Global AIDS Progress Report
January 2010 – December 2011

Acknowledgement
The 2008-2009 UNGASS document was the first submission from Timor-Leste on national reporting of HIV for a global forum. The Global AIDS Progress Report for 2010 – 2011 will provide data on the increase in the uptake of HIV and STI services, additional operational research that was undertaken during the last 2 years as well as provide a deeper understanding of opportunities, gaps and challenges related to the HIV/AIDS response in Timor-Leste at a national, global and regional level.

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

Due to an increase in financial and human resources for the National program, HIV programming in the following 5 years will increase geographical and programmatic coverage and implementation of the national response as well as the strengthening of health and political systems essential to respond to the HIV situation in Timor-Leste.

Acronyms

ABC	Abstinence, Be faithful, Condoms
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
AUSAID	Australian International AID Agency
BCC	Behavior change communication
CCM	Country coordination mechanism
DD	Dublin declaration
DRTL	Democratic Republic of Timor-Leste
FSW	Female sex worker
FDTL	Forca Defesa de Timor-Leste
GAPR	Global AIDS Progress Report
HEMI	HIV Epidemic and Impact Model Study
HIV	Human immunodeficiency virus
IBBS	Integrated biological and behavioral survey
IDU	Intravenous drug user
IEC	Information education communication
MARPS	Most at risk populations
MOH	Ministry of Health
M&E	Monitoring and Evaluation
MSM	Men who have sex with Men
NAC	National AIDS Commission
NGO	Non governmental organization
NSP	National strategic plan
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PNTL	Policia Nacional de Timor-Leste
STI	Sexually Transmitted Infection
TB	Tuberculosis
TGF	The Global Fund
UP	Uniformed personnel
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNMIT	United Nations Mission in Timor
UA	Universal access
USAID	United States International AID Agency
WHO	World Health Organization
VCT	Voluntary counseling and testing

1. Status at a Glance

1.1. Inclusiveness of the stakeholders in the report writing process

The preparation of the 2010 – 2011 Global AIDS Progress Report involved consultation with HIV stakeholders in country, including government officials, bi-laterals, civil society and faith based organizations and United Nations Agencies. Interviews were held with key government and civil society partners and a consensus building process was ensured. This process has enabled stakeholders to take stock of the current HIV situation as well as provide guidance on future programme needs.

Data on the GAPR/UA/DD indicators were collated through a range of sources which included national program monitoring reports, Demographic Health Survey 2009 – 2010 and HIV behavioral and sentinel surveys, Compilation of the report was conducted by the HIV unit within the Ministry of Health with support from the World Health Organization.

1.2. Status of the epidemic

Timor-Leste is considered to have a low-level epidemic, with an estimated national HIV prevalence of approximately 0.1845%, which is non-generalized. Most HIV infections would appear to have been acquired through heterosexual contact, with other routes of transmission likely to include homosexual contact, injecting drug use, and peri-natal and blood transmission. Based on data from the 2010 sentinel surveillance, HIV prevalence among pregnant women is 0.68%. Based on a previous number of 24,190 live births in 2011, approximately 165 pregnant women would become HIV positive each year. Without intervention, this could translate into 45 babies being born with HIV annually.

The first reported case was in 2003, with a cumulative total of 235 HIV positive cases being reported to the National AIDS Programme as of December 2011. Fifty one (51%) percent of HIV positive cases in the last 12 months were reported among 16 and 30 years old and eight (8%) percent of HIV positive cases were within children under the age of 5. Among cases reported in men, 43% were positive and 57% HIV positive reported within women. National level cumulative data shows 63 cases of HIV in 2011. Almost all those found to be living with HIV reside in urban areas, predominantly in the capital Dili.

In 2010, the MoH conducted an integrated biological and behavioral survey in relation to HIV and STIs. HIV prevalence was 2.76% among FSW, 1.33% among MSM, and showed zero prevalence among the uniformed personnel. MSM and FSW showed 10% and 3.33% Hepatitis B rates, respectively, while male uniformed personnel had 12.1% and female uniformed personnel showed a Hepatitis B rate of 22.2%. Syphilis rates were 5.33% among MSM, 8.84% in FSW, 7.58% in male uniformed personnel and 11.11% in female uniformed personnel. Data on the female uniformed personnel should be taken with caution as the sampling group was smaller than required. These numbers indicate that risk behavior remains high. Preliminary data from the IBSS conducted in late 2011 in the southern border district with Indonesia with participants drawn from FSWs, men who have sex with men, uniformed personnel and clients of sex workers, showed syphilis rates around 15%.

In terms of behavior related to HIV, the 2010 IBBS demonstrated that 15.8% of MSM indicated 100% condom use with their regular male partner, 18.3% with a casual male partner and 15.6% of MSM indicated 100% condom use with their regular female partner,

20.5% with a casual female partner. Within MSM, 51.6% indicated condom use at last sex with a regular male partner and 49.5% with a casual male partner.

FSW reported 8.86 mean number of paying clients and 2.6 mean number of non-paying clients in the past 7 days. 21.2% of FSW reported 100% condom use with a paying client and 68.5% indicated condom use with their last client. In the uniformed personnel group, 4.9% indicated 100% condom use with their regular partner and 7.3% with a casual partner. In addition, they reported 19.8% use of condoms at last sex with regular partner and 21.8% with a casual partner. The most common reason stated, among the 3 at risk groups tested, for not using a condom was that they simply do not like condoms.

1.3. Policy and programmatic response

With the National Health Sector Strategic Plan 2008 – 2012, the Ministry of Health has included a significant HIV component. This plan calls for inter-sectoral engagement with the different sectors and support for community based organizations and focuses on:

- Supporting community based organizations
- BCC/IEC alignment to community-based health promotion and prevention programs
- Capacity development within the health system and within communities
- Public/private partnership enhancements
- Inter-sectoral engagement in particular with the education sector
- Integrated disease surveillance
- Prevention, control, diagnosis, treatment and rehabilitation
- Monitoring and evaluation

The National HIV/AIDS and STI Strategic Plan for 2006 – 2010 is comprised of five program components which focuses on prevention, VCT, clinical services, multi-sector approach and strategic information. Leadership within the Ministry of Health has been strengthened and there is an emerging leadership group within the NGO sector and within PLHIV organizations. A significant amount of work on HIV has been implanted through civil society organizations. There is overall broad consensus on the basic principles of partnership, evidence based responses and a human rights approach in relation to policy and programming.

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

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

During 2010, the subsequent strategy was developed. The National HIV and STI Strategy 2011-1016 provides clear direction for programming over the time-frame. As such it will be

used for ensuring alignment and harmonization of funding from different sources to maximize effectiveness and efficiency. With commitment from all partners Timor-Leste is well placed to strengthen the existing response to HIV, meet new challenges and achieve the goals of minimizing HIV transmission in Timor-Leste and ensuring high quality treatment and care for people living with HIV. The strategic priorities outlined in this strategy are:

- Access to a basic service package including HIV and STI knowledge, clinical services and availability of condoms for the general population
- Targeted prevention programs targeted for individuals with multiple partners outside of MARPs
- Strengthening intensive prevention programs targeted at MARPs (sex workers, clients of sex workers, MSM, Uniformed Services)
- Scaling up services in border districts
- Ensuring universal coverage of life skills based sex education for young people
- Achieving universal access to treatment for those who are infected by increasing coverage of testing and counselling
- Strengthening the capacity of the health system to respond to increased need for HIV treatment services
- Strengthening community sector systems to enhance quality of service delivery
- Establishing an enabling environment through a coalition for gender equality, sexual and reproductive health

1.4. Indicator data in an overview table

Note: not all of the indicators within the 7 target areas are relevant for the country; additionally some indicators that are relevant do not have data sources.

Target	Indicator	2010	2012	2012 Data Source	Remarks
Target 1. **Reduce sexual transmission of HIV by 50 percent by 2015** **General population**	**1.1** Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	28.3% can identify at least 2 ways of preventing HIV transmission	13.9%	Demographic Health Survey 2009 - 2010	Previous data came from the 2009 UNFPA Youth Reproductive Health: Quantitative and qualitative analysis
	1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Males between the ages of 20- 24 = 4% Age 15 at first pregnancy for women aged 20 – 24 = 9%	1.5%	Demographic Health Survey 2009 - 2010	Previous data came from the 2009 UNFPA Youth Reproductive Health: Quantitative and qualitative analysis
	1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	Male Uniformed Personnel – 34.8% MSM with female partners – 93.8%	1.35%	Demographic Health Survey 2009 - 2010	"% of men aged 15 - 49 who had sexual intercourse with 2+ sexual partners in the past 12 months."
	1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	Male Uniformed Personnel – 25% for vaginal intercourse and 14.3% for anal intercourse	3.85%	Demographic Health Survey 2009 - 2010	Indicator: Condom use at first sexual intercourse among youth aged 15 - 24

	1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	N/A	N/A		This question was not included in the last DHS survey in 2010.
	1.6 Percentage of young people aged 15-24 who are living with HIV*	N/A	0.88%	ANC clinic based sentinel surveillance	Data was collected from ten sites which included the National Hospital located in the capital Dili, four regional hospitals, three Community Health Center's and two private clinics. All facilities, except for the four regional hospitals, were located in the capital Dili.
Sex workers	**1.7** Percentage of sex workers reached with HIV prevention programs	50.0% FSW reached through NGO services 7.0% FSW reached through health services	87.22%	2011 IBBS	Indicator "Do you know where you can go if you wish to receive an HIV test?"
	1.8 Percentage of sex workers reporting the use of a condom with their most recent client	FSW – 65.3%	36%	2011 IBBS	

	1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	52.7% FSW have ever had an HIV test	66.3%	2010 IBBS	
	1.10 Percentage of sex workers who are living with HIV	3%	1.5%	2011 IBBS	Only female sex workers were included in the IBBS.
Men who have sex with men	**1.11** Percentage of men who have sex with men reached with HIV prevention programs	23.3% MSM reached through NGO services 9.1% MSM reached through health services	94%	2011 IBBS	Indicator "Do you know where you can go if you wish to receive an HIV test?"
	1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	With a regular partner – 37.5% Non regular partner – 43%	66%	2011 IBBS	
	1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	25.6% MSM have ever had an HIV test	32.5%	2010 IBBS	
	1.14 Percentage of men who have sex with men who are living with HIV	0.9%	1.3%	2011 IBBS	

Testing and Counseling	**1.15** Percentage of health facilities that provide HIV testing and counseling services	N/A	6.45%	MoH program reports	HIV testing centers: 1 National Hospital, 5 Referral (District) Hospitals, 1 private/public hospital, 9 Community Health Centers, 1 private clinic and 3 mobile clinics
	1.16 Number of women and men aged 15 and older who received HIV testing and counseling in the past 12 months and know their results	N/A	6,052	VCT and PMTCT registers	
Sexually Transmitted Infections	**1.17** Percentage of sex workers and MSM with active syphilis	N/A	9.8% - FSW 7.1% - MSM	2011 IBBS	
Target 2. **Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015**	**2.1** Number of syringes distributed per person who injects drugs per year by needle and syringe programs	N/A	N/A	N/A	N/A
	2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	N/A	N/A	N/A	N/A
	2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	N/A	N/A	N/A	N/A

	2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	N/A	N/A	N/A	N/A
	2.5 Percentage of people who inject drugs who are living with HIV	N/A	N/A	N/A	N/A
Target 3. **Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths**	**3.1** Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	4.5% of women estimated to be pregnant (50,180/1,114,534) with estimated number of HIV infected = 50,180 * .51% = 256	1.43%	PMTCT registers and estimated of # of HIV+ pregnant women	
	3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	N/A	N/A	N/A	N/A
	3.3 Percentage of child infections from HIV-infected women delivering in the past 12 months	N/A	30%	N/A	N/A
	3.4 Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labor and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	N/A	5.9%	PMTCT registers	
	3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	N/A	N/A	N/A	N/A

	3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	N/A	2%	PMTCT registers	
	3.7 Percentage of infants born to HIV-infected women (HIV-exposed infants) who received antiretroviral prophylaxis to reduce the risk of early mother-to-child-transmission in the first 6 weeks (i.e. early postpartum transmission around 6 weeks of age)	N/A	1.2%	N/A	N/A
	3.8 Percentage of infants born to HIV-infected women (HIV-exposed infants) who are provided with antiretrovirals (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period.	N/A	N/A	N/A	N/A
	3.9 Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	N/A	1.2%	N/A	N/A
	3.10 Number of infants born to HIV-infected women assessed for and whose infant feeding practices were recorded at DTP3 visit	N/A	N/A	N/A	N/A
	3.11 Number of pregnant women attending ANC at least once during the reporting period	N/A	33,725	HMIS	
Target 4. **Have 15 million people living with HIV on**	**4.1** Percentage of eligible adults and children currently receiving antiretroviral therapy*	35/151 23%	60/235 26%	HIV Unit, MoH	

antiretroviral treatment by 2015					
	4.2a Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy 4.2b Percentage of adults and children with HIV still alive and known to be on treatment 24 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2009) 4.2c Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2006)	31/35 78% - 12 months (27) 76% - 24 months	5/6: 83% (12 month) 9/9: 100% (24 month) 5/5: 100% (60 month)	HIV Unit, MoH HIV Unit, MoH HIV Unit, MoH	The data start on January to December 2010 The data start on January 2009 to December 2010 The data start on January 2008 to December 2010
	4.3 Number of health facilities that offer antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)	N/A	7	MoH program reports	
	4.4 Percentage of health facilities dispensing antiretrovirals (ARVs) for antiretroviral therapy that have experienced a stock-out of at least one required ARV in the last 12 months	N/A	0%	ART registers	
	4.6 Percentage of adults and children enrolled in HIV care and eligible for co-trimoxazole (CTX) prophylaxis (according to national guidelines) currently receiving CTX prophylaxis	N/A	6/6: 100% continue up to date	HIV unit	

Target 5. **Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015**	**5.1** Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Estimated number of new TB incident cases in 2009 = 3589. Estimated HIV prevalence in incident TB cases = .05% Estimated number of TB/HIV co-infected = 1.79 5/1.79	??		
	5.2 Number of health care facilities providing ART services for people living with HIV with demonstrable infection control practices that include TB control	N/A	7	MoH program reports	
	5.3 Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	N/A	N/A		
	5.4 Percentage (%) of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	N/A	N/A		
Target 6. **Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries**	**6.1** Domestic and international AIDS spending by categories and financing sources	$4,101,638.80	$6,144,201		

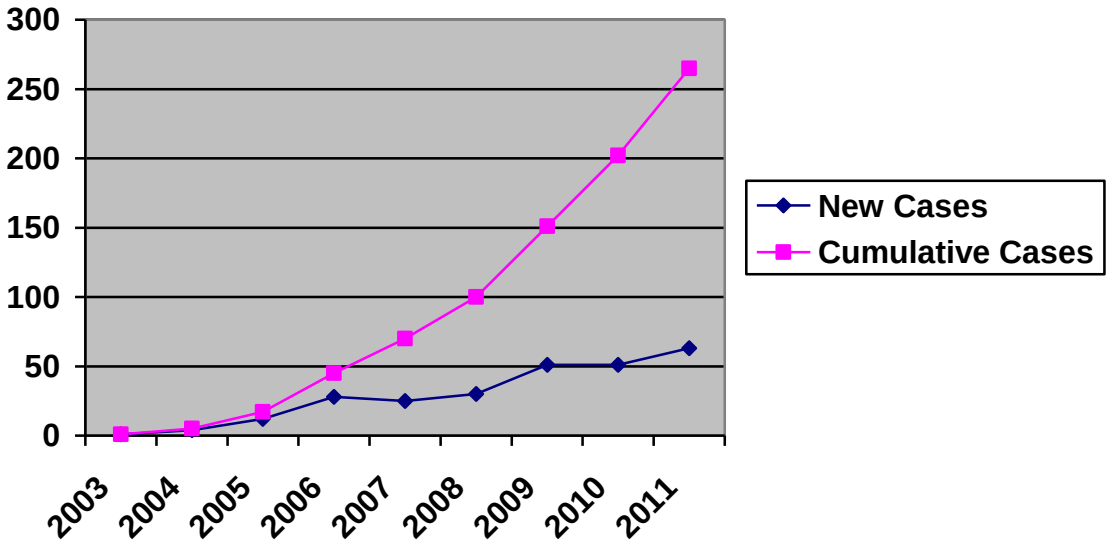
Target 7. **Critical Enablers and Synergies with Development Sectors**	**7.1** National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)	Annex	Annex		
	7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	N/A	29.45%	Demographic Health Survey 2009 - 2010	
	7.3 Current school attendance among orphans and non-orphans aged 10–14*	N/A	65.82% - lost both parents **87.2%** - living with at least one parent	Demographic Health Survey 2009 - 2010	
	7.4 Proportion of the poorest households who received external economic support in the last 3 months	N/A	N/A		Data from the Standard of Living Survey 2011 will be used to respond to this indicator. The final report is expected around May 2012.

2. Overview of the AIDS Epidemic

The first HIV positive infection was detected in 2003. By the end of 2011, a cumulative total of 235 people were confirmed HIV positive. Due to the increase in community outreach and testing facilities in all districts, there has been a steady increase in the number of diagnosed HIV infections. By 2011, the number of females who have tested positive is 36 or 2.5 %, while 27 males tested HIV positive or 1.4%. The majority of infections occur in those aged 25 to 44 years old.

HIV prevalence in Timor-Leste is estimated at approximately 0.1845% of adults aged 15-49 (2011), or 894 people living with HIV. This is five times higher than predicted through the HIV Epidemic and Impact Model Study undertaken in 2005 funded by the Australian Agency for International Development (AusAID). There is evidence that incidence of HIV is increasing. The support shows that the increase is occurring outside populations usually categorized as key populations at higher risk. HIV infection is concentrated in the urban areas of Dili and Maliana.

Table 1: Number of HIV positive cases from 2003 through December 2011



The 2006-2010 National HIV/AIDS and STI National Strategy was adopted in the context of a country with low levels of HIV infection and a relatively steady pattern of economic growth and social development. The Asian Epidemic model which prioritises containment of infection among most at risk populations (particularly Female Sex Workers (FSWs), Clients of FSWs, Injecting drug Users (IDUs) and MSM, provided a key reference point for strategic priorities. Likely epidemic scenarios for Timor-Leste described in the "HIV Epidemiological Model and Impact (HEMI) Study" supported the strategic approach adopted.

In the period since the adoption of the 2006-2010 strategy, Timor-Leste has experienced political and social upheaval with high levels of social conflict and population movement. Traditional sources of social authority such as the church and extended family structures have weakened and people are more exposed to a range of competing social influences. Concurrently, Timor-Leste has one of the fastest economic growth rates in the world resulting in the emergence of a growing population group with significant disposable income. The mix of all these factors has created an environment suitable for a higher transmission of HIV than existed at the commencement of the strategy.

There is evidence now emerging that actual HIV infection is spreading much more quickly then projected through the HEMI 2005 study. While the basic logic of the Asian Epidemic Model is still valid, sentinel surveillance shows heterosexual transmission outside identified Most at Risk Populations to be much higher than what was predicted.

The Asian epidemic model assumes:

- Never married women in Asia are much less likely to have sexual intercourse then elsewhere in the world. Consequently, HIV first becomes established among groups at greater risk (IDUs, sex workers, MSM) before spreading to the sexual partners of these groups
- Sex workers and MSM have high rates of partner change and therefore are a catalyst for broader transmission
- Infectivity through anal sex is higher then vaginal sex therefore contributing to higher rates of transmission among MSM (further increased by high rates of partner change)
- Injecting drug use through the sharing of injecting equipment results in rapid HIV transmission between IDUs and subsequently to sexual partners
- There is significant interaction between sex workers, MSM and IDUs
- Sex workers, MSM and IDUs have sexual partners outside their own group
- If a critical level of HIV infection becomes established among sex workers, clients of sex workers are the main bridge of HIV infection to women outside risk populations

Each of the above assumptions was applicable in Timor-Leste when the 2006 - 2010 strategy was developed. Based on sentinel surveillance undertaken in 2010, it appears that the prevalence of HIV in Timor-Leste is higher in the general population than projected but still relatively low among female sex workers and MSM. This may be attributable to interventions with MARPS having been relatively effective. The extent to which HIV prevalence is higher than predicted through the modeling undertaken in 2005 (projected prevalence 0.04%; sentinel surveillance estimate 0.68%) shows the urgency in scaling up the HIV program. Based on the sentinel surveillance, HIV infection among pregnant women is estimated to be 0.68%, approximately 350 women a year.

3. National response to the AIDS Epidemic

The Ministry of Health is the main government body that oversees, coordinates, implements and monitors HIV programming in Timor-Leste. Additionally, the MoH implements aspects of the multi-sectoral components of the NSP as there are few other bodies of government capable of doing so. The Global Fund against AIDS, Tuberculosis, and Malaria awarded a five year $8.36 million grant from June 2007 through December 2011, which funds the majority

of the activities in the Strategic Plan. The Ministry of Health as the Principal Recipient of the Global Fund Grant is implementing the National HIV/AIDS Program with its partners and sub-recipients. The National HIV/AIDS Program implements the National HIV/AIDS Strategic Plan and includes the following:

- Strengthening HIV and STI prevention especially targeted to most at risk groups
- Clinical services - providing diagnosis, treatment and care
- Counseling and Testing
- Institutional arrangements
- Community Systems Strengthening
- Strategic Information

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

Progress in the Implementation of the National Strategic Plan during 2010-2011

Prevention

The National Strategy has the following objectives for the prevention component:

- Improve knowledge across the general population of how to prevent HIV and STIs
- Enhance ability of young people to prevent risk of HIV and STI infection through life skills and knowledge regarding safe sex practices
- Ensure specific programs are targeted at most at risk groups to promote knowledge, create norms regarding condom use and enhance access to testing
- Increase availability of condoms through targeted outreach and at public health services
- To initiate a rapid response if evidence emerges in Timor Leste of significant risk of HIV transmission through injecting drug use.

These objectives were met through specific programs targeting:

- Most At Risk Groups (MARGs)
- Youth
- General Population

MSM and Female Sex Workers Program

Projects have been established targeting MSM, Female Sex Workers, Uniformed Services Personnel and clients of Sex Workers.

Under the Round 5 Global Fund HIV Grant, projects targeting MSM and FSWs include:

- Peer outreach in Dili, Baucau, Covalima, Bobonaro, Oecusse
- Establishment of a referral system to STI and VCT services in Dili, Baucau, Covalima, Bobonaro, Oecusse
- Advocacy in Dili, Baucau, Covalima, Bobonaro, Oecusse
- Drop in centre in Dili

Specific coverage targets for outreach have been exceeded and drop in centers have been established. Activities to enhance quality of interventions included worker training for various components of BCC including extensive interpersonal communication skills and peer education/support. All the SRs have the training aids, manuals and curriculum from the MoH.

Clients of Sex Workers

Activities (and targets) to reach clients of sex workers include:
Peer Education

- Outreach workers to reach clients in Dili, Covalima, Bobonaro, and Oecusse
- District field coordinators, master trainers and coordinate volunteer peer education/outreach workers to reach clients in Baucau, Liquica and Viqueque
- Production and broadcast of radio programs in all districts
- SRs organized community theatre in 12 districts

Uniformed Services

Activities implemented:

Advocacy

- PNTL and FDTL workshops to develop sector plans and workplace agreements
- PNTL and FDTL planning meetings to endorse policy and develop work plans

Peer Outreach

- Master trainers and peer leaders reach 3000 PNTL and 800 FDTL members

STI and VCT service provision and referral

- assess clinical facilities
- assist in service delivery
- STI or VCT information and services

Youth

HIV programming for young people in Timor-Leste is complex. Social norms place value on abstinence from sex until marriage. To reinforce these norms, programming includes a strong emphasis on the development of life skills. Most young people will be subject to pressure to engage in sexual activity. They need skills in assertiveness and negotiation if they are to take actions based on informed decision making. Those young people who engage in sexual experimentation need knowledge regarding safe sex to prevent risk of HIV transmission.

The Ministry of Health has developed a national behavior change communication strategy for Reproductive health, Family Planning and Safe Motherhood. The strategy includes a focus on safe sex (specifically ABC messages). Activities range from Edutainment (e.g. radio shows, street theatre), mass communication, community discussion and capacity development of heath providers in interpersonal communication.

UNICEF is implementing school based life skills education in cooperation with the Ministry of Education and Ministry of Health. UNFPA is supporting the Ministry of Education and Culture to ensure that life skills-based sexual and reproductive health education is integrated into the national secondary school curriculum and teacher training colleges; (b)

supporting the establishment of youth-friendly reproductive health services and a referral system; and supporting capacity-building for youth organizations and community advocacy.

General Population

The National Strategy identifies the need for HIV prevention targeted at the general population in order to:

- Promote an environment that is supportive of HIV strategy initiatives
- Ensure all members of the population have access to information to reduce their risk of HIV infection
- Reach people at higher risk that may not be accessed through more specifically targeted programs

Activities to promote HIV and STI knowledge among the general population are largely integrated into the National Reproductive Health Strategy. Community education and counseling are the main activities outlined in that strategy to address HIV and STI prevention. The National BCC Strategy for Reproductive Health, Family Planning and Safe Motherhood outlines activities to further strengthen BCC.

World AIDS Day is a high profile media event which has been conducted in both 2010 and 2011 to further promote HIV awareness and contribute to an environment which is supportive of HIV strategy initiatives.

Condom Distribution

Condom distribution has increased markedly over 2010 and 2011. The table below shows condom distribution against targets in 2010 and 2011.

Condom distribution	Targets	Condoms distributed
Jan-Dec 2010	147.000	211.012
Jan- Dec 2011	380.000	474.747
Total	527.000	685.789

Voluntary Counselling and Testing (VCT)

The National Strategy identifies the following groups as priority target populations for VCT:

- Most at Risk Groups
- People with multiple sexual partners
- pregnant women

17 VCT services have been established or strengthened at 1 National Hospital, 5 Referral (District) Hospitals, 1 private/public hospital, 9 Community Health Centers, 1 private clinic and 3 mobile clinics. It is planed to establish more VCT centers at MARP drop in Centers and in other districts. Extensive VCT training has been provided and a plan for service provision developed.

The following table illustrates the uptake of VCT in Timor-Leste by gender and the number of cases that were confirmed HIV positive. With the expansion and availability of the VCT program into all districts, the utilization of the services by females sharply increased.

VCT Data for 2010 and 2011									
Year	Male	Male HIV Positive	% HIV Positive (Male)	Female	Female HIV Positive	% HIV Positive (Female)	Total	Total HIV Positive	% HIV Positive
2010	947	29	3.1%	294	22	7.5%	1,241	51	4.1%
2011	1971	27	1.4%	1444	36	2.5%	3,415	63	1.8%
Total	2,918	56	1.9%	1,738	58	3.3%	4,656	114	2.4%

Prevention of Mother to Child Transmission of HIV

Since 2010, the Ministry of Health has started development of the PMTCT program. PMTCT guidelines were developed in 2010 along with training of health care staff, procurement of supplies and equipment and appropriate monitoring. In 2011, implementation of the program began in 6 districts; the following table shows the number of pregnant women accessing ANC services and testing for HIV.

PMTCT Report-ANC Testing in 2011														
No	District	Month												
		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
1	Dili	94	66	101	84	74	88	244	172	292	401	292	246	2,154
2	Baucau	0	0	0	0	0	50	62	48	106	127	121	73	**587**
3	Maliana	0	0	0	0	0	0	0	0	108	156	72	10	**346**
4	Covalima	0	0	0	0	0	0	0	0	0	0	0	0	**0**
5	Ainaro	0	0	0	0	0	0	0	0	0	0	0	0	**0**
6	Oecusse	0	0	0	0	0	0	0	0	0	0	0	0	**0**
	Total	**94**	**66**	**101**	**84**	**74**	**138**	**306**	**220**	**506**	**684**	**485**	**329**	**3,087**

The following table shows the results of HIV testing at ANC centers.

No	Health Care Facility	HIV Positives confirmed	CD4 test	ARV/ART	NVP Prophylaxis for HEC
1	Bairo Pite	4	N/A	2	2
2	National	2	N/A	2	1
3	RH Maliana	1	N/A	1	1
	Total	**7**	**0**	**5**	**4**

Clinical Services

The strategy addresses a range of issues regarding clinical services. While ensuring access to Anti retroviral treatment is the highest priority, a number of other clinical issues are also related to HIV. They include provision of STI services, infrastructure support in areas such as

laboratory and pharmaceutical services, and policies and procedures on issues such as infection control in health care settings and the safety of the blood supply.

By the end of December 2011, XX people were on ART, including XX children. XX people have adhered to ART for 12 months and XX have been on treatment for 60 months.

The Ministry of Health has significantly enhanced the STI component of the program. The National HIV Program has undertaken an initiative for quality assurance and quality improvement (QA/QI) of STI services. A facility assessment of all 66 STI service providing facilities was conducted. With support from TSF and UNAIDS, the following took place during the time frame:

- Initial Assessment Visit
- Development of the STI National Strategy
- Up date STI National Clinical Guideline
- STI Workshops
- Development of a two year Program Work plan
- First Batch of Trainings including:
    1. Communication and STI Program training
    2. Clinical Management Training
    3. STI Simple Laboratory training
    4. Mentoring activities

This multi-phased and complex series of trainings provided a thorough approach to health systems strengthening, thereby increasing the capacity of both the MOH and the health system from national to community level to better treat, respond, evaluate and monitor patients and their treatments. A stronger functioning health system in Timor Leste provides the base for the countries response to HIV and STIs and ability to roll out program implementation at the national, district and community level.

Multi-sectoral/Institutional arrangements

In regards to Cross sector policy development, since the adoption of the National Strategy programs have continued or been newly developed in key sectors. Specifically:

- A life skills program is being implemented in the education sector
- HIV program plans are being developed with the police and military
- activities are being implemented in other sectors (e.g. HIV awareness among Provedoria staff)

A core function of the National AIDS Commission (NAC) is to promote cross sector partnerships and advise on policy. The NAC has membership from a range of sectors. Funding has been allocated to the NAC to strengthen its basic infrastructure.

The church is a major social force in Timor-Leste. In other countries, the faith based sector has played a key role in promoting an environment and implementing activities that are supportive of PLHIV. Different faiths are represented on both the NAC and CCM in Timor-Leste. The NAC and UNFPA have facilitated the involvement of faith based organisations in regional forums and the NAC conducted a major forum in Timor-Leste aimed at strengthening the role of faith based organisations in responding to HIV. As the number of

people diagnosed with HIV increases in Timor-Leste, the church can play an increasingly important role in ensuring care and support.

Involvement of PLHIV

When the national strategy was being developed in 2005, people with HIV in Timor-Leste had minimal contact with one another and there was no sense of group identity. The PLHIV support group Esperanca was formed and by the end of 2007 it was estimated that more then half the people in Timor-Leste with HIV (it was then estimated that there were 43 people diagnosed with HIV, of whom 30 were still living) had some level of contact with Esperanca and received a level of peer support. In 2010, another PLHIV group formed under the name Estrela+ which focuses on advocacy for PLHIV. Estrela+ received technical assistance which supported the organizational development of the group to be successful in becoming a sub-recipient in the Round 10 Global Fund HIV grant. Estrela+ is a member of the CCM and has been involved in several international and regional workshop and conferences.

Esperanca members also expressed a desire to build the skills necessary to operate as an independent organization. While appreciative of the support provided by other agencies and supportive of continuing to work in partnership with those agencies, PLHIV are increasingly speaking on their own behalf.

Strategic Information

A key principle of the Timor-Leste HIV/AIDS/STI National Strategy is that decision making should be evidence based. Strategic information on which to make decisions is required so that:

- Interventions can be targeted geographically
- Populations most affected identified
- Specific diseases prioritized
- Disease outbreaks identified
- Changes in risk behaviors identified
- Contributing factors identified and monitored (e.g. knowledge, attitudes)
- Relevant cultural practices addressed (e.g. use of traditional healers)
- Health service usage monitored
- Programs can be evaluated

Significant advances have been made in building systematic and sustainable mechanisms for strategic information. Achievements include strengthening of routine surveillance, establishment of sentinel surveillance systems and integrated biological and behavioural studies have been undertaken in 2010 and 2011 and baselines are now in place for future studies

4. Best Practices

HIV Surveillance

The HIV Sentinel Surveillance undertaken in 2010 on pregnant women, TB and STI patients from the national and referral hospitals, private clinics and community health centers in five of thirteen districts of Timor-Leste will be used for future HIV programming.

A blood specimen was collected from 1473 pregnant women at the various health facilities, with 10 samples confirmed positive, giving a crude prevalence rate of **0.68%** (10/1473). One half of all HIV positive pregnant women were in the age group 20 – 24; all of them coming from the urban center of Dili. The 25 – 29 age group presented with the second largest number of positive pregnant women, again all from Dili. Out of the total number of positive samples, only 1 was located in the districts outside of the capital.

For the STI population group, a total number of 271 samples out of an expected 250 were collected and analyzed. A total of 7 samples were confirmed positive giving a crude prevalence rate of **2.58%** (7/271), of which 57% were positive women and 43% were positive men. All positive samples came from patients between the ages of 15 and 40. Again, all positive samples were found in health facilities in Dili.

The TB population group sampled was 266 out of an expected 250 samples collected. A total number of 3 samples were confirmed positive, giving a crude prevalence rate of **1.13%** (3/266). All samples confirmed were male patients from Dili, Baucau and Maliana Districts.

Integrated Biological and Behavioral Survey

From July to December 2011, an IBBS survey was conducted amongst selected population groups in 5 districts within Timor-Leste: Dili, Baucau, Oecussi, Bobonaro, and Covalima. The IBBS used a community-based sampling method to estimate the prevalence ratios of HIV and other sexually transmitted infections (STIs) and to provide indicators of risk behaviors and intervention exposures amongst these targeted populations. Respondent-driven sampling was used to recruit 206 Uniformed Personnel (UP), 159 men who have sex with males (MSM), 133 female sex workers (FSW), and 390 clients of sex workers (CSW). Behavioral and other data were collected through individual face-to-face interviews, while the prevalence of HIV and STIs were measured through oral swab, blood, and genital swab specimens.

Timor-Leste has been previously classified as a low prevalence country for HIV. The data from this IBBS bear out those data. However, the prevalence ratios for various STIs and data on the predicate risk behaviors within adult target group members remained unknown. Previous studies have been isolated to the capital city, and therefore could not be used to make inferences about the country as a whole. Because the 5 districts included in this study are representative of the whole country, there is statistical power to draw inferences about HIV, HepB, HepC, and syphilis prevalence ratios.

An early warning about HIV and AIDS trends for Timor-Leste can be gleaned from the STI data and the behavioral data among the high-risk populations of MSM, FSW, CSW, and UP. This community-based systematic surveillance focusing on MARPs provides estimates of HIV and STI and risk behaviors. The interesting aspect of HIV infection in Timor-Leste is that the

data show that infection rates are nested in sub-populations within the target groups, e.g., transgender MSM as opposed to all MSM sub-groups.

5. Major Challenges and remedial actions

5.1. Challenges faced throughout the reporting period (2010-2011) that hindered the national response, in general, and the progress towards achieving targets and concrete remedial actions that are planned to ensure achievement of agreed targets

Prevention

1. Coverage targets identified in the Round 5 Global Fund HIV grant are being met for all MARP groups. However those targets represent a small minority of the total number of MSM and clients of sex workers.
2. There was a lack of clarity regarding protocols and referral pathways for MSM and female sex workers to STI services. Regular STI testing and enhanced syndromic management were recommended as Standard of Care for MSM and Female Sex Workers. STIs increase risk of HIV transmission and MSM as well as female sex workers have much higher rates of STIs then the broader population. Because STIs are often asymptomatic, enhanced syndromic management was recommended. The MoH responded through development of STI guidelines and a series of specific STI training to health care workers in all districts.
3. Improved communication/coordination could contribute to sharing of resources for capacity development and shared learning from implementation amongst the sub-recipients and other stakeholders. Improved coordination between SRs covering sex workers and clients of sex workers might also result in better coverage of clients.
4. Youth who are unemployed and/or most lacking in social cohesion (e.g. living away from family and home community, not engaged/connected with traditional support structures such as the church) need to be specifically targeted in HIV prevention. They are highly likely to engage in sexual activity and priority needs to be given to ensuring they have knowledge about condom use and access to condoms.
5. The importance of specifically targeting youth most at risk (as described above) is largely overlooked in the 2006 - 2010 National Strategy. There have been some activities (e.g. outreach in IDPs) but largely they have been one off and not coordinated as part of an ongoing strategy.
6. The National BCC Strategy for Reproductive Health, Family Planning and Safe Motherhood did not clearly identify sub youth populations that may require more clearly targeted initiatives. Specifically as discussed above young people who are already regularly engaging in sexual activity and in particular those who are most socially marginalized, need to be encouraged to use condoms.
7. There is little attention given to people with multiple sexual partners in the 2006 - 2010 strategy. With an increase in disposable income among people in Timor-Leste as well as increased social mobility as the nation develops, there is likely to be an increase in this population group. A program targeting people with multiple sexual partners should be developed. Social research should be undertaken to assess the costs and benefits of promoting access to enhanced syndromic management for people with multiple sexual partners.

Clinical Services

1. All people diagnosed with HIV and needing and agreeing to Antiretroviral Treatment in Timor-Leste are receiving treatment. This is a significant achievement. There have however been difficulties experienced in maintaining high quality of treatment (e.g. treatment regimens being changed due to difficulties in maintaining supply of certain drugs) and agreement regarding standard treatment protocols. By the end of 2011, all service providers were using the agreed upon national protocol for ART and ARV prophylaxis.

2. Timor-Leste has experienced a similar pattern to many other countries where a significant number of clinicians are trained in HIV medicine but do not end up using that training due to lack of patients, for example. These resources may be better used in focusing on a small number of clinicians who provide high level clinical management with a significant patient load and training up other clinicians to undertake basic monitoring.

Multi-sectoral/Institutional arrangements

1. While significant advances have been made in multi sector responses there is a lack of capacity to prioritise key policy issues and develop appropriate responses. Policy issues such as safeguarding the rights of HIV positive people (e.g. confidentiality, protection from discrimination) need to be strengthened.
2. The mid-term review identified regulation of the sex industry as an important policy issue impacting on HIV prevention.

Involvement of PLHIV

While there have been advances, PLHIV still report widespread discrimination and stigma associated with their HIV status. Members identified discrimination from their own family, in local communities and at health services. Discrimination in health services was often at the level of nursing and ancillary staff rather then by doctors. This should be addressed through the development of education programs in the main health facilities providing services to PLHIV. Other agencies and particularly the church can play a key role in addressing discrimination against PLHIV in local communities and within families.

PLHIV have identified other needs. They relate to:

- transport
- accommodation
- nutrition support
- employment

Several members of the Esperanca group have expressed a wish to access more opportunities to develop skills that will assist in gaining employment and/or micro credit opportunities to establish small businesses.

Strategic Information

1. Existing monitoring and evaluation of the National Strategic Plan is systematic in the collection of information for the purpose of monitoring TGF funded inputs and outputs.

2. Lack of baseline data has been a barrier to establishing quantitative outcomes. This was probably the biggest gap in the program. However this is now being rectified.

3. Lack of baseline data resulted in what appears to have been a somewhat ad hoc approach in setting some targets for outputs. To some extent this may also reflect weaknesses in planning (i.e. assumptions are implicit that certain inputs will achieve outputs adequate to achieve sufficient coverage in outcomes able to impact on behavior).

4. Gender, Sexual Orientation and Gender Identity were important factors in the development of HIV Strategy. There are shared (e.g. disempowerment) and specific matters (e.g. stigma associated with male to male sex as well as sex work, expectations of women in caring for those who are ill), which impact on access to and utilization of health services, health seeking behaviors and ultimately health outcomes.

5. Gender, sexual orientation and gender identity need to be addressed across all components of strategic information. Strategic Information needs to be used in overall program design as well as specific interventions. Relevant components of strategic information include:
6. surveillance – need for disaggregation of data
7. Health service information systems – disaggregation of data
8. Social research – understanding underlying social, historical, cultural and other factors that help explain gender, sexual orientation and identity constructs
9. Monitoring/evaluation – assessing the impact of interventions to address issues of gender, sexual orientation and gender identity

10. Sexual Orientation and gender identity are given high priority in the current response to HIV in Timor-Leste. MSM, transgender and sex workers are priority target populations in prevention programs. There is also support given in these programs to efforts to strengthen community networks of MSM/transgender and sex workers. However more thought needs to be given to the extent to which a rights based approach is being utilized.

11. Gender is an important factor in understanding both vulnerability and risk of HIV infection (as well as STIs). Biological, socio-cultural, economic and political factors increase the vulnerability of women to infection. These factors need to be taken into consideration (hence the importance of strategic information) in the subsequent situation analysis and strategy design.

Capacity Building

Generally the process of capacity development has been similar to that implemented elsewhere in the world. Training is provided at a set period in time and sometimes followed up with refresher training. Unfortunately this approach to capacity development may have limited effectiveness in Timor-Leste. If training is to be most effective it needs to be clearly applied to the specific context in which it will be used and there need to be ongoing mechanisms to address issues that arise.

6. Support from the country's development partners

6.1. Key support

During the time frame 2010 – 2011, Timor-Leste's development partners supported an effective, coordinated response to the National HIV program to help control the epidemic; partners include bilateral donors such as USAID and AUSAID and multilateral organizations such as WHO, UNICEF, UNFPA, UNDP, UNMIT, World Bank, and The Global Fund. Additionally, implementation of significant activities and policy development came from International and National NGOs which includes Catholic Relief Services, Church World Service (CWS), CVTL, Marie Stopes International (MSI), and Fundasaun Timor Hari'i (FTH). The UN Theme Group on HIV/AIDS, the HIV Technical Working Group and the CCM provides a regular forum in which coordination, implementation and resource mobilization are discussed within a wide range of stakeholders.

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

6.2. Actions that need to be taken by development partners to ensure achievement of targets

In 2010 and 2011, the most significant resource of funding for the national HIV program came from the Global Fund Round 5 HIV grant. The Global Fund Round 10 HIV grant will start in January of 2012 and will be again provide the most significant pool of monetary support to the program. To ensure both national and other external commitments to the national HIV program, development partners need to advocate through various donors for additional resource mobilization and technical assistance.

7. Monitoring and Evaluation environment

7.1. Overview of the current M&E system

Monitoring and evaluation are crucial parts of the Timor-Leste National HIV/AIDS Program, and part of program design, implementation and management. Information gathered from M&E is fed back into the program planning and implementation process in order to improve program relevance and effectiveness. For monitoring purposes, input, process and output data are collected, analyzed, and reported to inform managers of implementing agencies, Ministry of Health, National AIDS Commission, Country Coordination Mechanism, GLOBAL FUND and other stakeholders on the progress of activities, and to flag implementation issues.

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

A monitoring and evaluation framework was developed in the NSP 2011 - 2016 that clearly outlines assumptions and linkages between inputs, outputs, outcomes and impact. For most indicators, existing data collection processes can be adapted to provide required information. Additional activities that need to be established include:

- HIV treatment observational database
- general population sexual behavior study
- service audit procedures

- PLHIV survey
- quality improvement report

Basic competencies in strategic and program planning are limited and basic concepts of coverage and quality are inadequately understood. Programming is largely driven by the availability of funds, learnt service delivery approaches and “good” ideas. Monitoring and evaluation are driven by the collection of information to meet indicator requirements of donors with minimal understanding of where they fit in a wider planning framework.

7.3. Remedial actions planned to overcome the challenges

The process of conducting strategy reviews, strategy development and proposal development has included capacity development on core competencies of strategic and program planning. This is intended to integrate a capacity development function into the technical working group of the CCM. CCM members include international technical staff, MOH officers with international level capacity, international advisers and community organizations.

7.4. Need for M&E technical assistance and capacity building

Given the capacity of government, civil society and CCM staff and members in M&E, it is recommended that additional funding and training be available, through internal and external resources, to increase the understanding on how to conduct, document, analyze and evaluate the National HIV program.