	Yes/refer	Yes/refer	Yes/refer
Refer children with severe acute malnutrition with any complications which need secondary care	yes	yes	yes	yes	yes	yes	yes	yes
Follow up of malnourished children under treatment until discharge (and check and address root causes for relapsing cases)	Yes/refer	Yes/refer	yes	yes	yes	yes	yes	yes
SCHOOL HEALTH	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Provide effective skill-based health education to promote healthy lifestyles among school children, teachers and community	Yes		yes	yes	yes	yes	yes	

Provide girls in pre-menarcheal age education and IEC materials on menstruation	Yes		yes	yes	yes	yes	yes	
Building life skills (e.g. self-awareness, empathy, critical thinking, etc.) in children and adolescents and provide them with psychosocial friendly support in schools and other community settings	Yes		yes	yes	yes	yes	yes	
Annual comprehensive health check-up (e.g. vision test, ear and dental examination, vital signs check- up, BMI, etc.)	Yes		yes	yes	yes	yes	yes	
Oral health promotion including daily supervised tooth brushing at school with fluoride paste	Yes		yes	yes	yes	yes	yes	
Periodical nutritional assessment (at least once per year)	Yes		yes	yes	yes	yes	yes	
Nutrition education programmes for students and parents	Yes		yes	yes	yes	yes	yes	
Supervise provision of quality school feeding programme (Class 1-9)	Yes		yes	yes	yes	yes	yes	
Health promotion and education about mental health	Yes		yes	yes	yes	yes	yes	

Early detection (sensitisation of teachers and educators) and referral of mental health issues among young people	yes		yes	yes	yes	yes	yes	
OTHER LIFE COURSE								
ADOLESCENT AND YOUTH HEALTH	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Mobilize young people (10-19 years) to promote healthy habits and behaviours and information about health services available for them	yes	yes	yes	yes	yes	yes	yes	
Supplement “folic acid and iron/ferro” for adolescent girls (10-18 years)	yes	yes	yes	yes	yes	yes	yes	
Promote healthy nutrition and discourage unhealthy eating habits	yes	yes	yes	yes	yes	yes	yes	
Provide young people with sexual and reproductive health youth-friendly counselling services	yes	yes	yes	yes	yes	yes	yes	
Health education and promotion about specific prevalent diseases (e.g. HIV/AIDS, TB, malaria, etc.) and follow-up treatment of young patients	yes	yes	yes	yes	yes	yes	yes	
Young people-adapted health education about harmful effects of tobacco, alcohol and other drugs	yes	yes	yes	yes	yes	yes	yes	

Health education and sensitisation about prevention of gender-based violence among young people	yes	yes	yes	yes	yes	yes	yes	
Health education and promotion about accident prevention	yes	yes	yes	yes	yes	yes	yes	
Health education and promotion about physical exercise and recreational activities	yes	yes	yes	yes	yes	yes	yes	
ADULT CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Annual screening and medical examinations	yes	yes	yes	yes	yes	yes	Yes/refer	yes
Overall treatment and care		yes	yes	yes	yes	yes	yes	yes
Family Health and Reproductive Health Services	yes	yes	yes	yes	yes	yes	yes	
Promotion of healthy lifestyles to include physical exercise, healthy diet and nutrition, recreational activities	yes	yes	yes	yes	yes	yes	yes	
ELDERLY CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Home visit to elderly according to stratification	yes	yes	yes	yes	yes	yes	yes	
Annual screening and medical examinations	yes	yes	yes	yes	yes	yes	yes	
Access to drugs for degenerative illness	yes	yes	yes	yes	yes	yes	yes	
Exercise and the promotion of general hygiene	yes	yes	yes	yes	yes	yes	yes	

Social/emotional/community support								
PALLIATIVE (END-OF-LIFE) CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Pain control	yes	yes	yes	yes	yes	yes	yes	yes
Support families	yes	yes	yes	yes	yes	yes	yes	yes

B. Control and management of communicable diseases

CONTROL AND MANAGEMENT OF COMMUNICABLE DISEASES								
COMMON COMMUNICABLE DISEASES								
PROMOTION AND PREVENTION	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Community mapping for identification of areas with high incidence of malaria, dengue, TB, HIV/AIDS in sub-district, suco and aldeia	yes	yes	yes	yes	yes	yes	yes	
Health education on prevention and control of communicable diseases with emphasis on high risk areas identified	yes	yes	yes	yes	yes	yes	yes	
TUBERCULOSIS	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**

Sputum collection or referral as per protocol	yes	yes	yes	yes	yes	yes	yes	yes
Diagnosis of TB as per protocol (incl. GenXpert)						Yes/refer	Yes/refer	yes
Treatment and follow up for TB patient as per protocol	yes	yes	yes	yes	yes	yes	yes	yes
Chemo prophylaxis for under five years who are directly in contact with TB patients	Yes	Yes	yes	yes	yes	yes	yes	yes
Supervision and support to private providers offering TB diagnostic/treatment						yes	yes	
DENGUE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Vector control	yes	yes	yes	yes	yes	yes	yes	
Rapid test for dengue	yes	yes	yes	yes	yes	yes	yes	yes
Dengue case management	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes	yes	yes
MALARIA	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
LLINs distribution including education about use and maintenance as per protocol	yes	yes	yes	yes	yes	yes	yes	
Malaria diagnosis (RDT/microscopy)	yes	yes	yes	yes	yes	yes	yes	yes

Treatment of uncomplicated malaria (DOTS)	yes/refer	yes/refer	yes	yes	yes	yes	yes	yes
Referral of malaria for cases with complications including pre-referral treatment	pre-ref. treat &refer	pre-ref. treat &refer	pre-ref. treat &refer	pre-ref. treat &refer	pre-ref. treat &refer	yes	yes	yes
STD/HIV/AIDS	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Promote healthy and safe sexual behaviour and measures to address other risk factors	yes	yes	yes	yes	yes	yes	yes	yes
Condom distribution	yes	yes	yes	yes	yes	yes	yes	yes
Identification, diagnosis and treatment for STIs including contacts (syndromic approach)	yes/refer	yes/refer	yes	yes	yes	yes	yes	yes
Support and promote VCT among at-risk populations (including STI patients)	yes/refer	yes/refer	yes/refer	yes/refer	yes	yes	yes	yes
Voluntary Counselling and Testing (VCT)	Refer	Refer	Refer	Refer	Yes	yes	yes	yes
Prevention of mother to child transmission (MTCT) (refer for delivery)	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes	yes	yes
VCT for all pregnant women attending ANC	Refer	Refer	yes	yes	yes	yes	yes	yes

VCT for all patients diagnosed with TB	Refer	Refer	Refer	Refer	Yes	yes	yes	yes
Treatment of HIV patient including referral for follow up	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer
Treatment (including secondary prevention) /referral of complications for HIV cases	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer
NEGLECTED TROPICAL DISEASES								
YAWS	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Detect wound cases due to yaws (torpid ulcer of more than 3 months of evolution)	yes	yes	yes	yes	yes	yes	yes	yes
Treatment of yaws ulcers	Refer	Refer	yes	yes	yes	yes	yes	yes
Reporting of Yaws cases	yes	yes	yes	yes	yes	yes	yes	yes
FILARIASIS	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Vector control for filaria					yes	yes	yes	
Identify, report and refer cases of "big foot" (LF)	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer
Case management of "big foot" (LF)	no	no	yes	yes	yes	yes	yes	yes
Secondary prevention for LF (e.g. limb hygiene, postural	yes	yes	yes	yes	yes	yes	yes	yes

oedema drainage, etc.)								
LEPROSY	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Sign detection, classification and reporting of skin diseases/leprosy and refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer
Treatment and follow up for leprosy patients	yes	yes	yes	yes	yes	yes	yes	yes
Identify early signs of complications and refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer	yes/refer
Advocacy for stigma and promotion and support for adherence to treatment	yes	yes	yes	yes	yes	yes	yes	
OTHER COMMUNICABLE DISEASES								
SKIN INFECTIONS	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Diagnosis and treatment of dermatitis and common infections and referral of other skin problems	yes	yes	yes	yes	yes	yes	yes	yes
REHUMATIC FEVER	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Presumptive diagnosis and referral	yes	yes	yes	yes	yes	yes	yes	yes
Secondary prophylaxis	Refer	Refer	Refer	Refer	yes	yes	yes	yes
Treatment acute RF	Refer	Refer	Refer	Refer	Refer	Refer	Refer	yes

Screening and referral of RF cases with suspected cardiopathy	Refer	Refer	Refer	Refer	Refer	Refer	Refer	Refer

C. Control and management of non-communicable diseases

CONTROL AND MANAGEMENT OF NON-COMMUNICABLE DISEASES								
COMMON NON-COMMUNICABLE DISEASES (PEN)								
PROMOTION AND PREVENTION	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Health education for prevention of NCDs including signs of alert and symptoms and promotion of healthy lifestyle	yes	yes	yes	yes	yes	yes	yes	
PREVENTION OF HEART ATTACK, STROKES AND KIDNEY DISEASE THROUGH INTEGRATED MANAGEMENT OF DIABETES AND HYPERTENSION	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
In people 40 years and above check seated blood pressure twice with 10 minutes interval and refer if ≥140/90	yes/refer	yes/refer	yes/refer	yes/refer				
Check urine sugar to all adults above 40 (if overweight and obese above 30) and refer if +	yes/refer	yes/refer	yes/refer	yes/refer				

Clinical history, physical examination and blood tests (urine albumin and blood sugar with glucometer) and refer as per PEN protocol					Yes/refer	Yes/refer		
Assess cardiovascular risk, smoking status, systolic blood pressure, cholesterol and diabetes; counsel, treat and/or refer as per PEN protocol					Yes/refer	Yes/refer		
Follow up visits checking for new symptoms, adherence to tobacco and alcohol advice, physical activity, healthy diet, medication, etc.; physical examination, estimate cardiovascular risk and treat and/or refer as per PEN protocol					Yes/refer	Yes/refer		
To all above 40, smokers, waist circumference >90 women and ≥100 men, known hypertension, known diabetes mellitus, history of premature CVD in first degree relatives or history of DM or kidney disease in 1st degree relatives: clinical interview, physical examination, urine and					Yes/refer	Yes/refer	Yes/refer	Yes/refer

blood tests, assessment of CV risk and treat/counsel and/or referral as per PEN protocol								
MANAGEMENT OF CHRONIC RESPIRATORY DISEASES (ASTHMA AND COPD)	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
To patients presenting with persistent cough (discard ARI), difficulty breathing, tight chest and/or wheezing refer	Refer	Refer	Refer	Refer				
To patients presenting with cough, difficulty breathing, tight chest and/or wheezing or referred from lower levels: clinical interview, measurement of peak expiratory flow rate (PEFR) and treat and/or refer as per PEN protocol					Yes/refer	yes/refer	Yes/refer	Yes/refer
Management of exacerbated asthma or COPD as per PEN protocol	Refer	Refer	Refer	Refer	Refer	Refer	Yes/refer	Yes/refer
CANCER	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Cervical cancer	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Vaccination against HPV as per EPI protocol	yes	yes	yes	yes	yes	yes	yes	yes

Refer all women presenting abnormal vaginal bleeding, foul smelling discharge or pain during vaginal intercourse as per PEN protocol	Refer	Refer	Refer	Refer	Refer	Refer	Refer	Refer
Breast cancer	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Health education about breast cancer (including self-exploration for early detection)	yes	yes	yes	yes	yes	yes	yes	yes
Refer all women presenting with breast lump or any change in shape or consistency of the breast, breast lump that enlarges and/or is fixed and hard or any other breast problems as per PEN protocol	Refer	Refer	Refer	Refer	Refer	Refer	Refer	Refer
Oral cancer	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Health education about prevention and early identification of symptoms of oral cancer	yes	yes	yes	yes	yes	yes	yes	yes
Screening and referral of people using tobacco (smoking or smokeless) or/and using areca nut with symptoms of OC as per PEN protocol	yes/referral	yes/referral	yes/referral	yes/referral	yes/referral	Yes/refer	Yes/refer	Yes/refer

OTHER NON-COMMUNICABLE DISEASES								
MENTAL HEALTH	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Home visit to people with mental problem					yes	yes	yes	
Counselling to patient with mental problem and family	yes	yes	yes	yes	yes	yes	yes	yes
Diagnostic and treatment for acute MH episodes (e.g. psychotic attack, epilepsy, etc.)	Refer	Refer	Refer	Refer	Refer	Refer	Refer	Refer
Identification and referral of suspected mental illnesses	yes	yes	yes	yes	yes	yes	yes	yes
Treatment follow up of patients diagnosed with mental illnesses	yes	yes	yes	yes	yes	yes	yes	
ORAL HEALTH	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Treatment of common dental problems requiring minor interventions (e.g. atraumatic restorative treatment, fissure sealant, scaling and topical application)	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Ident/refer	Yes/refer	Yes/refer	yes
Dental and mouth trauma	first aid/refer	first aid/refer	first aid/refer	first aid/refer	first aid/refer	Yes/refer	Yes/refer	Yes/refer
Referral and/or treatment of dental problems requiring tooth repair or	Refer	Refer	Refer	Refer	Refer	Refer	Refer	Refer

extraction								
Dental abscess treatment	first aid/refer	first aid/refer	first aid/refer	first aid/refer	first aid/refer	Yes/refer	Yes/refer	yes
EYE HEALTH	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Treatment for conjunctivitis and non-complicated eye diseases and refer complicated cases to a specialist	yes	yes	yes	yes	yes	yes	yes	yes
Early identification of visual problems (e.g. cataract, glaucoma, eye tumour) and refer for diagnosis and treatment	Yes/Refer	Yes/Refer	Yes/Refer	Yes/Refer	Yes/Refer	Yes/Refer	Yes/Refer	Yes/Refer
Emergency eye trauma	first aid/refer	first aid/refer	first aid/refer	first aid/refer	first aid/refer	first aid/refer	first aid/refer	first aid/refer
EAR HEALTH	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Identification and treatment for patient with uncomplicated ear infections (e.g. otitis)	yes	yes	yes	yes	yes	yes	yes	yes
Identification and referral of patients with complicated ear diseases including infections	Refer	Refer	Refer	Refer	Refer	Refer	Refer	Refer
Treatment of hearing loss or refer as required	Refer	Refer	Refer	Refer	Refer	Refer	Refer	Refer

D. Services & platforms and other services

SERVICES & PLATAFORMS AND OTHER SERVICES								
OUTPATIENT CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Management of common conditions	yes	yes	yes	yes	yes	yes	yes	
Interconsultancy with specialised services (e.g. paediatrics, surgery, internal medicine, Obs-Gyn, others)	yes	yes	yes	yes	yes	yes	yes	yes
Referral to higher levels	yes	yes	yes	yes	yes	yes	yes	yes
INPATIENT CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Management of common conditions requiring hospital admission						yes	yes	yes
Acute inpatient care						yes/refer	yes	yes
Long-term inpatient care						Refer	Refer	Refer
SURGERY AND TRAUMA CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Drainage of superficial abscess	refer	refer	yes	yes	yes	yes	yes	yes
Suture of lacerations	refer	refer	yes	yes	yes	yes	yes	yes
Abdominal surgery (e.g. laparotomy)								yes
Traumatology (only emergencies)								Yes/ref
HOME VISIT (SnF)	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Integrated visit to family		Yes						
Routine/regular domiciliary visit		Yes						
SUPPORT SERVICES								
LABORATORY	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Transport of samples to higher levels	yes	yes	yes	yes	yes	yes	yes	yes

Haematology	sample/ref	sample/ref	sample/ref	sample/ref	sample/ref	yes	yes	yes
Biochemistry	sample/ref	sample/ref	sample/ref	sample/ref	sample/ref	yes	yes	yes
Blood grouping	sample/refer	sample/ref	sample/ref	sample/ref	sample/ref	yes	yes	yes
Urinalysis	sample/refer	sample/ref	sample/ref	sample/ref	yes	yes	yes	yes
Serology	sample/refer	sample/ref	sample/ref	sample/ref	yes	yes	yes	yes
Bacteriology	sample/refer	sample/ref	sample/ref	sample/ref	yes	yes	yes	yes
Parasitology	sample/refer	sample/ref	sample/ref	sample/ref	yes	yes	yes	yes
TB microscopy	sample/refer	sample/ref	sample/ref	sample/ref	yes	yes	yes	yes
Hb	sample/refer	sample/ref	yes	yes	yes	yes	yes	yes
HCG	sample/refer	sample/ref	yes	yes	yes	yes	yes	yes
Glucose test	sample/refer	sample/ref	yes	yes	yes	yes	yes	yes
Malaria Rapid Test (RDT)	sample/refer	sample/ref	yes	yes	yes	yes	yes	yes
GeneXpert (molecular diagnosis of TB)	sample/refer	sample/ref	sample/ref	sample/ref	sample/ref	sample/ref	yes	yes
RADIOLOGY AND OTHER DIAGNOSTIC SERVICES	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Simple radiology	refer	refer	refer	refer	refer	Yes	Yes	yes
Obstetric ultrasound	refer	refer	refer	refer	refer	refer	refer	yes

Other ultrasounds	refer	refer	refer	refer	refer	refer	refer	yes
ECG	refer	refer	refer	refer	refer	refer	yes	yes
Spirometry	refer	refer	refer	refer	refer	refer	yes	yes
PHARMACY	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Storage and management of pharmacy stocks			yes	yes	yes	yes	yes	yes
Dispensing medicines for OPD	yes	Yes	yes	yes	yes	yes	yes	yes
Dispensing medicines for IPD						yes	yes	yes
Dispensing medicines for special programmes (TB, others.)							yes	yes
OTHER SERVICES								
EMERGENCY CARE	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Identification and stabilization of emergency cases			yes	yes	yes	yes	yes	yes
Resuscitation with basic life support measures			yes	yes	yes	yes	yes	yes
Referral (communication and transportation)	yes	yes	yes	yes	yes	yes	yes	yes
Management of mild emergencies			yes	yes	yes	yes	yes	yes
Management of complex emergencies			Stab. & Refer	Stab. & Refer	Stab. & Refer	Stab. & Refer	Yes/ref	Yes/ref
Emergency services and observation (max. 6 hours)				Yes		Yes		
Emergency services and observation (max. 24 hours)				No	yes	yes		

GENDER BASED VIOLENCE	SISCa/PT/MC	SnF	HP1	HP2	CHC-1	CHC-2	CHC-3	RH
Identification of survivors of GBV as per National Guidelines (Information Sharing Protocol)	Yes	Yes	yes	yes	yes	yes	yes	yes
First line support as per National Guidelines	Refer	Refer	yes	yes	yes	yes	yes	yes
Sexual assault examination and care for injuries and urgent medical issues including mental health assessment and care as per National Guidelines			Refer	Refer	Yes/refer	Yes/refer	Yes/ref	Yes/ref
Documentation (medico-legal) including collection of specimens as per National Guidelines			yes	yes	yes	yes	yes	yes
Referral to higher levels and sectors (e.g. social, police, legal) as required as per National Guidelines			yes	yes	yes	yes	yes	yes
CARE OF PEOPLE WITH DISABILITIES	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
Health education to patient with physical disabilities including self- care	yes	yes	yes	yes	yes	yes	yes	yes
Identify and refer patients with disabilities	yes	yes	yes	yes	yes	yes	yes	yes
Home visits to follow up people with disabilities with difficulties accessing health facilities		yes						
Provide medical certificates and support for persons with disabilities for provision of aids (refer to Ministry of Solidarity and Social Security)	yes	yes	yes	yes	yes	yes	yes	yes
ENVIRONMENTAL HEALTH								
Sanitation and Hygiene	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
KUBASA counselling & education	yes	yes	yes	yes	yes	yes	yes	

Inspection on sanitation and hygiene facility in community and public facilities.							yes	
Promotion of safe sanitation and hygiene behaviours, and monitoring for effectiveness	yes	yes	yes	yes	yes	yes	yes	
Food security	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
KUBASA counselling & education	yes	yes	yes	yes	yes	yes	yes	
Inspection of places preparing and producing food and storing, education on food safety, taking food samples for analysis							yes	
Vector Control	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
KUBASA counselling & education	yes	yes	yes	yes	yes	yes	yes	
Larva survey and treatment in mosquito breeding places, education to clean mosquito breeding places	yes	yes	yes	yes	yes	yes	yes	
Waste management	**SISCa/PT/MC**	**SnF**	**HP1**	**HP2**	**CHC-1**	**CHC-2**	**CHC-3**	**RH**
KUBASA, counselling & education	yes	yes	yes	yes	yes	yes	yes	
Medical waste periodical control and education			yes	yes	yes	yes	yes	

Staff Norms based on PHC ESC

Professional Cadre	Health post	Community Health Level 1 Centre	Community Health Centre Level 2&3 (< 20 beds)	Municipal Hospitals: Maliana & Covalima (25-30 beds)	Regional Hospitals: Maubisse, Baucau & RAEOA (>75 beds)
Health Service Managers	0	1	2	3	4
Medical specialist doctors	0	0	3	10	17
Anaesthesiologist				2	4
Cardiologist					
Dentist			1	1	1
Internist			1	2	2
Obstetrician				1	2
Paediatrician			1	2	2
Radiologist				1	2
Surgeon				1	3
Traumatologist					1
General doctors	1	3	4	6	18
Nurses general	1	3	20	24	68
Specialist Nurses	0	0	0	4	4
Anesthesia nurse				2	2
Surgery nurse				2	2
Midwives	1	4	8	8	16
Allied health professionals	1	3	12	15	26
Lab technician		1	2	3	5
Pharma technician		1	2	3	4
Radiology technician			2	2	4
Physiotherapist					4
Nutritionist		1	1	1	2

Dentist technician			1	1	1
Electro-medical technician			1	1	2
Public health	1	1			
Medical Records			1	1	1
Waste management			1	1	1
Subtotal technical staff	4	14	49	68	153
Subtotal general staff**	1	5	16	23	271
TOTAL per facility type/institution	**5**	**19**	**65**	**91**	**424**

Annex III: MoH Public Financial Management Road Map

Introduction

Ministry of Health (MoH) acknowledges that strong financial management systems are essential to delivering equitable and efficient health services throughout the country. Accordingly, financial management, which includes procurement, has been identified as an area to be strengthened within the NHSSP 2011-2030. There have been a number of reviews on financial management[12] and procurement[13] undertaken by MoH to identify the issues, with the main focus on how to improve the flow of funds and other core resources to the Municipal Health Services, given they are responsible for providing services to the majority of the population of Timor-Leste.

A public financial management (PFM) 'roadmap' has been prepared based on the findings of these reports, as well as from consultation with MoH departments, Ministry of Finance, and development partners working in the health sector. All district health teams provided input to the PFM roadmap through a series of regional workshops in mid-2012. The workshops were part of the consultations for developing the new NHSSP-Support Project (NHSSP-SP)[14] which will assist the MoH to develop and implement these core PFM systems and practices that are necessary for the accountable use of public resources and improved service delivery in Timor-Leste.

The roadmap has been split between Central Services and Municipal Health Services, and covers the period 2020 to 2024, there is a summary of each roadmap, and a more detailed step by step report included as an annex to the roadmaps.

PFM and National Health Sector Strategic Plan

In order to achieve the aims of the NHSSP, PFM Reform and capacity is required within MoH. The overall objective of PFM in the NHSSP is "to increase public resource mobilization to the health sector through efficient and sustainable means as to promote equity of access to cost effective and quality health services at all levels of care"[15]. Therefore, linking PFM to the NHSSP logically leads to the following key reforms for PFM in MoH:

- Improving the control and flow of funds to Municipal Health Services;

[12] Steps to Health Sector Wide Policy, Management and Improved Coordination towards a Sector Wide Approach (SWAp) in Timor Leste, Ann Canavan May 2009. District Health Directors Public Financial Management and Performance Improvement Workshop, Kathy Wimp September 2010. Mid Term Review, Joao Olivio da Silva, 2010.
[13] Procurement considerations for a Roadmap on PFM, John Blunt, May 2011.
[14] The primary development partners for NHSSP-SP are Australia (through AusAID), the European Union (through the European Commission) and the World Bank
[15] National Health Sector Strategic Plan 2011-2030

- Documenting and implementing strong financial internal controls and systems across the MoH;
- Improving the budgeting and planning processes through bottom up budgeting and linking plans to budget working towards One Plan, One Budget, and One Sector Monitoring and Evaluation Framework;
- Ensuring that the Health Sector is adequately funded, equitable and efficient; and
- Improving the capacity of financial staff within MoH.

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

- The MoH will have improved capacity in financial management at both the central and district levels;
- The MoH will have adequate well-functioning financial systems at both central and district levels;
- The MoH will be in a stronger position to receive sector budget support by 2025 under its One Plan, One Budget and One Sector Monitoring and Evaluation Framework.

Public Financial Management

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

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

In order to answer the questions listed above, managers must be competent in understanding financial reports and most importantly they should be able to rely on the financial system and finance staff to provide the relevant information for them to make informed decisions. It is

imperative that finance staff have the skills and capacity to manage, control and report on the finances of the division/ministry.

The roadmap for PFM in MoH can be linked to Managers being able to understand and answer the identified questions, as per the table below. While managers should be able to answer the questions, it is difficult in a centralised system for each Manager to be able to answer adequately, as they have little control over their budgets and expenditure; therefore the roadmap is structured to enable this by the end of 2024.

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

Has performance improved?	Improvement in health indicators/ targets met.	➢ Links policies with budget ➢ Service Delivery milestones

Implementation of PFM Roadmap

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

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

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

MINISTRY OF HEALTH - PUBLIC FINANCIAL MANAGEMENT (PFM) ROADMAP – CENTRAL

2020

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

Access to Freebalance DP funds EU, Global Fund	Finance & procurement manual prepared & training provided extract for districts produced Including design of new Chart of Accounts with MoF	Costing NHSSP II priority areas for 5 year period (MTEF discussion)	Develop budget templates for linking plans to budget (program based budgeting 2022) incorporating new chart of accounts program based reporting in Freebalance. Establish budget review committee within MoH.

2022

Continued training as per plan	Program based reporting begins monitoring & support required	Adopt resource allocation method based on NHSSP indicators ready for 2022 budget	Continue to strengthen budgeting processes (one plan, one budget for 2023)

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

2024

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

MINISTRY OF HEALTH - PUBLIC FINANCIAL MANAGEMENT (PFM) ROADMAP MOH - MUNICIPALITIES

2020

Develop system for reporting and monitoring pasta mutin (including procurement rules)	Develop system for reporting and monitoring fuel usage		Improve monthly & quarterly reports provided by MoH Central, provide training on reading & understanding finance report

2021

Assess finance skills Develop & deliver training (note training will be over longer Period than 2022)	Finance & procurement manual prepared & training provided	Open bank accounts	Budget templates for linking plans to budget introduced (program-based budgeting 2022)

2022

Continued training as per plan	Freebalance access and training	Municipalities receive budget envelope from State Administration in coordination with MoH As part of one plan, one budget

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

2024

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

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

Reform/Tasks as per Roadmap	Indicator/Target	Responsible Division and Officer	Resources Required	Timeline
Set up PFM Working Group as per attached Terms of Reference Identify champion for PFM Roadmap within MoH	Working Group meeting monthly	MoH Finance – Director Planning and Finance	Nil	December 2021
Assess finance and procurement skills in Central Services and develop training plan: ▪ Document number of staff ▪ Qualifications of staff ▪ Job Descriptions of staff ▪ Survey on skills to be developed ▪ Training plan to be developed Survey of staff skill set to be undertaken, basic numeracy/bookkeeping training to be provided to staff at Health Posts, CHC's and District Health Services. Ongoing training and support to be provided by MoH Central	Training plan developed % of staff with job descriptions % of staff trained	MoH Finance – Director Planning and Finance with TA support MoF – access to training	Existing TA support Cost of training plan NGO agreement to deliver district training District Finance advisors	March 2022 September 2022
Access to Freebalance: - covering both MoH GoTL and NHSSP-SP, Global Fund ▪ Meeting with MOF to review connection status; ▪ Review staff access to Freebalance and skill set for producing reports and utilising Freebalance ▪ Development of chart of accounts for HSSP-SP ▪ Discussion and development of chart of accounts – Global Fund ▪ Training in Freebalance for staff	MoH utilising Freebalance Timeline for NHSSP-SP & Global Fund to move to Freebalance	MoH Finance with TA support from NHSSP-SP & Global Fund	Existing TA support Cost of access to Freebalance system for NHSSP-SP & Global Fund	February 2022 February 2021
Develop template for monthly reports ▪ MoH Central to provide monthly finance report to all divisions by 15th of each subsequent month ▪ Format for monthly report to be developed – may be straight from Freebalance ▪ Training in how to read and understand finance reports to be delivered to all finance staff and directors	Monthly reports prepared	MoH Finance with TA support	Training costs	February 2022

▪ Consolidated quarterly report for MoH Executive to be prepared by 15th of month following end of quarter ▪ Template for format on consolidated report to be developed, must include all sources of funds – template to be provided to DP's to ensure consistency in reporting ▪ DP Funds to be reported (budget vs actual) to MoH Central on a quarterly basis by 10th of month following end of quarter				
Access to Freebalance DP Funds, NHSSP-SP, Global Funds: ▪ Data entry of transactions ▪ Reports being prepared	Using Freebalance 1/3/22	MoH Central, DPM	Trained finance staff	March 2022
Finance and Procurement Manuals prepared and training provided: ▪ Develop a finance manual for MOH covering internal controls as listed below and provide training on manual. Prepare a simple extract of manual for districts. SAMES to determine accounting basis (cash or accrual) and manual to be developed for SAMES. ▪ Basis of accounting as per GoTL ▪ Internal Controls – ensure separation of procurement and finance ➢ Basic forms to be used; ➢ Monitoring of expenditure and procurement ➢ Internal Audit Function ➢ External Audit Function ▪ Budgeting and budget control: ➢ Virements for all divisions must be approved by Head of division (including District Health Directors ➢ Virements for all divisions must be approved by Head of division (including District Health Directors ➢ Basic approval form to be developed ➢ Develop simple excel budget control spreadsheet for districts to	Finance manual % of finance staff received training on manual	MoH Central, with TA support	Accounting firm to prepare manual and undertake training TA Finance to SAMES TA to Procurement Training funds	Manual prepared by June 2022 Training completed by September 2022

monitor & manage budget (Vote control) ➢ Delegation authorities/decentralisation ▪ Expenditure – including: ➢ Purchasing limits to be set, including nature of purchase i.e. capital items to be procured centrally ➢ Fuel - Districts determine amount of fuel required per annum and delivery dates - this to be incorporated into contract and districts receive a copy of contract. ➢ Contract management and monitoring to be strengthened. ➢ Current system of purchasing emergency fuel to be continued through pasta mutin. ➢ System for monitoring & managing fuel distribution from districts to be developed. ➢ Drugs – system to monitor and report on drug supply - Payment for drugs to SAMES to be discussed more based on nature of SAMES (refer below) - Stocktaking; - Forms control; - Delivery dates – buffer stock ▪ Revenue/User Fees ➢ System for ensuring collection of fees receipted and banked appropriately ▪ Salary & Wages ➢ Robust system for approving overtime; ➢ Monitoring leave entitlements, attendance etc ▪ Cash Control ➢ Pasta Mutin: - Imprest tracking and acquittal process for all divisions of MoH, including district health centres and health posts.				

➢ Bank Accounts: - District Health Services to hold bank accounts (to be discussed with MoF) ▪ Assets - Asset policy to be set in accordance with GoTL system. ➢ Asset monitoring and tracking system to be developed. Freebalance asset module to be utilised, training and access in module required. In absence of or while preparing for access to Freebalance simple excel or manual system to be developed. ▪ Procurement and logistics ➢ Skill assessment, job descriptions and procurement capacity development plan to be developed ➢ Annual MoH procurement plan to be prepared ➢ Procurement Manual to be developed covering: - Procurement structure within MoH and links to GoTL procurement systems; - Improve specification setting for tenders eg fuel - Standard Bidding documents; - Procurement delegations; - Procurement processes for NCB, ICB, Competitive bidding - Evaluation and reporting mechanism - Complaints mechanism ▪ Contract Management – training in how to manage contracts: ➢ Improve communication between logistics, procurement and budget holders for major contracts eg fuel ▪ FMIS/Freebalance ➢ IT Skills to be assessed and training provided where applicable ➢ Purchase International computers driver license (or similar program) to provide basic IT skills to District Staff.				

➢ Ensure adequate computers, printers and UPS in districts. ➢ MoH intranet to be introduced and used to send reports and share data (refer IT unit MOH) ▪ Data input into Freebalance (currently MoH central) to move to Districts. Access to Freebalance required and training in Freebalance. Discussion with MoF re whether this can be directly to Health or through MoF District Treasurers				
Costing of NHSSP Priority Areas ▪ Preparation of Medium Term Expenditure Framework costing out NHSSP (five year period), utilising normative costing where applicable: ➢ Five Year MTEF ➢ Capturing all resources in sector ➢ Funding Gaps highlighted ➢ Sets Finance Indicators (refer MTEF): - % of GOTL allocation to health - % recurrent expenditure per capita for BSP - Per capita allocations by district - % of recurrent expenditure on hospital - % of recurrent expenditure on support services (incl. Systems strengthening) - Set targets to reduce reliance on DP funding for key health inputs eg drugs over 5 year period ▪ Capacity Building approach to producing MTEF, including District input ▪ MTEF to be updated annually prior to budget setting ▪ MTEF to be used as basis for resource allocation to divisions/districts	NHSSP costed for 5 year period by Sept 2021	MoH Central Finance & planning units MOF MoH Central & all Divisions MoF (Budget Unit, Planning and Freebalance Unit)	Technical Assistance DP assistance (in providing data)	June 2022
Develop budget templates for linking annual plans to Budgets	Template prepared	MoH Planning and Finance	TA support District finance	Begin 2022 – support provided

▪ Budget envelopes to be set by MoH central based on MTEF, resource allocation method. ▪ Annual budget and planning timetable to be set by MoH. ▪ Budget and planning manual to be developed, including templates linking plans to budgets. ▪ Training on budget/planning to be provided to all ▪ MoH to review and amend current chart of accounts with MOF to move to activity (output) based structure for 2013 budget. ▪ Discussion with MoF Freebalance Basic spreadsheet to be developed to ensure that costing of activities (as included in annual plans) – begin for 2012 budget. ▪ One annual plan to be prepared for each division, incorporating all activities and funding (one plan one budget). ▪ MoH Central set up budget review committee, annual plans and budget submissions to be presented by budget holders, feedback and amendments to budget submission discussed with budget holders. ▪ Additional bids for funds to MOFT Budget unit based on gaps identified and resource ▪ Managers to receive approved budgets within 2 weeks of budget being passed (MoH to produce annual budget and plan book	Resource allocation adopted Annual timetable set Manual produced and training provided		advisors support Cost of Training	through to 2025
Internal audit unit to be strengthened ▪ Training/linking with internal audit to be investigated (eg NT Internal Audit undertake performance audits based on Canadian model of performance auditing) ▪ PER/other expenditure reviews ▪ Internal audit unit to carry out performance audits	Annual internal audit plan Audit committee functioning	MoH, MoF	Training costs TA	2024

Annex IV: Selected NHSSP II Indicators

A. MATERNAL, CHILD & ADOLESCENT HEALTH

Selected Indicators	Year of Implementation					Source of Information
	2021	2022	2023	2024	2030	
Maternal Health						
Contraceptive prevalence rate	√	√	√	√	√	RSE, DHS 2022/23
Prevalence of anemia among women in reproductive age	√	√	√	√	√	RSE, DHS 2022/23
Antenatal Coverage	√	√	√	√	√	RSE, DHIS2, DHS 2022/23
Births attended by skilled health personnel	√	√	√	√	√	RSE, DHIS2, DHS 2022/23
Postnatal Coverage	√	√	√	√	√	RSE, DHIS2, DHS 2022/23
Exclusive Breastfeeding	√	√	√	√	√	RSE, DHIS2, DHS 2022/23
Health facilities providing basic/comprehensive emergency obstetric care (BEOC/CEOC)	√	√	√	√	√	HMIS, DHIS2, DHS 2022/23
Fertility Rate			√		√	DHS 2022/23
Infant Mortality Rate			√		√	DHS 2022/23
Maternal Mortality Rate			√		√	DHS 2022/23
Child Health						
Prevalence of anemia among children under 5Yrs Old	√	√	√	√	√	DHS 2022/23
Vitamin A supplementation Coverage	√	√	√	√	√	RSE, DHIS 2, DHS 2022/23
under 5 years fully immunized	√	√	√	√	√	HMIS, DHS 2022/23
% of Children attending growth monitoring services	√	√	√	√	√	RSE, DHIS2, DHS 2022/23
under 5 years who are underweight			√		√	RSE, DHIS2, DHS 2022/23
under 5 years with stunting			√		√	DHS 2022/23
under 5 years with wasting			√		√	DHS 2022/23

Selected Indicators	2021	2022	2023	2024	2030	Source of Information
Child Mortality Rate			√		√	DHS 2022/23
School children correctly de-wormed at least once per year	√	√	√	√	√	HMIS, DHIS2
Adolescent Health						
% of adolescents accessing integrated SRH services		√	√		√	DHS 2022/23
Prevalence of teenage pregnancy			√		√	DHS 2022/23
% of girls who received HPV vaccine		√	√	√	√	RSE, DHIS2, DHS 2022/23
% of CHCs with functional adolescent/youth friendly health spaces		√	√	√	√	HMIS
% of Municipalities with functional support systems to promote healthy life styles for the adolescent/youth population		√	√	√	√	HMIS
Health for the Elderly and People with Special Needs						
% of targeted population receiving home visits for NCDs	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
No. of nurses trained in basic geriatric care		√	√	√	√	INS Annual Report, HMIS
No. of people with disability and impairments managed at home and health facilities (per gender and age)	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
% of health facilities with accessible spaces for people with disability		√	√	√	√	RSE, DHIS2, DHS 2022/2023

B. CONTROL OF COMMUNICABLE DISEASES

Selected Indicators	Year of Implementation					Source of Information
	2021	2022	2023	2024	2030	
Malaria						
Malaria incidence rate	√	√	√	√	√	DHS 2022/2023
Resurgence of malaria cases in areas where malaria has been eliminated	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
# deaths due to malaria	√	√	√	√	√	RSE, DHIS2

% of LLINs distributed to protect pregnant mothers and children under 5 years	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
Tuberculosis						
TB incidence rate	√	√	√	√	√	DHS 2022/2023
% of smear positive cases of TB successfully treated out of new smear positive registered	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
% of TB treatment successful rate	√	√	√	√	√	RSE, DHIS2
% of multi-drug resistance TB cases successfully treated			√		√	RSE, DHIS2, DHS 2022/2023
TB/HIV cases on ART	√	√	√	√	√	RSE, DHIS2
No. of TB/HIV persons receiving adequate support		√	√	√	√	RSE
STI & HIV-AIDS						
No. of new HIV infections per age and gender	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
% of women and men who received HIV VTC and know their results			√		√	RSE, DHIS2, DHS 2022/2023
% of men and women with HIV who knew their status in the past year			√		√	RSE, DHIS2, DHS 2022/2023
% of HIV pregnant women who receive ART to reduce risk of mother-to-child transmission	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
% of men and women who reported an STI in the past 12 months	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
Neglected Tropical Diseases						
No. of new cases of lepra detected	√	√	√	√	√	RSE, DHIS2
Lepra treatment success rate (RFT)	√	√	√	√	√	RSE, DHIS2
Mass drug administration to combat lumbriga and lymphatic fIlariasis		√			√	HIMS

C. CONTROL OF NON-COMMUNICABLE DISEASES

Selected Indicators	Year of Implementation					Source of Information
	2021	2022	2023	2024	2030	
Chronic Diseases						
Reduction of premature mortality from NCDs			√		√	STEPS Survey, HMIS, DHIS2
No. of cancer treatments by type	√	√	√	√	√	DHIS2, DHS 2022/2023
No. of hospitals conducting cancer screening	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
No. of women and men with cardiovascular diseases	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
Raised blood pressure among adults	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
Raised blood glucose/diabetes among adults	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
No. of cases of renal failure	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
% of population who are cigarette smokers, per gender and age group			√		√	STEPSM Survey, DHS 2022/2023
Mental Health						
No. of mental health patients treated out of mental health cases reported	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
No. of epilepsy cases treated	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
Oral Health						
% of schools participating in oral health promotion and education	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023
% of schools visited at least once by a health professional	√	√	√	√	√	HMIS, DHIS2
Eye Health						
% of CHC implementing basic eye care treatment protocols	√	√	√	√	√	RSE, DHIS2, DHS 2022/2023

D. OTHER PRIORITY PUBLIC HEALTH PROGRAMMES

Selected Indicators	Year of Implementation					Source of Information
	2021	2022	2023	2024	2030	
Nutrition						
% of CHCs and Hospitals offering therapeutic feeds as part of nutrition support services	√	√	√	√	√	DHIS2, DHS 2022/2023
Nº of facilities with stock-outs of nutritional supplements	√	√	√	√	√	DHIS2, DHS 2022/2023
Nº of Municipalities that organize health education and promotion activities targeting the nutritional status of children, adolescents and women at childbearing age	√	√	√	√	√	HMIS, DHIS2
Environmental Health						
% of households sprayed for malaria and dengue control	√	√	√	√	√	HMIS, DHIS2
No. of cases of food-borne diseases	√	√	√	√	√	HMIS, National Health Laboratory Report
No. of water quality tests conducted	√	√	√	√	√	HMIS, National Health Laboratory Report
No. of Municipalities with clear sanitation procedures	√	√	√	√	√	HMIS
% of health facilities following WASH standards	√	√	√	√	√	HMIS
No. of public and private institutions that adopt and display occupational health guidelines		√	√	√	√	HMIS
No. of reported cases of injuries and illness from specific workplace		√	√	√	√	HMIS, DHIS2
No. of training conducted on health and safety at workplace, as per area of work		√	√	√	√	HMIS, INS Annual Report
No./types of health information and communication material produced and distributed to allow for appropriate health seeking behaviour	√	√	√	√	√	HMIS

Selected Indicators	2021	2022	2023	2024	2030	Source of Information
Public Health Emergencies						
No. of staff trained in IHR 2005 core capacities, per area of work	√	√	√	√	√	HMIS, INS Annual Report
Proportion of epidemic preparedness plans and guidelines developed and distributed	√	√	√	√	√	HMIS
Emergency Operation Centres established at each Municipality	√	√	√	√	√	HMIS, SNAEM Annual Report
Number of health facilities with adequate equipment to perform epidemiological data management	√	√	√	√	√	HMIS
No. of operational research studies on health security and public health emergency carried out and documented		√		√	√	HMIS, INS Annual Report
Proportion of outbreaks with laboratory confirmation results		√		√	√	National Health Laboratory Report, HMIS, DHIS2
No. of outbreaks reported and results investigated		√		√	√	HMIS, DHIS2
% of health facilities with adequate isolation rooms for treatment of viral infections		√		√	√	HMIS, DHIS2

E. SUPPORT SYSTEM & SERVICES

Selected Indicators	Year of Implementation					Source of Information
	2021	2022	2023	2024	2030	
Medicines and Pharmaceutical Product						
National Drug Policy updated and adopted	√	√	√	√	√	
Legislation on Pharmaceutical Activities, Medicines and Medical Supplies reviewed and adopted	√	√	√	√	√	RSE, DHS 2022/23
Essential Drug List reviewed updated and adopted in line with Standard Treatment Guidelines	√	√	√	√	√	RSE, DHIS2, DHS 2022/23
Guidelines for rational drug use and pharmacovigilance developed and	√	√	√	√	√	RSE, DHIS2, DHS 2022/23

used in more than 50% of health facilities						
National drug regulatory authority established	√	√	√	√	√	RSE, DHIS2, DHS 2022/23
Health Diagnostic Services						
% of hospitals providing accurate imaging diagnostic results (without errors)	√	√	√	√	√	HMIS, MOH Annual Report
% of Stock-out of essential reagents	√	√	√	√	√	HMIS, MOH Annual Report
% of hospitals providing accurate lab diagnostic results	√	√	√	√	√	HMIS, MOH Annual Report
Number of Hospitals with radiologist and medical physicists	√	√	√	√	√	HMIS, MOH Annual Report
% of hospitals implementing QI/QA activities towards accreditation			√		√	HMIS, MOH Annual Report
Comprehensive package of Diagnostic Services developed, as per level of care			√		√	HMIS, MOH Annual Report
Number of CHCs with a fully resourced and equipped lab technician			√		√	HMIS, MOH Annual Report
% of health facilities with planned equipment preventive maintenance contracts	√	√	√	√	√	HMIS, MOH Annual Report
Health Management Information System						
HMIS Policy defined and adopted	√	√	√	√	√	MOH Annual Report
Computer systems upgraded to enable electronic sharing of data between health facilities and the HMIS Department		√	√	√	√	MOH Annual Report
% of Health facilities that submits accurate and on-time reporting		√	√	√	√	HMIS
% of Health facilities with functional electronic record process		√	√	√	√	HMIS
% of population registered on the HMIS database or RSE		√	√	√	√	HMIS

F. HEALTH GOVERNANCE

Selected Indicators	Year of Implementation					Source of Information
	2021	2022	2023	2024	2030	
Leadership						
Review of MOH structure, including National and Referral Hospitals, CHCs Structure finalized and implemented	√	√		√		MOH Annual Report
Hospitals and Municipal Health Services develop Mid-term Strategic Plans		√	√			Hospital and Municipal Health Services Annual Reports
Legislations reviewed and gaps identified	√	√	√	√		MOH Annual Report
Dialogue with stakeholders strengthened and formal partnership arrangements are routine	√	√	√	√	√	MOH Annual Report
Health Sector Decentralization Framework defined and contractual agreements signed with State Administration	√	√	√	√	√	MOH Annual Report
National and Municipal Health Commissions fully operational	√	√	√	√	√	MOH Annual Report
National Regulatory Authorities established (for Sanitation surveillance, Medicines, Laboratory)		√				MOH Annual Report
Equity						
Areas with limited access to health services defined and investment plan adopted	√	√				MOH Annual Report
Budget allocation criteria for municipal health services reviewed		√				MOH Annual Report
Action Plan to address municipal disparities ready; targeting under-served health needs		√	√			MOH Annual Report
Resource gap defined, funding identified and interventions initiated		√	√	√		MOH Annual Report
Funding for health increased each year per MTEF		√	√	√		MOH Annual Report

Plan to improve gender and social inclusion in the health service provision defined and implemented	√	√	√	√	√	MOH Annual Report
Efficiency						
Costing of Annual Operational Plans for Hospital and Municipal Health Services done regularly	√	√	√	√	√	MOH Annual Report
Preparedness for introducing national health accounts initiated	√	√	√			MOH Annual Report
MoH and Autonomous Institutions Mid-term Plans reviewed and updated				√		MOH Annual Report
Annual Auditing and accounting undertaken	√	√	√	√	√	MOH Annual Report
Effectiveness						
Human resource re-deployment	√	√				MOH Annual Report
INS mid-term training plan ready and announced annually		√				INS Annual Report
Municipal Health Plans aligned with national programs		√	√			MOH Annual Report
Results-oriented performance management operational between managers at different levels		√	√	√		MOH Annual Report
Uniform HMIS in place and M&E system harmonized in digital format		√	√			HMIS, MOH Annual Report
Standard treatment guidelines, professional competency norms and ethics defined and updated		√	√	√		MOH Annual Report
Inventory of relevant laws initiated to create public awareness of health rights and obligations	√	√	√	√		MOH Annual Report
Evaluations & Reviews						
Planning Summit to adopt new AAP	√	√	√	√	√	MOH Annual Report
Review Summit for existing AAP	√	√	√	√	√	MOH Annual Report
Demographic Health Survey		√	√			MOH Annual Report
Midterm NHSSP II evaluation and review				√		Commission for NHSSP II Evaluation Report

KONTRU KONSULTASAUN
ALARGADA BA
NSS 2011-2030 2ª EDISAUN

ENKONTRU KONSULTASAUN
ALARGADA BA
REVIZAUN PENSS 2011-2030 2ª EDISAUN

MINISTRY OF HEALTH
Dili, Timor-Leste

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NATIONAL HEALTH SECTOR
STRATEGIC PLAN II
2020-2030

Towards a
"Healthy East Timorense People In
a Healthy Timor-Leste"

NATIONAL HEALTH SECTOR STRATEGIC PLAN II 2020-2030

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Ministério da Saúde