Global AIDS Response Progress Report

Timor-Leste

National AIDS Programme

Ministry of Health

Timor-Leste

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Abbreviations

ART	Antiretroviral treatment or antiretroviral therapy
ANC	Antenatal care
BCC	behavior change communication
CCM	Country Coordination Mechanism
DHS	Demographic and health survey
FSW	Female sex worker
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HTC	HIV testing and counseling
IBBS	Integrated behavior and biological survey
IDU	Injecting Drug User
M&E	Monitoring and Evaluation
MNCH	Maternal, newborn and Child Health
MOH	Ministry of Health
MSM	Men who have sex with men
NAP	National AIDS Programme
NSP	National Strategic Plan
NGO	Non-governmental organization
PEP	post-exposure prophylaxis
PITC	Provider initiated testing and counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission

SI	Strategic Information
STI	Sexually Transmitted Infection
TB	Tuberculosis
TPHA	a type of syphilis-specific blood test
UNAIDS	Joint UN Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	voluntary counseling and testing
VDRL	a type of generic blood test for syphilis
WHO	World Health Organization

Indicators at a glance

Indicator	Value	Comment
Target 1. Reduce sexual transmission of HIV by 50% by 2015		
1.1 Young People: Knowledge about HIV Prevention		No new data
1.2 Sex Before the Age of 15		No new data
1.3 Multiple sexual partners		No new data
1.4 Condom use at last sex among people with multiple sexual partnerships		No new data
1.5 HIV Testing in the General Population		No new data
1.6 HIV prevalence in young people		No new data
1.7 Sex Workers: Prevention programmes		No new data
1.8 Sex Workers: Condom Use		No new data
1.9 HIV testing in sex workers		No new data
1.10 HIV prevalence in sex workers		No new data
1.11 Men who have sex with men: Prevention programmes		No new data
1.12 Men who have sex with men: Condom Use		No new data
1.13 HIV testing in men who have sex with men		No new data
1.14. HIV prevalence in men who have sex with men		No new data
1.15 Number of health facilities that provide HIV testing and counselling services	55	National programme report
1.16 HIV Testing and counselling in women and men aged 15 and older	33,768	National programme report
1.16.1 Percentage of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months		No data

1.17 Sexually Transmitted Infections (STIs)		
1.17.1 Percentage of women accessing antenatal care (ANC) services who were tested for syphilis	55.6%	1 district in Dili
1.17.2 Percentage of antenatal care attendees who were positive for syphilis	0.52%	1 district in Dili
1.17.3 Percentage of antenatal care attendees positive for syphilis who received treatment		No data
1.17.4 Percentage of sex workers with active syphilis	0	1 district in Dili
1.17.5 Percentage of men who have sex with men with active syphilis	8.3%	1 district in Dili
1.17.6 Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months		No data
1.17.7 Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months		No data
1.17.8 Number of men reported with gonorrhoea in the past 12 months		No data
1.17.9 Number of men reported with urethral discharge in the past 12 months	1084	National case report
1.17.10 Number of adults reported with genital ulcer disease in the past 12 months	477	National case report
1.19 Diagnosis of HIV/AIDS cases		
1.19.1 Number of HIV cases diagnosed from 2010–2013, by sex from 2010–2013	76	Cases of other years, see narrative report
1.19.2 Number of AIDS cases diagnosed from 2010–2013 by sex from 2010–2013		No data
Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015		
2.1 People who inject drugs: prevention programmes		No data
2.2.People who inject drugs: condom Use		No data
2.3 People who inject drugs: safe injecting practices		No data
2.4 HIV testing in people who inject drugs		No data

2.5 HIV prevalence in people who inject drugs		No data
2.6 People on opioid substitution therapy		No data
2.7 NSP and OST sites		No data
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths		
3.1 Prevention of Mother-to-Child Transmission	19.5%	National estimate. PMTCT implemented only in 6 districts.
3.1a Prevention of mother-to-child transmission during breastfeeding		8 HIV+ pregnant women breastfeed babies
3.2 Early infant diagnosis	33%	
3.3 Mother-to-child transmission of HIV (modelled)		No data
3.3a Mother-to-child transmission of HIV (programmatic data)		No data
3.4 Pregnant women who were tested for HIV and received their results	19.3%	National estimate. PMTCT only implemented in 6 districts.
3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months		No data
3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	19.5%	PMTCT only implemented in 6 districts
3.7 Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child-transmission in the first 6 weeks	12.1%	National estimate. PMTCT only implemented in 6 districts
3.9 Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth	18.2%	PMTCT only implemented in 6 districts

3.10 Distribution of Outcomes of HIV-Exposed Infants		No data
3.11 Number of pregnant women attending ANC at least once during the reporting period	38,653	Estimated based on 80% pregnant women access ANC
3.12 ANC and EID facilities (UA)		
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015		
4.1 HIV treatment: antiretroviral therapy	173	(ART coverage is 67% with national criteria; 37% of the total PLHIV)
4.2a Twelve-month retention on antiretroviral therapy	82%	Programme data
4.2b Twenty-four month retention on antiretroviral therapy		No data
4.2c Sixty-month retention on antiretroviral therapy		No data
4.3 Health facilities that offer antiretroviral therapy	7	
4.4 ARV stock-outs	0	
4.5 Late HIV diagnoses	61%	
4.6 HIV care	203	
4.7 Viral Load		No data
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015		
5.1 Co-Management of Tuberculosis and HIV Treatment	24	
5.2 Percentage of people living with HIV newly enrolled in HIV care with active TB disease	39%	
5.3 Percentage of people living with HIV newly enrolled in HIV care, started on isoniazid preventive therapy		Implemented but not reported
5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	70%	

Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22–24 billion in low- and middle-income countries		
6.1 AIDS Spending - Domestic and international AIDS spending by categories and financing sources (GARPR)		No data
Target 7. Eliminating gender inequalities		Some background in narrative report
7.1 Prevalence of recent intimate partner violence (IPV)		No data
Target 8. Eliminating stigma and discrimination		
8.1 Discriminatory attitudes towards people living with HIV (GARPR)	30.5%	DHS survey 2009-10, for question 1
Target 9. Eliminate Travel restrictions		
Target 10. Strengthening HIV integration		
10.1 Orphans school attendance		No new data
10.2 External economic support to the poorest households		No data

1. The country context

The Democratic Republic of Timor-Leste is located to the east of Indonesia with which it shares borders. It is a young country having reasserted independence in 2002. There are 13 districts, each with four to six sub-districts. Dili and Baucau are the two largest urban centers with 32.4% of the population. The country has been described as one of Asia's 'least developed countries'[1]. The current population is about 1.2 million and the annual population growth rate is 2.4% (2010-2012)[2].

Around 50% population lives below the poverty line and about 50% are illiterate[3]. The survey results found 45% of children under-5 years of age were malnourished (45.5% of boys and 43.8% of girls), 58% stunted (60% of boys and 56% of girls) and 19% showed wasting (20% of boys and 17% of girls)[4]. The 2013 Global Hunger Index[5] rates the situation in Timor-Leste as 'alarming' with a hunger index of 29.6 in 2013 (up from 26.0 in 2005) which is worse than any other country in the South, East and Southeast Asia region.

In 2012, the World Bank classified Timor-Leste as an upper lower-middle-income country (U-LMIC) largely due to offshore oil and gas resources which were estimated to contribute to 80% of government revenues. In 2005, the Government created the Petroleum Fund as a repository for all petroleum revenues and to preserve the wealth for future generations. The Fund held assets of USD14.9 billion as at December 2013.

1.1 Education

Education is provided free in Timor-Leste for the first nine years. Between 2008 and 2010, school enrolment rates were relatively high in primary schools (around 80%), rates dropped significantly in middle (just over 20%) and high school levels (just under 20%). At all levels of education the enrolment of girls marginally exceeds that of boys by 2-4%.

It is estimated that around 50% of citizens are illiterate. Adult literacy is amongst the lowest in the world with only 63% of men and 52% of women aged 15 years or above being literate. More than half (58%) of women aged 25 and above have never been to school compared to 43% of men. Only 16% of women aged 25 and over have completed secondary or tertiary education compared with 25% of men.

[1] United Nations General Assembly Economic and Social Council, A/68/88–E/2013/81, 17th May 2013 (multiple indicators)
[2] National Statistics Directorate Ministry of Finance Democratic Republic of Timor-Leste; Timor-Leste Demographic and Health Survey 2009-2010, preliminary report (pp 5-25)
[3] Global Fund Portfolio Analysis November 2014 (p 1)
[4] Demographic Survey (pp 5-25)
[5] Global Hunger Index 2013

Traditional attitudes towards women and older girls often require they remain in or near the home and travelling the distances required to attend school or university may be discouraged by family members. Teenage pregnancy also plays a role in prematurely ending the education of young women. Also, where the costs of education are difficult to meet, families may consider higher education for boys a better investment. This presents a significant challenge in relation to assuring knowledge and skills dissemination in relation to sexual and reproductive health. In addition, these factors and a conservative religious environment have a very significant impact on women building capacity to negotiate safe sex. It is essential to seek multiple avenues for conveying HIV related knowledge and prevention skills and to begin this process as early as possible in the education cycle. To maximize the reach of these information programs in this context information programs need to be verbal and messages consistent.

1.2 Legal environment

The legislative environment is non-specific in relation to sex work and homosexuality. Sex work and male to male sex is not illegal however there are high levels of stigma and discrimination expressed in the community and police harassment is reported. While sex work is not illegal, brothel keeping is and police prosecute brothel operators. Criminalizing these other aspects of sex work effectively cloaks sex work activities in illegality. To date, sex workers and others involved in the business of sex work report being regularly arrested and/or detained by police in Dili.

There is also no specific legislation in relation to the protection of rights for people living with HIV. The constitution of the Democratic Republic of Timor-Leste includes reference to the responsibilities of the government in ensuring the protection of all people against stigma and discrimination on the basis of “colour, race, marital status, gender, ethnic origin, language, social or economic status, political or ideological convictions, religion, education and physical or mental condition”. People living with HIV are protected under Article 228 of the Penal Code: Refusal to provide medical assistance. This states that if medical officials or any medical professionals refuse to provide medical assistance to people living with HIV, punishable with up to 3 years imprisonment or a fine.

1.3 Gender inequalities

The 2013 Community and Gender Assessment report lists a series of profound issues underlying women’s poor access to health services generally. These include lower education levels than their male counterparts and high fertility rates affecting capacity to find work and be economically independent and in their ability to make reproductive health decisions. Women

are four times more likely than men to be unemployed, and are often therefore economically dependent on others.

Violence against women is a pervasive problem in Timor-Leste. While it takes many forms, the most common type of gender-based violence in Timor-Leste is domestic violence. Women are particularly affected. Information from the Timor-Leste Demographic Health Survey (2010) indicates that 38% of young Timorese women reported suffering some form of physical abuse. (Quote from the National Action Plan for gender based violence (GBV) in Timor-Leste).

2. The health systems and community systems

The government has demonstrated strong commitment to improve health systems and institute universal access to health care as a right of all Timorese. This commitment reaches to the inclusion of diagnosis and treatment of HIV and AIDS, sexually transmitted infections (STI) and tuberculosis (TB) form part of the basic service package (BSP) for primary health care and hospitals.

The health sector is centrally managed through the Ministry of Health in Dili. The Ministry develops policy and administers the health sector. Technical oversight and management of clinical services is provided through the Communicable Disease Control Department.

In-patient and outpatient services are delivered through a network of health facilities. The HNGV, a national hospital, located in Dili, is a modern low-rise building with a full range of secondary level medical and surgical services. There are five (5) referral hospitals located in each of the larger districts (Bacau, Bobonaro, Oecusse, Covalima and Ainaro). These provide basic secondary inpatient and outpatient health services. All of these facilities provide HIV testing and ART and STI testing and treatment services.

The 68 community health clinics (CHC) are facilities providing primary and secondary level medical and laboratory services. The CHCs provide HIV testing but not all has capacity to dispense ART.

Health posts, staffed by at least three health professionals, provide services to 3-4 villages. There are currently 236 of these facilities however a large expansion is planned to ensure greater access to care at the sub-district and community levels. Sparsely populated areas and areas of very low capacity in health service delivery are supplemented by the Sisterna Integradu Sauda Communitaria (SISCa). At these levels of the health system HIV prevention is promoted and referral for HIV testing is provided.

The health system is primarily staffed by remotely trained doctors and nurses. Many of the existing staff have been trained in Cuba, Indonesia or Australia. However, nurses and doctors are now also trained at the University of Timor-Leste. This being said, there are indications that the staffing levels in the districts are very low with only one district (Manatuto) reaching the 25 professional staff for 10,000 people recommended by WHO. The lowest staffing ratios are in Oecusse, Dili, Bacau, Ainaro and Ermera which are all under 10:10,000.

Health services are based on the delivery of a basic service package (BSP) which includes primary level health services such as maternal, neonatal and child health (MNCH) and immunization programs. HIV testing, care and treatment are also included in the BSP.

Health sector development is on-going. Large increases in the numbers of health service sites and staffing is planned over the next several years. This will include an increase in the number of health posts to over 400, each of which is planned to be staffed by three staff; a doctor, a nurse and a pharmacist (Draft Strategy from Timor-Leste Ministry of Health). These staff are also expected to deliver the BSP and man.a.ge all referrals, testing and pharmaceutical management. However, in relation to HIV, in the low prevalence environment, it is probable that STI/HIV component of the BSP will be managed through a paper based risk assessment with referral to the CHC level for HIV and syphilis testing. As the expectations become clearer with the finalization of the draft development plan the N.A.P anticipates working with relevant organisations to ensure that a program of capacity development and on-going supervision is planned and implemented and reporting systems are developed.

The government provided health system is supported by non-government health provision. Faith based health services and other non-government services compliment the government facilities. The Bairo Pite Clinic, a non-government in-patient and out-patient facility, in Dili is a favored location for access to health services. The clinic is funded through private donation and for HIV services the government provides the clinic with HIV test kits and ART and STI test kits and STI drugs. The clinic is well established as a key service provider for inpatient and outpatient secondary services. For HIV, the clinic provides around 20% of the HIV testing and 60% of treatment and care. Of the clients known to be co-infected with TB and HIV in 2014 the Bairo Pite Clinic provided care and support to 10 of the 24 clients. Of the cases of TB notified in Timor-Leste 30% were reported from Bairo Pite Clinic.

HIV services are also provided by other non-clinical non-government organization (NGOs) and community based organisations (CBOs). HIV testing and STI treatment is provided in the community by Fundasaun Timor Hair'i (FTH) in Dili, Baucau, Bobonaro, Covalima and Oecusse

(in six months of community based service provision this organization undertook around 4000 HIV tests).

The relationships between the government and the non-government sector appear to be excellent. Services are delivered and reporting occurs based on agreed government protocols and systems. Clinical referral systems exist and are made between services in Dili and between Dili and the districts. In the HIV service there are also connections made to CBOs. For example, where a person living with HIV begins treatment service providers will contact social networks for people living with HIV who will then actively promote their services and provide follow-up in the community as required.

3. The reporting process

The National AIDS Programme (NAP) under the Ministry of Health (MoH) in collaboration with stakeholders and with support from WHO , led the Global AIDS Response Progress (GARP) reporting process in Timor-Leste. The reporting had the inputs from UNAIDS- HQ, civil society organizations, people living with HIV, private sector, multilateral organizations and international NGOs.

Staff from NAP and technical partners, particularly those from WHO, discussed the data several times for the report.

4. HIV and STI Epidemiology

Timor-Leste is still a low HIV prevalence country, where HIV prevalence of general population is well below 1%, while it is lower than 5% in any of the key population, including sex workers, men who have sex with men, and injecting drug users. There are areas and groups where the HIV epidemic is “concentrated”, however. This status has been determined from surveillance information, an integrated bio-behavioral survey (IBBS) in key populations (2011)[6] and HIV sentinel surveillance undertaken in 2010 and 2013. The current status of the HIV epidemic and key population distribution in Timor-Leste is shown in the map below (Figure 1).

6 Results from the HIV/STI Integrated Biologic & Behavioral Surveillance (IBBS) Survey Democratic Republic of Timor-Leste (2011) (p 19)

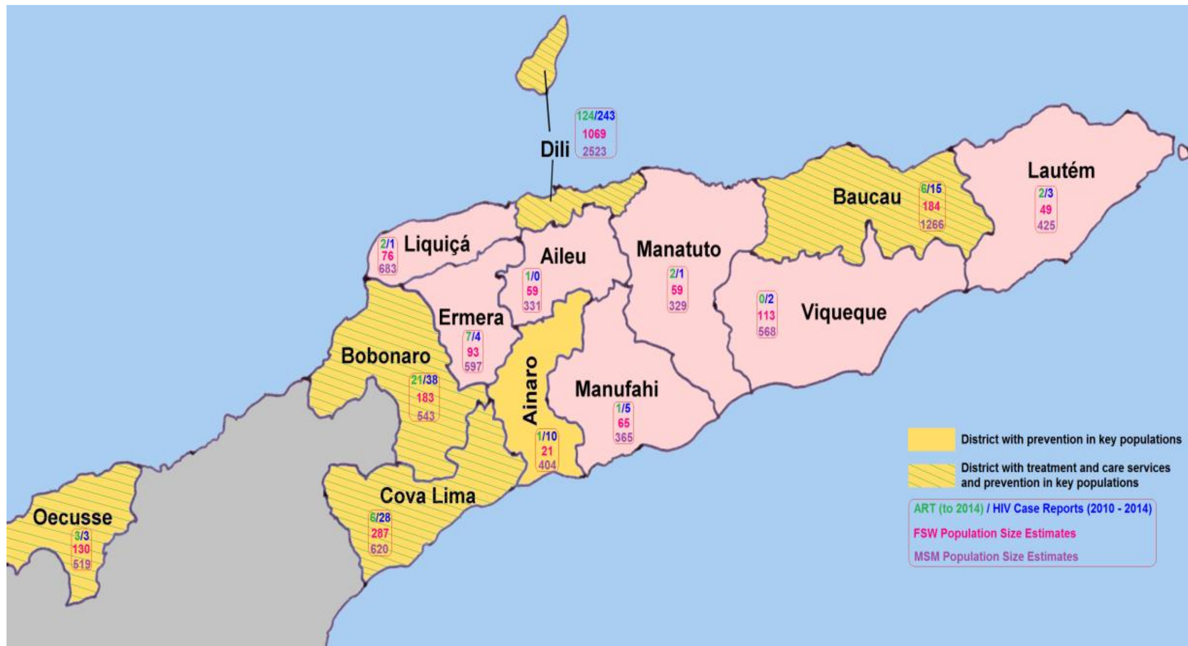

Figure 1. Current status of HIV epidemic and distribution of key population inTLS

4.1 HIV case based surveillance

The first case of HIV was reported in 2003. At the end of December 2014, 484 cumulative cases had been reported. The majority (84%) of people living with HIV as of December 2014 are aged between 15 to 44 years of age and sexual transmission is thought to be the main route of transmission[7].

Over the years the numbers of newly reported cases has risen. Between 2003 and 2005 less than 10 cases were reported per year. Between 2006 and 2008 the numbers of cases reported per year had risen with 70 cases reported for that three year period. Case reporting in 2011 increased to 79, in 2012 cases reported dropped to 68 and in 2013 case reporting rose again to 78. For 2014, up until the end of December, 76 new cases had been reported[8] (Table 1). It is however not clear whether the expanding of HIV testing could be attributable, at least partially, to the rising number of HIV cases reported in recent years.

[7] Transmission route is not collected in the national surveillance system

[8] No unique identifier is introduced for case reporting. No effort is made to de-duplicate the HIV cases.

Table1. No. reported HIV cases by year, 2003-2014, Timor-Leste

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Male	na	na	na	na	na	na	na	29	40	37	43	40
Female	na	na	na	na	na	na	na	23	39	31	35	36
Total	1	3	7	22	22	26	50	52	79	68	78	76
Cumulative	1	4	11	33	55	81	131	183	262	330	408	484

Note: na – not available

It shows considerable differences in the disease burden across the country (refer to the map above): Dili accounted for more than 69% of all reported cases between January 2010 and September 2013, while in Bobonaro (border district) accounted for 10.3%. It is unclear if this distribution is due to different levels of capacity to undertake HIV testing, lack of case reporting and/or the actual prevalence being lower in districts outside of Dili.

4.2 HIV surveillance surveys

So far, two rounds of HIV sentinel surveillance has been carried out in antenatal care services (ANC), clinics diagnosing and treating TB and in clinics treating STI in 2010 and 2013, respectively. The 2013 HIV Sentinel Surveillance Report[9] indicates that HIV prevalence is much lower than the surveillance findings in 2010. HIV prevalence in the different sentinel populations was:

- 0.04% (0.00% – 0.13%) in ANC attendees compared to 0.68% in 2010
- 0.38% (0.00% - 1.25%) among TB clinic attendees as compared to 1.1% in 2010
- 0.37% (0.00%– 1.09%) among STI attendees compared to 2.6% in 2010.

9 National HIV STI National Control Program HIV Sentinel Surveillance Report 2013 (p 4)

These changes in HIV prevalence are significant. The results of the two rounds of surveillance should be compared with caveats, however. The 2010 HIV sentinel surveillance did not use the two test algorithm to confirm first test findings. In addition, the 2010 sentinel surveillance was run over an eight month period whereas the 2013 sentinel surveillance results were generated in a two month period. The next round of sentinel surveillance is planned for 2015.

In 2011, an Integrated Behavior and Biological Survey (IBBS) was conducted to several selected population groups across the country. This is currently the only country wide information available on the status of the epidemic in key population groups. The report suggests that HIV was predominantly prevalent among MSM (1.3%), sex workers (1.5%) and uniformed personnel (UP) (0.5%). There was no HIV found among clients of sex workers (CSW).

The 2011 IBBS showed that there was good knowledge of condom access however the rates of use were extremely low for all groups (less than 50% reporting condom use in the last sexual contact). This indicated poor access to condoms and poor knowledge and skills for use. The 2011 IBBS also indicated that services were variably accessible based on location. For example, in Covalima and Oecusse fewer MSM knew where to get condoms than men in Dili, Bacau and Bobonaro.

The 2011 IBBS indicated that the majority of sex workers in the areas covered by the IBBS have had an HIV test before the IBBS. However, only 50% of MSM have had an HIV test before the IBBS.

4.3 HIV Estimation and projection

A recent modelling exercise with SPECTRUM provided by UNAIDS indicated that 464 people are estimated to have been infected with HIV to the end of 2014. It also indicated a rising trend of the HIV prevalence and incidence in the country in the next several years, given the current available HIV surveillance and programme data. It however indicated that the adult HIV prevalence will still keep a low lever over the years ahead (Table 2).

Table 2 Estimates of HIV prevalence, incidence and deaths in Timor-Leste, 2014-2020

Year	2014	2015	2016	2017	2018	2019	2020
PLHIV (**Total**)	464	542	623	711	806	909	1,021
Male	237	277	318	363	412	465	523
Female	227	265	305	347	394	444	498
Prev.% (15-49)	0.08	0.09	0.10	0.11	0.12	0.13	0.14
HIV new infection (Total)	89	99	109	119	131	142	155
Male	46	51	56	61	67	73	80
Female	43	48	53	58	63	69	75
Annual AIDS deaths (Total)	7	8	11	12	14	16	17
Male	4	4	6	7	7	8	9
Female	3	4	5	6	7	7	8
Cumulative AIDS deaths (total)	63	71	82	94	108	124	141
Male	33	38	43	50	57	65	75
Female	30	33	38	44	51	58	66

This gives one of the best possible scenarios for the HIV epidemic TLS at this time. However, given the limited data available (only 2 HSS and 1 IBBS results), any attempt to estimate the HIV burden prove to be challengeable and should be treated with caution. This should be carefully considered together with other information for development and implementation of the prevention, care and treatment activities. It also should be adjusted once more information on the epidemic and programme implementations is available.

4.4 Size estimation of key populations

A population size estimation exercise was conducted in 2014 with multiple methods - network scale up (NSU), service multiplier method, wisdom of the crowd (WOTC), key informant estimates and public & grey literature review. It indicated that there are 8,703 MSM (range 7,821 – 9,585) and 1,688 sex workers (range 1,333 – 2,044) in Timor-Leste. It is also estimated that there are 53 people who inject drugs, and 388 People who use drugs. The detailed report is available for reference[10].

[10] UNSW. Population size estimation of female sex workers, men who have sex with men and people who use and inject drugs in Timor-Leste. April 2015.

4.5 STI epidemiology

According to 2013 sentinel surveillance, prevalence of syphilis among ANC attendees was 1.05% (0.64% – 1.46%). The majority of cases of syphilis found in antenatal clinic attendees were in Covalima where there was 2% prevalence among ANC attendees and in Bacau and Dili where 1% of ANC attendees were found to have syphilis.

The 2011 IBBS highlighted significant syphilis rates among key population groups. An overall rate of 9.8% was found among sex workers and 7.1% among MSM. Clients of sex workers had the highest rates of syphilis at 16% of those tested while 13.9% of uniformed personnel were found to have syphilis.

From July to December 2014 a program of syphilis testing was started in Dili. Through this program 2,293 tests were carried out in the antenatal period. Of these 12 women tested positive, a prevalence of 0.52%.

5. The national response

Implemented by the NAP and supported by the National Commission to Combat HIV and AIDS in Timor-Leste (CNCS-TL), the National HIV/AIDS Strategic Plan (2011-2015) (HIV NSP) is to "reduce STI and HIV/AIDS mortality and morbidity in Timor-Leste by enhancing related prevention and treatment services". This is to be achieved by the implementation of five objectives:

Objective 1: Improve and increase coverage of strategic HIV and STI prevention services. This objective is implemented through behavior change communication (BCC), community outreach to key populations and those with higher risk sexual behaviors. The provision of HIV testing and counseling (HTC), prevention of mother to child transmission (PMTCT), management of STIs, social marketing, safe blood transfusion and universal precautions and provision of post-exposure prophylaxis (PEP) to those who are exposed to transmission in high risk professions and members of the community who are identified at risk.

Objective 2: Strengthen and expand HIV-AIDS treatment and care. The key program interventions are the provision of antiretroviral treatment (ART) and prophylaxis and treatment for opportunistic infections (OI). This objective also includes the provision of care and support.

Objective 3 and Objective 4 relate to strengthening health systems and community services to manage HIV and STIs. These objectives relate to strengthening national program management and strategic information systems and building capacity to deliver accessible services at the community level.

Objective 5: Build an enabling environment for implementation of STI and HIV programs. Achieving the service delivery areas in this component of the strategy relies heavily on other programs and high level engagement in the response to HIV. The strategic activities are social mobilization for addressing stigma and discrimination, promoting gender equality, policy advocacy and legislation, institution building for HIV/AIDS governance and co-ordination and the promotion of a multi-sectoral response.

It appears that some results have been achieved in areas of the HIV NSP. The mobilization and development of the CNCS-TL has led to the mobilization of a multi-sectoral response. The capacity of the N.A.P team is developing and the teams have been allocated responsibilities in program management, HIV prevention and health promotion, STI management, ART and OI treatment and care, monitoring and evaluation and administration. The focal points in these key areas are working to co-ordinate and monitor their respective areas of responsibility.

5.1 Prevention services particularly to key populations

In Timor-Leste, key populations include MSM (including transgendered persons, which is distinct but not listed separately, and male sex workers) and sex workers. Other groups such as UP, victims of sexual violence and prisoners are also included as populations vulnerable for HIV transmission in Timor-Leste.

Sex work and male to male sex are poorly tolerated and socially unacceptable in Timor-Leste. Women and men who sell or transact sex may do so sporadically in periods where families or individuals are under financial stress or for other reasons. Transactional sex, for a small proportion of men and women is their predominant source of income. There are several “locations” where sex workers can be found in Dili however these are very “fluid”. Contacts between sex workers and their clients can occur in hotels, bars or through informal networks.

HIV prevention targeted information has been made available through the services provided and outreach to all of the target groups described in the strategy. This is evidenced in the findings of the 2011 IBBS where all of the groups participating in the survey (CSW, MSM and UP) had heard of HIV and knew how to prevent it.

Outreach programs for key populations being implemented in Dili, Bacau, Bobonaro, Oecusse and Covalima. Till end of 2014 these programs (HIV prevention information and condoms) have reached 1858 MSM (21.3% of the total population) with prevention interventions in the community and 1209 sex workers (which represents 72% coverage (1209/1688) for the country.

5.2 Scaling up of HIV testing

HIV testing and counseling (HTC) is the entry point for accessing to the prevention and care services. Scaling up of HTC is vital for expanding the HIV treatment and care services. According to the reporting from the NAP:

- Scaling up of HIV testing has been phenomenal in 2014: a total of 33,768 HIV tests (as compared with 8,416 HIV tests in 2013) have been done through different services: VCT, PMTCT, blood banks and lab services of different level of hospitals across the country.
- The number of testing sites rose significantly from 26 sites being able to provide these services in 2013 to 55 in 2014.
- Women tested in ANC rose from 5,837 in 2013 with 9,345 women being tested in 2014 in six districts covered by the joint NAP/MNCH program.
- HIV testing in TB clinics has risen significantly. In 2011, 6.5% of all TB patients were tested for HIV and 1.4% of them were found to be HIV positive. In 2012, the proportion of people with TB tested for HIV was 20% (761 of 3837 clients) this rose in 2013 to 38% and in 2014 this has risen to 54%[11].
- HIV testing started in community level HIV testing services in 2014. Community based HIV testing services have been provided to 2,068 MSM and 1,741 sex workers, indicating that the program has good networks and that people not necessarily reached by the outreach service are also accessing these services.

However, there are still significant gaps for HIV testing: HIV testing for ANC attendees has not been expanded to all districts across the country; the needs for HIV testing for key populations and other at-risk groups are still not met.

5.3 Expansion of care and anti-retroviral treatment services

If about 56% of the estimated PLHIV (estimated 464 PLHIV in 2014) were eligible for ART (with CD4 count less than 350 cells/mm^3), the number eligible for ART is 260 according to the previous national ART guideline (2010 WHO guideline). This estimate would be adjusted in 2015 since the new ART guideline (2013 WHO guideline) has been implemented since July 2014, with CD4 cut off of 500 cells/mm^3, and immediate treatment after HIV testing positive of pregnant women, children, TB patients and sero-discordant couples.

[11] Data from National TB Programme.

A total of 173 people living with HIV are now on antiretroviral treatment (ART) at the end of 2014. The estimated ART coverage is 67% in 2014 according to the national eligibility criteria set by previous ART guideline, which is 37% of the total number of estimated PLHIV in TLS in 2014.

A cascade analysis of HIV testing and care services demonstrated several key issues: there is a significant gap for diagnosing those infected with HIV and enrolling them for care and ART; it is hard to know the number of individuals living with HIV who are diagnosed, since there is no way to de-duplicate the case reporting database (no unique identifier for the patients); viral load testing as important outcome indicator is not currently available for patient monitoring (Figure 2).

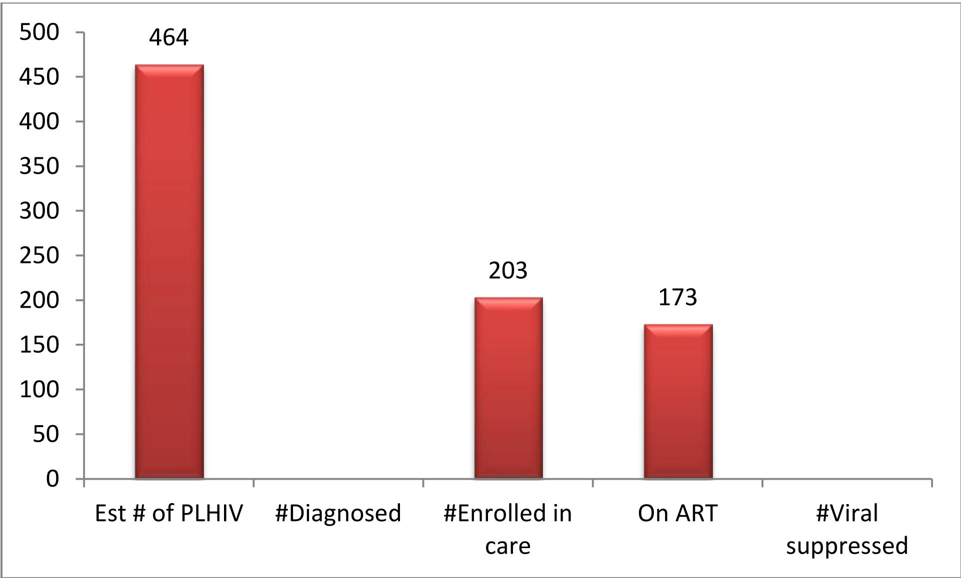

Fig. 2. Cascade analysis of HIV testing, care and treatment services in TLS

Of the 76 new cases identified up to December 2014, 61 people entered the treatment program (82%) as compared to the 66% that initiated ART in 2013 which indicates that service improvements are occurring. However, many PLHIV are still not receiving ART. The reasons for an insufficient coverage are due to lack of knowledge of HIV status, lack of referral and follow-up and fear of stigmatization in health services. The implementation of the WHO treatment guidelines (2013) began from July 2014 and this would have significantly increased access to care and treatment. The guidelines have been implemented by a process of provider notification and adaptation of existing training programs to include the new guidelines.

Of the 173 PLHIV currently on ART, 87 were men and 86 were women (17 are children). It seems there are equitable chances for women to access ART as compared with men, though the case based surveillance indicated there are slightly more men reportedly infected with HIV.

Of those that were receiving treatment at the beginning of 2013 the overall one year retention rate in the ART program is 82%. This is largely comparable with the treatment outcome of other developing country settings.

It is reported however, that many people are still coming to services late in the disease process indicating that early case reporting figures may not be reliable. About 61% (37/61) of the PLHIV are with CD4 count <200 at the first CD4 count.

CD4 is provided at the Hospital Nacional Guido Valadares (HNGV) (National Hospital in Dili) and in Baucau, Covalima and Bobonaro Viral load monitoring is not available at this time. However, the necessary equipment has been procured and introduction of this is planned for April 2015 or later this year. Viral load testing will be available for those being treated at the national level initially and expanded to other referral hospitals with relatively higher caseloads.

5.4 Management of TB/HIV co-morbidities

TB and HIV program collaboration has been managed as an on-going process and is found in all aspects of the implementation of the TB and HIV programs. Collaboration is supported by policy, program oversight, management structures and implementation strategies. The joint responsibility for this collaboration is reflected in the National Strategic Plans for both the programs.

About TB screening, out of 203 adults and children in HIV care in 2014, 142 (70%) have their TB status screened and test result recorded during their last visit for pre-ART or ART. A number of 24 PLHIV with incident TB have been provided with combination TB and ART treatment. Isoniazid preventive therapy (IPT) for PLHIV has been implemented in the country, but data was not collected thus not reported to the NAP.

The implementation of collaboration is managed at all levels including representation of the HIV and TB programs on the CCM Oversight Committee and the CCM. Collaboration is also actively supported by the Communicable Disease Division (CDC) of the MoH. This unit facilitates interactions between the programs with shared counterparts from the MoH and Communicable Disease Control Department working directly with both programs to assure integration and implementation of the WHO Guidelines for HIV and TB.

Collaboration also occurs at the program implementation level. To facilitate program management the HIV and TB programs meet quarterly to provide TB and HIV program oversight. Preventing TB for people living with HIV is a priority for both programs. In addition to clinical prevention, TB diagnostic questions are asked by all ART service providers on each visit. Isoniazid is accessed through the TB program procurement and supply mechanisms. While all ART service providers have been trained in these key prevention areas the scale of the implementation of these interventions is not reported in all instances.

5.5 Provision of prevention of HIV mother to child transmission (PMTCT) services

The estimated number of pregnant women is 48,316 nationally, and 28,478 in the 6 districts. HIV testing among pregnant women has been scaling up in 6 districts with collaborative NAP/MNCH activities. In 2014, a total of 9345 women were tested, of which 8 were found to be HIV positive. Of these women, 6 were recorded as having delivered in 2014 and of the exposed babies all received early infant treatment. However, of 6 babies born to HIV positive mothers, only 2 infants received an HIV test within two months of birth, during the reporting period.

However, HIV testing to pregnant women is still limited given the limited geographic expansion and insufficient coverage. This can be further illustrated by the cascade analysis below. It demonstrates a significant gap for providing HIV testing services to the pregnant women in the whole country. Moreover, insufficient early infant diagnosis (EID) is provided to babies born to HIV infected mothers (Figure 3).

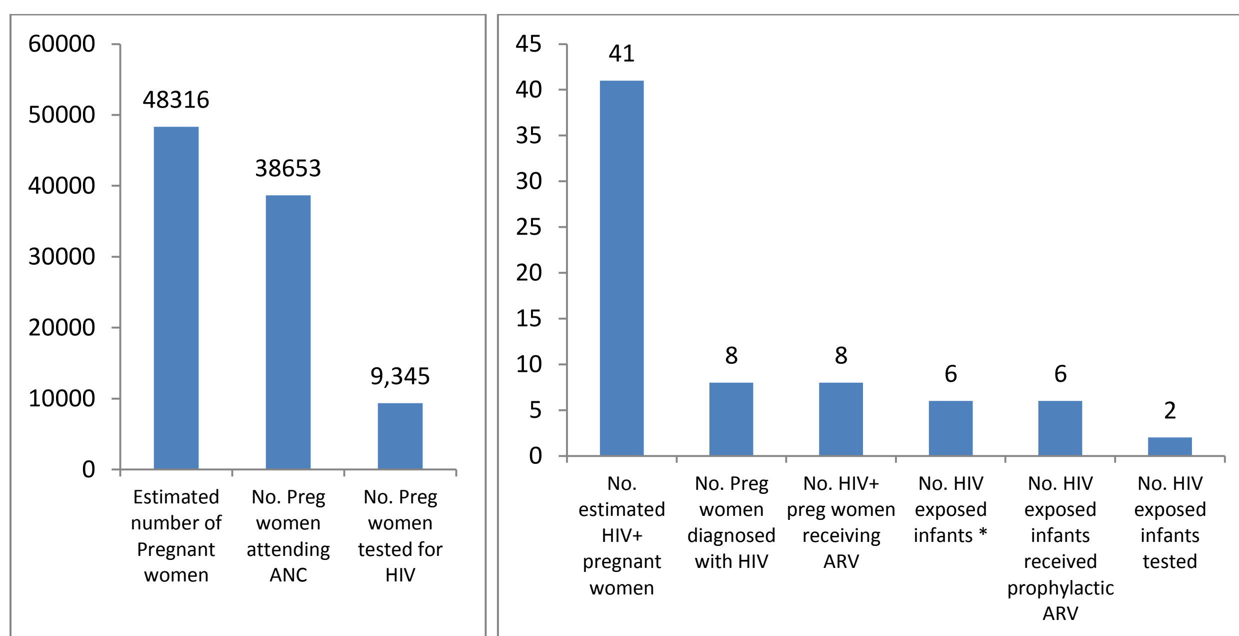

Figure 3. Cascade analysis of PMTCT services in TLS, 2014.

The postnatal cascade of care for HIV exposed infants is managed at the HNGV. Diagnostic dry blood spot samples are sent by the Timor-Leste national laboratory to Sydney (Australia). At this time there are 17 children on pediatric ART aged between 0-14 years.

5.6 STI services:

As per the activity plan 5 districts have been selected for syphilis testing in pregnant women in a phase manner till 2016. However during the reporting period only 1 district of Dili started

implementing activity since July 2014. This is under implementation, and limited results are available so far.

It seems there is difference between men and women accessing STI services: women are more likely to access health services overall including services related to pregnancy and child birth and when they accompany children for health care. While regular access to health services may increase health seeking behaviors for women it is also likely that midwives trained in STI diagnosis and treatment may be providing STI services for women, presenting during pregnancy and child birth. Therefore trained midwives providing ANC and labor and delivery support will report STI cases derived from testing in pregnancy. Sexually active young women who are not pregnant may also not be accessing STI services however this is not fully understood from the information reported.

For men, the lack of access to STI services is thought to be due to STI services being predominantly delivered by women. When men do present they do so, only as a last resort were symptoms have not resolved from pharmacy advised and/or self-treatment.

These combined features indicate that further analysis is required to understand the barriers for men's access to STI services. Mechanisms to improve access to services should be explored to increase the number of male health workers providing STI services and improve accessibility to community based services delivered by other health and non-health sector services and programs.

6. ***Gaps, challenges and way forward***

6.1 The HIV epidemic may evolve from 'low-level' to "concentrated", and sexually transmitted infections (STI) may fuel the HIV transmission

Timor-Leste has been reported as a 'low-level' HIV epidemic. The overall picture suggests that the HIV epidemic is rising, though slowly, and may be evolving from 'low level' towards "concentrated" in "pockets" of districts and sub-groups.

There are high STI prevalence across the at-risk groups including FSWs, MSM, clients of sex workers, and uniformed personnel. All studies so far in the general population and key populations showed low rates of use and inconsistent use of condoms. Paid sex is not uncommon in some occupations and border districts. This is complicated by the pattern of healthcare seeking behaviour for STI treatment where 1 in 2 persons do not seek care from health profession.a.ls, and in FSWs, one in five persons. Sexual mixing, that is, MSM who have sex with women as well as other men, FSW having regular partner and clients, and at-risk groups having sex with lower-risk partners (e.g. wives) promotes transmission of untreated STIs in the population. Lastly, asymptomatic STIs in women and MSM (anal infections), are probably not treated and adds to the issue of untreated STIs in the population. High prevalence of STI may fuel the transmission of HIV if not controlled.

Way forward:

- Strengthen the HIV and STI surveillance, including case reporting and sentinel surveillance, and IBBS as necessary. Utilize the information generated from the surveillance activities to guide the planning and programme implementation.

- Expand the STI screening and treatment activities to cover more districts. The current testing and treatment for ANC attendees and for key population need to be expanded to other districts when experiences accumulated.

<u>6.2 Coverage and quality of cascade of HIV services both need to be improved</u>

While there have been increasing coverage of services for key populations, both reach/coverage and the quality of programme requires strengthening. The package of services for sex workers and MSM/transgender persons require re-examination to include prevention and management of asymptomatic STIs. Skills and competencies for peer education need strengthening. At-risk populations particularly FSWs need encouragement to access health services, which should be non-discriminatory. The principles of "voluntary, confidential, informed consent" must continue to guide strategies for KPs.

While there are expansions of HIV prevention, care and treatment services in recent years, quality of services should also be improved. For example, after there are leakages along the HIV testing, care and treatment services. Many people lost to follow up after tested positive, or referred to care and treatment services. Capacity is limited to track the patients for those who are on ART, and data collection and analysis and use for programme improvement is particularly weak.

Way forward:

- Prioritize and focus the programme activities on expansion of cascade of HIV testing, care and treatment services, and provision of prevention services to key population.

- Retention needs to be improved from the time of HIV diagnosis in VCT/PITCT to having a baseline CD4 assessment to see if ART is required, to having regular CD4 and clinical follow-up; and adherence to ART treatment once initiated, and to have viral load test according to the WHO recommendations.

<u>6.5 Coordination and capacity need to be strengthened</u>

In the HIV/STI programme, service providers comprise not only healthcare personnel, but also a broad network of NGOs/FBS/CBO/PLHIV organisations which serve as an extension of the

health system. In order to optimise service delivery by these functionaries, capacity building is required and which will evolve over time with the changing programme needs.

Way forward:

- NAP take cohesive efforts and coordinate all programmes – HIV/STI, TB and MCH programmes and all implementing partners to accelerate scaling up the coverage and quality of cascade of HIV services. HIV services should be planned and provided in the overall framework of universal health coverage.

- Institutionalize the capacity building of the national programme. Technical support from donors and developmental partners should be incorporated into the overall capacity building plans for human resources in HIV/health. Immediate needs are in capacity building for strategic information (SI) and M&E which could be initiated rapidly in the short-term.

- Continue to work for enabling environment for HIV and STI prevention and care programme, and address the social determinants for health, especially for the vulnerable and key populations.