

2017 Country Assessment on Sexual Reproductive Health Rights (SRHR) in Timor- Leste



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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CRC	Committee on the Rights of the Child
CSE	Comprehensive Sexuality Education
DHS	Demographic and Health Survey
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
LGBT	Lesbian, Gay, Bisexual and Transgender
mCPR	modern Contraceptive Prevalence Rate
MSM	Men who have Sex with Men
NAP-GBV	National Action Plan on Gender-Based Violence
PDHJ	<i>Provedoria dos Direitos Humanos e Justiça</i> (Office of the Ombudsman for Human Rights and Justice)
PLHIV	People Living with HIV
SDGs	Sustainable Development Goals
SISCa	<i>Serviso Integrada Saude Komunitaria</i> (Integrated Community Health Services), Ministry of Health program launched in 2008
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
UN	United Nations
UNFPA	United Nations Population Fund
UPR	Universal Periodic Review
WHO	World Health Organization

Executive Summary

Since its independence in 2002, Timor-Leste has made significant progress in social and economic development. The country achieved lower middle-income status in 2011 and has ambitions to reach upper middle-income status by 2030. As the country continues to experience socio-economic and security-related advances, the situation for women, men, girls and boys in Timor-Leste has also improved. However, major challenges remain in the area of sexual and reproductive health and rights.

The Country Assessment on Sexual and Reproductive Health and Rights (SRHR) in Timor-Leste is a partnership initiative between the Office of the Ombudsman for Human Rights and Justice (Portuguese abbreviation – PDHJ) and the United Nations Population Fund (UNFPA). The Country Assessment provides an overview of challenges in the areas of maternal and child health, family planning, comprehensive sexuality education, HIV and sexual health, and gender-based violence. The key findings in these thematic areas are as follows.

Maternal and child health: Since independence, Timor-Leste has made great gains in this area by significantly reducing maternal, infant and child-under-five mortality. However, maternal deaths remain a challenge, despite the majority of deliveries being attended by skilled personnel. Pregnant women and mothers have difficulty accessing adequate antenatal and post-natal care, and children are still dying from preventable causes. Inequalities in access to maternal health care are evident nationwide, with rural women and girls facing particular challenges in accessing sexual and reproductive health services, especially skilled care at birth, emergency care, and antenatal and post-natal care. The Government of Timor-Leste is committed to addressing these issues and the National Health Sector Strategic Plan 2011–2030 identifies maternal and child health as the two highest priorities of the national health programs.

Key recommendation: Strengthen measures to ensure that all women – including young women and rural women – have timely access to quality antenatal and post-natal care, emergency obstetric and newborn care in line with the Emergency Obstetric and Newborn Care Plan of Action.

Family planning: Since independence, the modern contraceptive prevalence rate (mCPR) in Timor-Leste has increased more than three-fold—from 7% in 2003 to 24% 2016. Though the use of family planning continues to rise, one out of four (25%) married women still has an unmet need for family planning. Timorese people, especially adolescents and unmarried people, have difficulty accessing contraceptive information and services. This has contributed to women having unwanted pregnancies and large numbers of babies. There are a high proportion of adolescent pregnancies and early marriages, with adolescent pregnancies contributing to higher rates of death and disability for adolescent mothers and their children. Abortion is restricted to protection of the life of the mother.

Key recommendation: Provide to all Timorese people access to family planning services and effective modern contraception to reduce the incidence of unintended pregnancies and unsafe abortions in Timor-Leste.

Reproductive health education: Reproductive health education, or comprehensive sexuality education (CSE) as it is known globally, is recognized as an age-appropriate, culturally relevant approach to teaching about sexuality and relationships, providing scientifically accurate, realistic, non-judgmental information. In general, Timorese people – particularly young people – have a poor understanding of sexual and reproductive health, including knowledge about modern contraceptive methods, how to get pregnant and Human Immunodeficiency Virus (HIV) prevention. The lack of sexual and reproductive health education has contributed to the incidence of unwanted pregnancies, early marriage and other consequences. While the Timorese law and policy environment is broadly supportive of reproductive health education, cultural taboos make it difficult to implement. The prevailing cultural view is that young unmarried people should abstain from sexual relations and should not be taught about sexual and reproductive health. However, global evidence shows that CSE has a positive impact on sexual and reproductive health, notably contributing towards reducing sexually transmitted infections (STIs), HIV and unintended pregnancy, and delaying sexual debut. For married people (young or not), the lack of

sexual reproductive health education has significant consequences with couples unable to plan their families effectively or take proper care of family health.

Key recommendation: Ensure universal access to comprehensive sexuality education – both in school and out of school – that is age-appropriate, unbiased, scientifically proven and gender sensitive.

HIV and sexual health: The fight against HIV and STIs in Timor-Leste has to date focused on key populations, including sex workers and their clients, men who have sex with men, transgender persons, uniformed personnel and the partners of these key populations. While Timor-Leste is a low-prevalence country, with 711 cases identified up to 2017, there are concerns that transmission is occurring in the general population which requires close monitoring. STIs, on the other hand, are very high with rates of 16.1% in clients of sex workers. Despite the prevalence of STIs and HIV in Timor-Leste, the population generally has a low knowledge of and access to STI and HIV prevention, testing and treatment. Young people, who are globally recognized as particularly vulnerable, have especially low levels of knowledge about comprehensive methods of preventing HIV and STI transmission and are not specifically targeted by information campaigns.

Key recommendations: Increase HIV and STI prevention through non-discriminatory, comprehensive voluntary counseling, testing and treatment for the most at risk populations. Improve HIV testing in the general population, targeting women through routine antenatal care, for people identified with STIs and other routine service delivery modalities. Moreover, increase non-discriminatory HIV and STI prevention efforts with specific education and messaging targeting young people.

Gender-based violence: Gender-based violence is widespread in Timor-Leste. Intimate-partner violence is one of the most pervasive types of violence, but there is also prevalence of sexual violence, child abuse and trauma. Particularly vulnerable groups include lesbian, gay, bisexual and transgender people, and people living with disabilities. Factors contributing to the high incidence of gender-based violence include unequal gender norms, attitudes that justify violence and other manifestations of male dominance over women. The physical and mental health consequences of gender-based violence can be serious for women, and may include injury, disability, unintended pregnancy, depression, suicidal thoughts, and impacts on sexual and reproductive health. Children are also affected both as victims and as witnesses. Yet few survivors of gender-based violence seek help from health authorities for these conditions. Timorese laws and policies prohibit gender-based violence, but there is low accountability due to a low reporting rate, and insufficient investigations, prosecutions and convictions.

Key recommendation: Strengthen awareness-raising and educational activities targeted at men and women, traditional leaders, health-care and social workers, with support from civil society, to eliminate prejudices related to violence against women.

Conclusion: The Country Assessment on SRHR acknowledges vulnerable groups of people who have particular difficulty accessing sexual and reproductive health and rights, identifies the context of and challenges in each of the five key areas, and makes specific recommendations for improvements in every one of them. These suggestions feed into Timor-Leste's overall plan to achieve the SDGs on health and well-being (SDG 3) and gender equality (SDG 5) before 2030.

General recommendations: Proposals to develop systems within the Ministry of Health and its programs, particularly SISCa, to improve service delivery, and ideas to share information on SRHR in the broader community will expand general understanding and achievement of reproductive health rights.

1. Introduction

Since gaining independence in 2002, Timor-Leste has made significant progress in social and economic development. The country achieved lower middle-income status in 2011 and has ambitions to reach upper middle-income status by 2030. As the country has experienced socio-economic and security-related advances, the situation for women, men, girls and boys in Timor-Leste has also improved. However, major challenges remain in the area of sexual and reproductive health and rights.

Purpose

This Country Assessment on Sexual and Reproductive Health and Rights (SRHR) in Timor-Leste provides an overview of five key areas: maternal and child health, family planning, reproduction health education, HIV and sexual health, and gender-based violence. The analysis identifies key progress and challenges, and the factors that influence these.

This assessment is designed to support evidence-based action, particularly through effective implementation of:

- key national strategies and policies, including the National Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health 2015–2019
- the national Sustainable Development Goals plan
- recommendations from the Universal Periodic Review and United Nations Treaty Bodies such as the Committee on the Elimination of all forms of Discrimination Against Women (CEDAW), and the Committee on the Rights of the Child (CRC).

The Office of the Ombudsman for Human Rights and Justice (*Provedoria dos Direitos Humanos e Justiça* – PDHJ) and the United Nations Fund Population Fund (UNFPA) have undertaken this assessment in partnership.

What do sexual and reproductive health and rights (SRHR) cover?

In 1994, states gathered together in Cairo, Egypt at the International Conference on Population and Development. In that meeting, 179 countries agreed that population, development and human rights are inextricably linked, and that empowering women and meeting their needs for reproductive health are critical components of people-centered development. They further recognized that reproductive rights are human rights and defined them.

Subsequently, the 1995 Beijing Platform for Action expanded these definitions by affirming the right to exercise control over and make decisions about one's sexuality, including sexual and reproductive health, free of coercion, discrimination and violence, as quoted directly in the box.

Delivering on the Sustainable Development Goals (SDGs)

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health; it also includes their right to make decisions concerning reproduction free from discrimination, coercion and violence.

**1995 Beijing Platform for Action,
Paragraph 96**



At the UN Sustainable Development Summit in September 2015, member states adopted *The 2030 Agenda for Sustainable Development*, highlighting the SDGs. This transformative agenda strives for a world that is just, rights-based, equitable and inclusive, with a central imperative of ‘leaving no one behind’ and addressing inequalities and discrimination.

This Country Assessment provides an analysis that hopes to guide the actions of the Government of Timor-Leste and national stakeholders to deliver on the SDGs and related targets relevant to sexual and reproductive health and rights, particularly health and well-being (Goal 3) and gender equality (Goal 5).

Methodology

The Country Assessment is a review of information and data compiled from secondary sources to identify and understand the progress and challenges in fulfilling the countries’ human rights commitments related to sexual and reproductive health and rights (SRHR).

The data were collected and analyzed in a two-step process, which also focused on developing the capacities of the PDHJ staff to advance effectively SRHR, through evaluation and monitoring. An initial workshop was held in November 2015 to introduce the foundations for how the Country Assessment was to be conducted. There were five teams, each focusing on one key theme, with members of PDHJ, UNFPA, civil society and other UN agencies working together. Each team collected data on their thematic area. The second workshop, held in June 2016, was for data analysis – to review the material

collected, collaborate on methods of analysis, and identify gaps and recommendations.

There were some limitations related to the data available at the time of the workshop. Much of the analysis contained in the Country Assessment is based on the then most recent Demographic and Health Survey (DHS) in Timor-Leste, 2009–2010. Preliminary data from the 2016 DHS became available in early 2017 and has been incorporated in the report where it differed significantly from the previous DHS data used.

The thematic areas particularly affected by the availability of DHS data are maternal and child health, family planning, and HIV and STIs. The reproductive health education section does not rely heavily on data from the DHS and the gender-based violence section is largely based on research conducted by The Asia Foundation in 2015.

Human rights standards related to SRHR

Human rights standards applicable to the area of sexual and reproductive health and rights are summarized in the table below. Additional human rights principles are discussed in Annexes B and C.

Figure 1: Human rights standards of SRHR

AVAILABLE, ACCESSIBLE, ACCEPTABLE AND OF GOOD QUALITY	
States must ensure that reproductive health information, goods and services are available, accessible, acceptable and of good quality.	
AVAILABLE	There needs to be an adequate number of functioning health-care facilities, services, goods and programs to serve the population, including essential drugs as defined by the WHO Model List of Essential Medicines, which includes contraception and emergency contraception.
ACCESSIBILITY	Health facilities and services need to be physically and economically accessible to all, particularly in terms of providing information, and especially to the most marginalized and vulnerable, both legally and actually, without discrimination. The health-care locations need to be safe and within a reasonable distance for all, with provisions for the disabled. The services must be affordable for all, whether public or private, and payment needs to be equitable, so that impoverished communities do not bear a disproportionate burden of health costs. All individuals need to be able to seek, receive and disseminate information on reproductive health issues.
ACCEPTABILITY	Health facilities, services and goods must be respectful of the culture of individuals, including the needs of minorities and indigenous populations, and different genders and age groups; They have to respect medical ethics, and ensure confidentiality and informed consent.
QUALITY	Reproductive health care must be of good quality, and scientifically and medically appropriate by being equipped with skilled (trained) medical personnel, and scientifically approved and unexpired drugs and equipment.
<p>The Committee on the Rights of the Child General Comment No. 15 on adolescent health has applied these norms to adolescents. States parties should provide health services that are sensitive to the particular needs and human rights of all adolescents, a term used to refer to individuals between the ages of 10 and 19.</p>	

2. Context

Timor-Leste's obligations in national laws and policies regarding SRHR

Figure 2: National laws and policies regarding SRHR

*For corresponding obligations under international law, see the Annexes.

Right to health*	Constitution article 57 National Health Sector Strategic Plan 2011–2030 identifies maternal and child health as the two highest priorities of the national health programs
Right to education and information	Constitution articles 40 and 59 National Health Sector Strategic Plan 2011–2030 National Family Planning Policy (2004) National Youth Policy (2016)
Right to equality and non-discrimination	Constitution articles 16, 17 Labour Code (Law No. 4/2012) of 21 February 2012 guaranteeing

	equality of opportunities and treatment in employment
Right to decide number and spacing of children	National Family Planning Policy (2004)
Right to privacy	Constitution article 36
Right to consent to marriage and equality in marriage	Constitution article 39 Civil Code (Law No. 10/2011) of 14 September 2011 providing for equal rights of women and men in marriage
Right to be free from torture or other cruel, inhuman or degrading treatment or punishment	Constitution article 30
Right to be free from practices that harm women and girls, including sexual and gender-based violence	Constitution article 18 – child protection Law Against Domestic Violence (Law No. 7/2010) of 3 May 2010, which criminalizes domestic violence, including sexual violence within marriage Penal Code 2009 Witness Protection Law 2009 Labour Code (Law No. 4/2012) of 21 February 2012 prohibiting verbal and non-verbal and physical and sexual harassment National Action Plan on Gender-Based Violence 2016–2011 Ministry of Education “Zero Tolerance” policy against administrative malpractice in the education sector covering sexual violence and corporal punishment
Right to an effective remedy	Constitution articles 26 and 27

Timor-Leste is also a party to many of the main United Nations human rights conventions, which protect the above listed rights relevant for sexual and reproductive health (details in Annex A). Timor-Leste’s constitution gives effect to its international human rights obligations.

Timor-Leste’s national priorities for SRHR

The first Universal Periodic Review of Timor-Leste took place in October 2011. The recommendations put forward by the states included a strong emphasis on advancing gender equality, addressing gender-based violence, including domestic violence and sexual violence, and child marriage. Family planning information and services, Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs), maternal and child health, and reproductive health education were not highlighted at that stage. The second Universal Periodic Review of Timor-Leste took place in November 2016. Salient issues emerging from reports submitted to the process thus far include maternal and child health, family planning, adolescent pregnancies and gender-based violence.

The Committee on the Elimination of all forms of Discrimination Against Women (CEDAW) made recommendations to Timor-Leste in several areas in 2015: violence against women, reproductive health education, access to sexual and reproductive health services including family planning, antenatal, delivery and post-natal services. The Committee on the Rights of the Child (CRC) also made recommendations in the same year related to: domestic violence, child abuse and neglect; neonatal, prenatal and post-natal care; malnutrition; breastfeeding; the high prevalence of adolescent pregnancy and early marriage; and access by adolescents to sexual and reproductive health services, including for the prevention of HIV and STIs.

The National Strategy on Reproductive, Maternal, Newborn and Adolescent Health includes actions on maternal and child health and family planning, as outlined in the table below:

Figure 3: National Strategy on Reproductive, Maternal, Newborn and Adolescent Health: actions in two key themes

Thematic Area	Strategy
Maternal and child health	<p>Aims to</p> <ul style="list-style-type: none"> • reduce the maternal mortality ratio and to increase coverage of skilled care at birth • double the coverage of post-natal care • reduce the rates of malnutrition of children under five
Family planning	<p>Aims to</p> <ul style="list-style-type: none"> • increase the contraceptive prevalence rate • reduce the total fertility rate • reduce the adolescent birth rate

For each of the thematic areas, the situational analysis, the key challenges and the recommendations are presented in Sections 3 to 7.

3. Maternal and Child Health

The country has made great gains since independence such as reducing maternal, infant, child and under-five mortality. The Government of Timor-Leste continues to be committed to addressing issues in maternal and child health; ensuring improvements in the maternal mortality ratio, which remains very high; reducing child mortality from preventable causes; reducing the malnourishment levels, and increasing access to antenatal and post-natal care.

The Ministry of Health’s SISCa program – *Serviso Integrada Saude Komunitaria* (Integrated Community Health Services) – continues to expand the reach of services across the country, with a core focus on pregnant women and children under five. Similarly, the National Health Sector Strategic Plan 2011–2030 has identified maternal and child health as the two highest priorities of the national health programs.

Maternal deaths are a significant challenge

Maternal survival has significantly improved since independence. However, the maternal mortality ratio is still very high and a Timorese mother has four times the likelihood of dying in childbirth than her Indonesian sister. There is under-reporting of maternal deaths through the routine Health Management Information System.

A key strategy for reducing maternal illness and death is ensuring that every birth occurs with the assistance of skilled health personnel, meaning a medical doctor, nurse or midwife. The proportion of births attended by skilled personnel has improved since independence, with three in five babies delivered by a skilled care provider.

Inequalities in access to maternal health care are evident. Women and girls in remote and rural areas face significant challenges, particularly with skilled care at birth – two in five rural babies are delivered with skilled care compared to four in five in urban areas – and antenatal and post-natal care. The inequalities of skilled care at birth per region are stark with Dili the highest (85%) and the lowest in Ermera (20%), Ainaro (23%) and Oecusse (34%). Less than half of the health facilities nationwide have the infrastructure, equipment and staff trained to address obstetrical emergencies, and emergency health care is extremely limited in rural areas. Other disparities exist based on wealth and on the mother’s education. For the poorest women, only one baby in four has skilled care on delivery compared to nine in ten for the wealthiest. If the mother has higher than secondary education, nine in ten babies are delivered by skilled care contrasting to only two in five babies born to mothers with primary education.

The Government of Timor-Leste has acknowledged these challenges in its National Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health 2015–2019. In addition, the Emergency Obstetric and Newborn Care Improvement Plan of Action in Timor-Leste 2016–2019 recommends improving the coverage, availability and geographic distribution of Emergency Obstetric and Newborn Care facilities throughout the country.

Inadequate access to antenatal and post-natal care

Increasing access to quality antenatal and post-natal care is a key strategy to achieving maternal health and limiting maternal and child death and illness.

Antenatal care

The World Health Organization (WHO) recommends a minimum of four antenatal care visits during pregnancy, where women should receive at least a basic care package, including nutritional advice, and should be alerted to warning signs indicating possible problems during their pregnancy, and get support in planning a safe delivery. At least three in five pregnant women in urban areas in Timor-Leste make the recommended minimum number of antenatal care visits during pregnancy, compared with only half of rural women.

Post-natal care

A large proportion of maternal and neonatal deaths occur during the 24 hours following delivery. In addition, the first two days after delivery are critical for monitoring complications that arise from the delivery. WHO recommends at least four post-natal visits: the first within 24 hours; the second within 72 hours; the third between days 7 to 14; and the fourth up to six weeks after the birth. However, a majority of mothers in Timor-Leste do not receive professional post-natal care and, among those who do, it may not be timely enough to prevent maternal and neonatal deaths.

Inequities and contributing factors

Large disparities in access to post-natal care exist in Timor-Leste based on wealth, education and for those in rural areas. The poorest women are four times less likely to receive post-natal care than their wealthiest sisters; women educated to more than secondary level are similarly advantaged over mothers with no education. The majority of reported barriers to post-natal care include the non-availability of a health-care provider, especially one who is female, non-availability of drugs, and difficult access to the health facility due to distance or lack of transport; women and girls in remote areas have significant challenges in reaching services. Furthermore, there are not enough trained midwives, with only 102 midwives for 232 government Health Posts, so 130 Health Posts are vacant, which the Ministry of Health hopes to fill. The problem is worse in rural areas, with the lowest coverage in Oecusse, Ermera, and Ainaro.

Child mortality from preventable causes

Timor-Leste has made significant progress in enhancing children’s survival, development and protection since independence. It reduced its under-five mortality (the probability of dying between birth and five years of age) rate from 83 deaths per 1,000 live births in 2003, to 41 in 2016, one of the biggest

CHILDREN IN TIMOR-LESTE DIE OF PREVENTABLE CAUSES



One in 24 children dies before their 5th birthday



Most of these deaths occur in the first week of life and nearly half during the first month.



Malnutrition of mother and child is the main cause. Only half of Timorese babies are exclusively breastfed till 6 months. Prevalence of stunting is one of the highest in the world

From 2003 to 2016 Under-5 child mortality fell from 83 to 41 deaths per live birth

IMR fell from 60 to 30 deaths per live birth

65

percent of deaths are in rural areas.

Attributed to

Increase in antenatal care and contact

Increase in assisted delivery

reductions in child mortality in the world. Moreover, the country's infant mortality rate – the probability of children dying before their first birthday – fell from 60 deaths per 1,000 live births in 2003 to 30 in 2016. Some of the key reasons why there have been such large rates of decline in overall child mortality in Timor-Leste include: an increased level of antenatal care contact and an increase in assisted delivery.

However, the child and infant mortality rates are still very high, with 1 in 16 children born in Timor-Leste dying before their fifth birthday. Most deaths among children under the age of five occur during the first year of life, with half of those occurring in the neonatal period – the first month of the baby's life. Reasons for high under-five child mortality rates include the prevalence of diseases and high levels of malnutrition for either the child or the mother, or both. Only half of Timorese infants are breastfed for six months, rates of stunting among children under five are among the highest in the world at 50.2% in 2013. The SISCa program's focus on increasing immunization coverage for children under five, while having a positive impact on vaccination uptake with 49% of children between 12 and 23 months fully immunized in 2016, has had only limited success reducing the high rates of malnutrition: for example, in 2016, only 13% of children aged from 6 to 23 months were receiving the minimum acceptable diet.

As discussed above, women in remote and rural areas face significant challenges in accessing skilled care at birth, and post-natal care after delivery. Rural women and poor women have less education and their children are disproportionately affected, with under-five and infant mortality rates 60% higher for children in the poorest households than for children in the richest.

Recommendations to improve maternal and child health in Timor-Leste

1. Strengthen measures to ensure that all women – including young women and rural women – have timely access to quality emergency obstetric and newborn care services.
 - Continue to strengthen efforts to ensure the provision of adequate financial and human resources to implement the Emergency Obstetric and Newborn Care Plan of Action to ensure that no village is more than two hours from a health facility and no health facility is more than two hours from a higher level referral facility.
 - Ensure that there are an adequate number of competent service providers with the right knowledge, skills and attitudes, and establish a quality assurance system.
 - Expand the community birth preparedness initiative to increase the number of deliveries at health-care facilities, and increase the ability to recognize when birth complications arise in time to allow for the woman's immediate transfer to hospital.
2. Strengthen the Maternal and Perinatal Death Surveillance and Response system in order to eliminate preventable maternal and perinatal deaths.
 - Take action to make maternal deaths a notifiable event.
 - Improve civil registration and strengthen linkages between the health sector and the Ministry of State Administration to improve reporting and response.
 - Establish a capacity development as well as a monitoring system in relation to surveillance and response. .
3. Promote healthy timing and spacing of pregnancies in order to reduce the risk of adverse maternal, perinatal and infant outcomes.
 - After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months; after a miscarriage or induced abortion it is at least six months.
 - Provide necessary information and services to young persons in order to avoid pregnancy until they are at least 18 years old.
 - Educate people about high-risk pregnancies such as in women who are too young, too old or too ill and for women who already have numerous children or who have been too frequently pregnant.

4. Educate women in the need to breastfeed exclusively until the infant is six months old.
5. Expand and improve the SISCa program at community level to weigh and assess children under-five years, promote good nutrition and provide supplementary feeding for malnourished children.
6. Conduct Behavior Change Communication programs specifically targeting the vulnerable populations in order increase the uptake of health services.
 - Incorporate programs on nutrition, hygiene and having regular health check-ups.

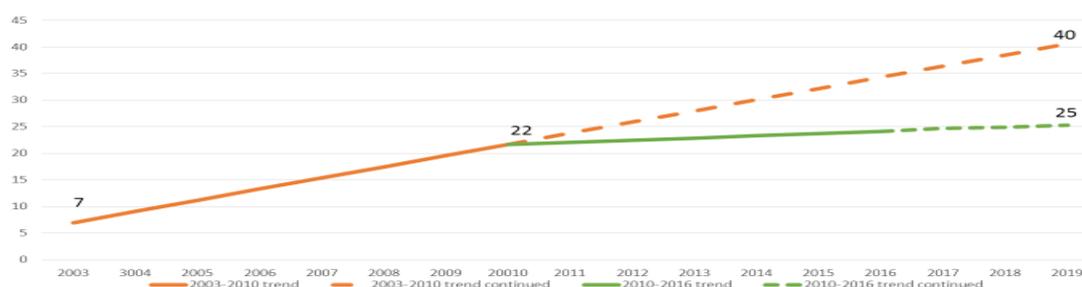
4. Family Planning

The importance of reproductive health and access to family planning in particular are now well recognized, not only to improve women’s chances of surviving pregnancy and childbirth, but also to contribute to related issues such as gender equality, better child health, an improved response to HIV, greater education outcomes and poverty reduction. Contraceptive information and services are also critical to preventing pregnancies resulting from sexual violence, and in preventing STIs. It enables individuals and couples to determine the number and spacing of their children, contributing to the achievement of the highest attainable standard of health and increasing their autonomy and well-being. Such information and services are not just for those planning families, but are for all, including adolescents.

Timor-Leste has made significant progress in expanding access to family planning since independence. Modern contraceptive prevalence rate (mCPR) in Timor-Leste increased more than three-fold between 2003 and 2009–10, from 7% to 21%. However, since 2010 modern contraception usage has increased only slightly, rising to 24% in 2016.

Timor-Leste has set a goal to reach the equivalent of 40% of married women using modern contraception by 2019 and was on track to achieve this goal before mCPR plateaued after 2010. The orange line on the graph below shows the 2003–2010 trend and its continuation. The green line shows the most recent trend from 2010 to 2016 and its expected continuation. If the current trend in mCPR growth continues, Timor-Leste will only reach 25% prevalence in 2019, well short of the 40% mCPR goal.

Figure 3: Modern Contraceptive Prevalence Rate (mCPR) in Timor-Leste



Source: 2003, 2009-10 AND 2016 DHS

Difficult to access contraceptive information and services

Use of contraception contributes to reducing the number of unintended pregnancies, unsafe abortions and maternal deaths. A majority of Timorese people has heard of modern contraceptive methods, although knowledge is limited among younger, less educated, rural and poor people. In 2016 the total demand for family planning was 25% and unmet need was 51%. Though the use of family planning has

increased over the past five years, less than half the demand for modern contraception has been met and one in four married women has an unmet need for these services.

Barriers to accessing family planning include:

- socio-cultural and religious influences
- women's limited decision-making power regarding the use of family planning
- limited exposure to family-planning messages, misinformation and incorrect perceptions about the health risks of modern methods – e.g. limited knowledge of the fertile period in a woman's menstrual cycle in which conception is more likely
- a high incidence of intimate partner violence
- logistical problems getting to clinics
- attitudes of health-care providers and their practices towards unmarried people and adolescents affect their access to family-planning services

One factor affecting overall efficiency of family planning services documented in Timor-Leste is skewed contraceptive method mix. It occurs when more than half the population relies on only one type of contraceptive. In Timor-Leste in 2010, three out of five women using family planning relied on injectable drugs and, in 2016, the number fell to just under half. It might indicate that only one kind of contraceptive is available (in a 2014 survey, two out of three Health Posts did not have the standard minimum of three methods available) or that supplies are not always available (three out of five Health Posts had one or more methods out of stock) or there is provider bias in favor of a particular method.

Certain populations – such as those in poor rural areas, adolescents and unmarried people – are disproportionately affected. Among the estimated 25,000 married women aged 20 to 24, less than 40% have their demand for family planning met which is the lowest in the Asia Pacific region. Contraceptive use is lower among unmarried, rural and poor women (for instance, sexually active unmarried women have an 81% unmet need for contraception), and it is almost non-existent among adolescents.

As all family planning commodities in the public sector come from UNFPA, there needs to be careful planning and coordination with the government for an exit strategy, to make the phase-out process smooth, without hampering the country's family planning users, so that the 40% coverage goal is more achievable. UNFPA commodity donations will phase out over the program period of 2015–2019 and technical support will be provided to the Ministry of Health to ensure efficient and quality-assured public sector procurement.

The states have committed to ensuring that all Timorese people have access to unbiased, comprehensive and evidence-based information and services for sexual and reproductive health, including family planning and contraception. In 2004, the Democratic Republic of Timor-Leste ratified a national Family Planning Policy, supported by the Parliament and the Roman Catholic Church. The government subscribes to the principles enunciated in the Programme of Action agreed upon by the world's nations at the International Conference on Population and Development. In particular, the government endorsed Principle 8, which mentions the rights to access health-care services, including family planning and sexual health, with individuals and couples having the autonomy to decide on the number of children and spacing, and having access to information in order to assist decision-making to do so.

Postpartum family planning

The postpartum period – especially the time immediately after the birth – is when couples generally have multiple encounters with the health-care system. Providing contraception during this time is cost-effective and efficient because it does not require significant increases in staff, supervision or infrastructure. Also, for many women who rarely use health-care services, family-planning advice and methods provided in the immediate postpartum period does not require the expense and inconvenience of returning to the facility, thus expanding the opportunities for engaging couples in contraceptive use.

Integrating postpartum family planning into maternal, newborn and child health programs and services contributes to expanded services for women during the first year postpartum and the increased use of family planning by women and their partners during the year after the birth. It can result in dramatic reductions of high-risk pregnancies, reduces the unmet need for family planning, and improves the health

and survival of mothers and children.

Consequences of low contraceptive use

The low rate of contraceptive use in Timor-Leste has led to outcomes such as high rates of fertility and adolescent pregnancy, an increase in early marriages and raised maternal mortality from unsafe abortion.

High fertility rate

The total fertility rate – the average number of births per woman – is 4.2 in Timor-Leste. Rural women have on average about one child more than urban women.

Adolescent pregnancies and early marriage

Timor-Leste has one of the youngest populations in the world. Two-thirds of the population is under age 30, with 20% being in the 15–24 age group. There are high numbers of adolescent pregnancies in Timor-Leste. While the frequency has been decreasing since independence, the adolescent birth rate is still high – 51 live births for every 1,000 adolescent girls. This is higher in rural areas, where adolescents are poorer and less educated. Another measure, the mother's age at her first birth, shows that nearly one in four Timorese women has given birth by age 20. Of mothers aged from 15 to 19, half of them have more than one child.

Recent research shows that the main causes for adolescent pregnancies include their lack of knowledge on reproductive health matters, their lack of access to contraception as well as young women's limited agency in terms of deciding whether or not to have sexual relations.

Adolescent pregnancies do not always happen within a marriage. Some unmarried young Timorese people are sexually active; the majority of sexually active young people (married and unmarried) report that their first sexual experience between the ages of 15 and 19.

While the perceived social norm is that sexual debut is a consequence of getting married, in practice marriage may be the consequence of unintended pregnancy. Unmarried pregnant adolescents may face social costs such as rejection by their families, the end of their education and the threat of violence. Girls may resort to unsafe abortion, often involving toxic or unsterile procedures and performed by unskilled practitioners. The results can be sterility, physical impairment and death.

Data show a high correlation between adolescent pregnancy and early marriage, with around two-thirds of adolescent mothers in Timor-Leste being married. As it is socially unacceptable to be an unmarried mother, young pregnant women are often pushed into marrying the father of their child. In other cases, young women marry early, sometimes even before the legal age of 17 (marriage at 16 is allowed with parental consent as per the civil code). Currently, 19% of young women are married by the time they turn 18.

Adolescent mothers and their children face greater risks of difficult births and mortality, and neonatal complications. In Timor-Leste, adolescent mothers die nearly twice as often as mothers in their twenties and have the highest number of stillbirths and infant deaths in the first week of life, and less chance of the baby surviving to age five.

Moreover, an early start to childbearing greatly reduces the educational and employment opportunities of women, as the group has large numbers of school dropouts among them, and their children have higher school dropout rates as well. Adolescent pregnancy is also associated with increased levels of fertility.

Unsafe abortion and lack of access to post-abortion care

Unsafe abortion continues to be a major factor in maternal deaths in the region. Mortality due to unsafe abortion for Southeast Asia is estimated at 14% of all maternal deaths and 13% for South Asia. Annually, approximately 2.3 million women in the region are hospitalized for treatment of complications from unsafe abortion. Abortion is restricted in many parts of the region. In Timor-Leste abortion is restricted on all grounds, except when it is to save the life of the woman. The CEDAW Committee has recommended a review of this provision and to legalise abortion in cases of rape, incest and serious impairment of the foetus, and to remove the requirement of authorization by a panel of three doctors.

Though abortion is legal in Timor-Leste to protect the life of the mother, it is a stigmatized issue in Timor-Leste, posing moral conflicts for Timorese, compounded by the religious beliefs in the predominantly Catholic country. The restrictive legal environment does not stop abortions; instead, it pushes women to seek illegal abortions performed by non-medical personnel including self-trained practitioners. Women have little choice but to resort to unsafe providers, causing deaths and illnesses.

The National Family Planning Policy states that the Government of Timor-Leste subscribes to the principles enunciated in the Programme of Action agreed upon by the countries of the world at the International Conference on Population and Development. The Programme of Action declares that:

Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning.

The Programme of Action **urges** all governments and relevant intergovernmental and non-governmental organizations to

strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services.

It **emphasizes** that

prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling.

It **stresses** that,

in circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly.

According to a 2009 study, abortions were often carried out in secret, very unsafe ways, endangering the lives of Timorese women. Unsafe abortions happened throughout the year in all districts, with high numbers in Dili and Baucau, the two most populous cities. Around 40% of cases of emergency obstetric care in several hospitals in Timor-Leste required post-abortion management for incomplete and complicated abortions.

Severe complications from unsafe abortions may result in long-term health consequences, such as chronic pain, inflammation of the reproductive tract, pelvic inflammatory disease and infertility. The negative consequences go beyond health, as complications may reduce women's productivity, increasing the economic burden on poor families, and place further burden on the health system.

Recommendations to improve family planning services in Timor-Leste

Family planning is a key tenet in reducing poverty, promoting economic development, raising female productivity, managing population growth and enhancing environmental sustainability. Increasing awareness about family planning and use of contraceptives requires that women not only have access to family-planning services and contraceptives, but that they also have the decision-making power to choose to use contraceptives.

1. Provide to all Timorese people access to family-planning services and effective modern contraception to reduce the incidence of unintended pregnancies and unsafe abortions in Timor-Leste. Ensure that vulnerable populations, including rural, young, adolescent and unmarried women, are able to access information and services, including the full range of contraception to enable them to make informed decisions about the method that is right for them.
2. Develop awareness-raising campaigns and programs on the harmful effects of early pregnancy on the physical and mental health and well-being of girls and their babies, targeting households, local authorities, religious leaders and judges.
3. Ensure family-planning services are available according to the Reproductive Maternal Newborn Child and Adolescent Health Care Strategy—Health Posts to provide fertility-awareness methods counseling, condoms, oral contraceptives and injectable drugs; Community Health Centers to provide the methods available at Health Posts as well as Inter Uterine Devices (IUDs) and implants; and hospitals to provide male and female sterilization in addition to the methods offered at Community Health Centers.
4. Prioritize reaching postpartum women, the group of women with the greatest unmet need for family planning, in strategic and operational plans and budgets, including updating the knowledge and skills of a range of providers, offering integrated postpartum family-planning services in facilities and communities, and ensuring that a broad range of contraceptive options are available to women, men and couples.
5. Ensure government allocations for contraceptives to guarantee funding for family planning in the national budget and support the implementation of national health accounts and reproductive health subaccounts as a strategy for making evidence-based policy decisions, and to ensure that the findings are used to support contraceptive security efforts.

5. Reproductive Health Education

A majority of adolescents worldwide lack the knowledge required to make decisions about their sexual and reproductive health responsibly, leaving them vulnerable to coercion, STIs and unintended pregnancy. Reproductive health education – comprehensive sexuality education, or CSE as it is referred to globally, is structured education that aims to equip children and young people with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality, in the context of their emotional and social development.

Poor understanding of sexual and reproductive health

There is generally a poor understanding about sexual and reproductive health, including knowledge about modern contraceptive methods, about how to get pregnant, and HIV and other STI prevention in Timor. For instance, only one in ten Timorese women could correctly identify the most fertile time where conception is most likely as being half way between two menstrual periods. Also lacking is comprehensive knowledge about HIV prevention, testing and treatment, especially among women, young people and those in rural areas. The perception that young unmarried people are not sexually active may not be accurate, as evidence suggests otherwise.

Obstacles to advocating for reproductive health education

The law and policy environment in Timor-Leste is broadly supportive of reproductive health education. The constitution protects the rights to maternity, information, health and education. Moreover, a range of policies in Timor-Leste advocate for reproductive health education, and access to sexual and reproductive health information, such as the National Youth Policy, the National Health Sector Strategic Plan 2011–2030 and the Timor-Leste National HIV and STI Strategy 2011–2016. The National Conference on Reproductive Health, Family Planning and Sex Education in 2010 recommended incorporating sex education into the school curriculum at pre-secondary level and through informal education programs, as well as supporting adolescent mothers to return to school.

There have been efforts from the government to undertake activities related to reproductive health education. One such initiative was teaching a module called *Learning about Myself* to orient children on the functioning of their body, developing a comprehensive curriculum on adolescent sexual and reproductive health for secondary schools, which was piloted in ten schools in seven districts, with an invitation to the Ministry of Health to facilitate student education sessions. The initiatives, however, have not been sustainable; they did not reach every student and were not comprehensive in scope. Indeed, one recommendation from CEDAW noted that Timor-Leste's sexual and reproductive health and rights curriculum is too narrow in scope, does not contain a gender focus and mainly considers the biological perspective.

Cultural taboos tend to act as deterrents in health education. In Timor-Leste the prevailing view is that young unmarried people should abstain from sexual activity and not be taught about sexual and reproductive health.

Moreover, traditional attitudes towards women and girls contribute to their high dropout rate from school, which affects their access to school-based reproductive health education. These include the prioritization of boys' over girls' education, and negative attitudes about women and girls traveling the distances required to go to school. Gender-based violence and early pregnancies are other factors that contribute to girls dropping out of school. In general, there is lower attendance at secondary school for both boys and girls. The Ministry of Education drafted an inclusive education policy guaranteeing equal access to education for all, including adolescent mothers, which was approved by the Council of Ministers in April 2017.

The President of the *Grupo das Mulheres Parlamento Timor-Leste* (Group of Timorese Women Parliamentarians – GMPTL) stated at the National Conference on Reproductive Health, Family Planning and Sex Education in 2010:

“There cannot be full health without also having sexual health. Sex education is an essential part of providing modern, professional health care and is crucial to reducing teenage pregnancy or early pregnancy. Therefore, we must start talking about sex education more openly, even though the topic has traditionally been considered ‘taboo’ in Timor-Leste. In order to protect our youth, we must challenge some of the traditions which make them vulnerable, including to early pregnancy.”

Positive impact of comprehensive sexuality education

There is clear evidence that CSE has a positive impact on sexual and reproductive health, notably contributing towards reducing STIs, HIV and unintended pregnancy. Sexuality education does not hasten sexual activity; instead it has a positive impact on safer sexual behaviors, and it can delay sexual debut and increase condom use.

The Programme of Action agreed upon by world nations at the International Conference on Population and Development explicitly calls on governments to provide age-appropriate education on sexuality, both in schools and at the community level that specifically aims to address gender inequality. Specific topics should include gender relations and equality, violence against adolescents, responsible sexual behavior, contraception, family life, and the prevention of STIs, HIV and Acquired Immunodeficiency Syndrome (AIDS). A majority of countries are now embracing the concept of CSE, informed by strong evidence and international guidance, and are engaged in strengthening its implementation at national level.

CSE, as outlined in the joint UN International Technical Guidance on Sexuality Education, is most effective when there is emphasis on gender. A 2015 Population Council study found that sexuality and HIV education programs that address gender and power in intimate relationships are five times more likely to be effective than programs that do not.

Effective Comprehensive Sexuality Education:

Principles

Age-specific	Human Rights
Effective CSE starts early in childhood and progresses through adolescence and adulthood, building knowledge and skills that are appropriate for each stage through a carefully phased process over time, like any other subject in the curriculum.	CSE has a firm grounding in human rights – including the rights of the child, and the empowerment of children and young people – and is a reflection of the broad concept of sexuality as a natural part of human development.
Adaptable	Trained Teachers
CSE content must respond appropriately to the specific context and needs of young people in order to be effective. This adaptability is central to culturally relevant programming, and includes understanding the messages that cultures convey around gender, sex and sexuality. This may include a concerted focus on topics such as gender discrimination, sexual and gender-based violence, HIV and AIDS, early marriage and harmful traditional practices.	Delivering high-quality CSE requires adequate training and capacity. Well-trained, supported and motivated teachers play a key role in the delivery of good quality sexuality education. Clear sectoral and school policies and curricula help to support teachers in this regard.
Inclusive	Community Engagement
Effective CSE has to be both inclusive and non-stigmatizing, addressing sexual and gender-based violence and promoting gender equality, as well as ensuring the needs and rights of all young people, including those living with HIV.	Engaging parents and communities in the implementation of CSE is critical – both to ensure that there is support for the subject in the school community and to enhance the overall understanding of the issues facing adolescents and young people. While young people often seek information from their peers, the internet or other sources, CSE delivered by trusted and trained adults is proven to be more effective in promoting healthy sexual behavior.

Recommendations to improve reproductive health education in Timor-Leste

1. Ensure universal access to comprehensive sexuality education – through primary, pre-secondary and secondary curricula, media, health facilities, youth centers and parents. – providing both knowledge and skills through appropriate participatory methodology. CSE should be age-appropriate, unbiased, scientifically proven and gender sensitive, and train teachers in how to create supportive learning environments for young people. It should educate about the transformation of gender relations, unequal power in those relations, healthy relationships, responsible sexual behavior, prevention of early pregnancy and STIs. It should challenge inequitable social norms and practices harmful to women and girls.
2. Ensure that CSE is supported by increasing access to information and services, including contraception, especially for unmarried and young people, made possible through the availability of health services that should be youth friendly, non-judgmental, non-discriminatory against unmarried adolescents, and respect the privacy and anonymity of clients.
3. Strengthen the roles of male adolescents and youths in addressing sexual and reproductive health and violence. Males and females should be equally responsible for healthy and non-violent relationships, and positive sexual and reproductive health outcomes.
4. Seek multiple avenues for conveying HIV- and STI-related knowledge and prevention skills, and begin this process as early as possible in the education cycle. To maximize the reach of this information, programs in this context need to be verbal and messages consistent.
5. Implement policies that allow and encourage pregnant girls to stay in school and return after giving birth. Establish measures to allow adolescent mothers to return to school, including positive school dialogue, community support and child care measures.

At a Glance: Adolescents in Timor-Leste across the Five Key Themes

Maternal and Child Health

Young women and girls face the greatest difficulties in accessing skilled care at birth, and emergency, antenatal and post-natal care. In Timor-Leste, a third of young women between 15 and 19 years are below normal for their weight and height – below the expected height for age is called stunting. Stunting means younger women are at greater risk of experiencing difficulties at birth, and are in greater need of access to skilled help to avoid injury or death and of their newborn.

Young women in Timor-Leste suffer from anemia and iron deficiency, which are common forms of nutritional deficiencies worldwide. Adolescent girls are particularly vulnerable to malnutrition as their rate of growth is very high. Severe and moderate anemia places women at higher risk of death during delivery and the period following childbirth.

Family Planning

Family planning information and services are not just for those planning families, but for all, including adolescents.

Certain populations – such as those in poor rural areas, adolescents, and unmarried people – are disproportionately affected by barriers to accessing contraceptive information. Among the estimated 25,000 married women aged from 20 to 24, 70%, women have an unmet need for family planning, among the highest in the Asia Pacific region. Contraceptive use is lower among unmarried, rural and poor women, and is almost non-existent among adolescents.

Timor-Leste has one of the youngest populations in the world. Two-thirds of the population is under age 30, with 20% being in the 15–24 age group. There are high numbers of adolescent pregnancies in Timor-Leste. While the frequency has been decreasing since independence, the adolescent birth rate is still high – 51 live births for every 1,000 adolescent girls. Another measure, the mother's age at her first birth, shows that nearly one in four Timorese women has given birth by age 20. Among mothers aged from 15 to 19, half of them have more than one child.

Adolescent mothers and their children face greater risks of difficult births and mortality, and neonatal complications. In Timor-Leste, adolescent mothers die nearly twice as often as mothers in their twenties and have the highest number of stillbirths and infant deaths in the first week of life, and less chance of the baby surviving to age five.

Reproductive Health Education

A majority of adolescents worldwide lack the knowledge required to make decisions about their sexual and reproductive health responsibly, leaving them vulnerable to coercion, STIs and unintended pregnancy.

Traditional attitudes towards women and girls contribute to their high dropout rate from school, which affects their access to school-based reproductive health education.

These include prioritization of boys' over girls' education, and negative attitudes about women and girls traveling the distances required to go to school. Gender-based violence and early pregnancies are other factors that contribute to girls dropping out of school.

While young people often seek information about sex, sexuality and relationships from their peers, the internet or other sources, comprehensive sexuality education that is delivered by trusted and trained adults is proven to be more effective in promoting healthy sexual behavior.

HIV and STIs

Coverage of anti-retroviral treatment (ART) among people living with HIV (PLHIV) is relatively low in Timor-Leste – in 2017, less than 50% or the estimated number of PLHIV in the country were enrolled in clinical care (203 out of 464) and only 285 were on ART. New global HIV treatment guidelines recommend ART for all PLHIV, therefore the treatment coverage rate in 2017 was only 40%.

Key populations have low access to HIV prevention and treatment services, due to a lack of knowledge of HIV status, insufficient referral and follow up, and fear of stigmatization in health services. Furthermore, there is a misguided perception that effective treatment is not possible for HIV.

Key populations may not include groups, such as youth, and that would lead to a risk that the actual prevalence may be higher than perceived. Among the young in Timor, there is a non-negligible level of unprotected sex, with 40% of young men sexually active and 14% reporting that they used a condom during their last sexual encounter. This may have a link to the low level of knowledge that condoms prevent the spread of HIV and the limited availability of condoms. Other high risk behaviors are injecting drug use, and commercial sex, with 10% of men in the 20–24 age group reporting that they had paid for sex in the previous month.

Gender-based violence

Domestic violence is the most common form of violence against women. Timorese women and girls also endure non-partner rape and sexual assault, incest, sexual harassment, and trafficking. The 2016 *Nabilan* Study showed that approximately three in five Timorese women had experienced intimate-partner violence. However, prevalence generally rises with the woman's age and tapers off slightly beyond age 30, and is worse in urban areas. This puts adolescents at greater risk.

Sexual violence begins at an early age and reoffending is common. More than half of all men who had perpetrated rape did so for the first time when they were adolescents. This finding shows that men learn to use violence during adolescence and youth, and to pursue sexual entitlement over women as part of a dominant masculine identity.

Child abuse and trauma is also extremely pervasive in Timor-Leste. Approximately three in four women and men reported that they had experienced some form of physical or sexual abuse as a child. 80% reported that they experienced emotional abuse or neglect as a child. Approximately 60% of women and men reported that they did not have enough food to eat during their childhood. Moreover, corporal punishment (or physical violence) as a way of disciplining children both at home and in school is widely practiced.

6. HIV and Sexual Health

Effective prevention, diagnosis and treatment of HIV and other STIs are an important part of SRHR. HIV is life-threatening to the person living with HIV (PLHIV) and to their sexual partners and children. Other STIs can cause significant morbidity for the person infected, their sexual partners and to their children, and can reduce fertility rates. The presence of untreated STIs also increases susceptibility to HIV infection.

HIV prevalence

Although Timor-Leste has a relatively small and concentrated HIV epidemic, incidence rates are growing annually, the coverage of anti-retroviral therapy (ART) is low among PLHIV and there remains a gap between the number of PLHIV and the number who do not know their HIV status.

In 2014, the prevalence of HIV in the general population was estimated at well below 1% (0.05% among pregnant women at antenatal care in 2013). HIV prevalence rates are significantly higher in some key populations – sex workers, clients of sex workers, men who have sex with men (MSM) and uniformed personnel. In 2011 the following HIV prevalence rates were estimated:

- Sex workers – national average 1.5%; Dili 3.6%; Maliana 2.6%
- MSM – national average 1.3%; Bobonaro 5.7%; Maliana 3.6%
- Uniformed personnel – national average was not available; Bobonaro 2.6%

Low rates of HIV testing and treatment

HIV testing rates remain low among key populations – in 2011, 33% of MSM had accessed an HIV test in the previous twelve months. By the end of 2017, of the estimated 711 PLHIV in Timor-Leste, only 285 are on ART (40%).

Access to HIV testing and counselling (HTC) for women in antenatal care remain low and poorly geographically distributed. In 2014 only 19% of the estimated number of pregnant women in Timor-Leste accessed HTC. Of these, eight were diagnosed with HIV and six received ART or Prevention of Mother-To-Child Transmission. Follow-up HIV testing rates of these women's babies was low (two out of eight).

STI prevalence

In Timor-Leste the rates of some sexually transmitted infections (STIs), such as syphilis, are much higher than for HIV in certain populations; current reported infections are as high as 16.1% for clients of sex workers. Over 12,000 cases of STIs were treated between January and September 2017.

STI rates in 2014:

- Sex workers – national average 9.8%; 15% Covalima
- Clients of sex workers – 15% Covalima; 6% Bobonaro
- MSM – national average 7.1%; 16.6% Covalima; 10.7% Dili
- Uniformed personnel – national average 13.9%; 20% Covalima
- Women attending antenatal care – 0.51% in Dili

Need for data on STI prevalence

Data on prevalence rates of syphilis and other STIs in the general population are not currently available in Timor-Leste, nor is a disaggregation of this data by age. Having this data available would assist in the planning of services, particularly for young people.

Information on prevalence rates and the context of risk among young people is particularly important given the high proportion of young people in Timor-Leste's population and the relatively early sexual debut. Given the high syphilis rates among uniformed personnel and clients of sex workers, it would be useful to conduct STI campaigns targeted at women with undiagnosed STIs and increasing access to STI testing for women attending primary care services (not just antenatal care). It would also be helpful to include STI testing in antenatal care, particularly in districts with high rates of syphilis in sub-populations of men.

STIs can have serious health effects, particularly for women. Untreated syphilis in up to 40% of pregnant women can result in infant death. [Other STIs, such as chlamydia](#) and [gonorrhoea](#), if left untreated, raise the risk of chronic pelvic pain and life-threatening [ectopic pregnancy](#). Chlamydia and gonorrhoea also can cause infertility.

Vertical programming results in condom promotion for male and female sex workers through outreach. However, it does not pay adequate attention to dual-method contraception – condom use plus the addition of more effective contraceptive methods to prevent unintended pregnancy and reduce unsafe abortion.

Only one-third of young women and almost half of young men aged between 15 and 24 know that condoms can be used to prevent HIV. The level of comprehensive knowledge on HIV transmission is also very low and decreasing, with only 7% of young women and 14% of young men reporting comprehensive knowledge. This is particularly dangerous as globally the epidemic is known to be growing the fastest among young people. National campaigns on ABC – Abstinence, Be faithful, use a Condom – have been inconsistent, with 'C' increasingly standing for "Control yourself" instead of using condoms.

Figure 4: Knowledge of HIV Transmission and Use of Condoms

Indicator	Value (Year)	Value (Year)
Proportion of population aged 15–24 with comprehensive correct knowledge of HIV transmission	14% (2010)	11.1% (2016)
Condom use in last sexual act by men with two or more partners	19% (2010)	24% (2016)
Condom use by Female Sex Workers in last sexual act with a client	36% (2011)	44.9% (2016)
Condom use by MSMs in last sexual act with a male	66% (2011)	45.5% (2016)

DHS, 2010 and Key Indicators DHS 2016

Recommendations to reduce HIV and improve sexual health in Timor-Leste

Timor-Leste is going through a period of transition and the environment could lead to the rapid spread of HIV if the HIV program, the Ministry of Health and the government, and development partners do not remain vigilant in the fight against HIV. The warnings are present to support this possibility with widespread STIs, a large sexually active population, low knowledge levels, low condom use, and internal and external migration.

1. Increase HIV and STI prevention (and regular partner notification levels) for clients of sex workers and uniformed personnel in key districts. Target more precise outreach to these key populations on improving access to HIV and STI testing and treatment.
2. Include STI testing in antenatal care, particularly in districts with higher rates of syphilis in sub-populations of men and include this in the guidance materials for the implementation of the National Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health 2015–2019.
3. Promote the development of STI campaigns targeted at women with undiagnosed STIs and increase access to STI testing for women attending primary care services, not just antenatal care. Promote dual-method contraception (condoms to prevent STIs and modern contraceptive methods to reduce unintended pregnancy and reduce unsafe abortion) and make sure that post-exposure prophylaxis (PEP) is universally available at sexual assault services.
4. Efforts and evidenced-based clinical interventions and information dissemination should focus on the REAL possibility of eliminating mother-to-child transmission of syphilis and HIV from Timor-Leste, including making more effort contacting isolated populations.
5. Increase access to HTC through antenatal care and increase follow-up and prophylactic treatment for children of women with HIV and increase the access of PLHIV to ART through improved access to HCT in key populations.
6. Integrate HIV and STI information in reproductive health education and ensure that young people have access to scientifically accurate and non-judgmental HIV and STI information and education, preventions measures (condoms) and testing (particularly addressing consent issues allowing young people not living with their parents to access testing without parental consent). Prevention strategies, such as ABC campaigns, should be evidence-based, clearly stating that condoms can stop people from catching HIV and STIs.
7. Improve strategic information available on HIV and STIs, particular STI rates in the general population with specific data on young people to assist in service planning.

7. Gender-Based Violence

Gender-based violence – primarily violence against women – stems from gender inequality and discrimination. It is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men, and to the prevention of the full advancement of women. It is also used to maintain women's subordinate position compared with men. The term "violence against women" means any act of gender-based violence that results in (or is likely to result) in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

According to recent global estimates, 30% of women aged 15 years or older have experienced physical and/or sexual intimate-partner violence during their lifetimes. It is the leading global cause of homicide death in women, and has many other major health consequences. The economic and social costs associated with violence against women are significant, and global evidence shows that violence consistently undermines development efforts at various levels, driving the depreciation of physical, human and social capital.

Gender-based violence is widespread

In Timor-Leste, current research points towards widespread experiences of gender-based violence across the country, primarily affecting women and children, who are both witnesses and victims. Women are subjected to many forms of physical, psychological, sexual and economic violence, cutting across all divisions of income, culture and class. While the literature indicates that domestic violence is the most common form of violence against women, Timorese women and girls also endure non-partner rape and sexual assault, incest, sexual harassment and trafficking. The 2015 *Nabilan* Study showed that approximately three in five Timorese women had experienced physical or sexual partner violence in their lifetime, and nearly one in two (46%) of those women in the 12 months before the interview. The prevalence of violence generally rises with the woman's age, tapers off slightly beyond the age of 30 and is worse in urban areas.

Figure 5: Gender-based violence and child abuse in Timor-Leste



Intimate partner violence is one of the most pervasive types of violence in Timor-Leste. This is behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors, including financial control.

Sexual violence by someone other than an intimate partner is less common but prevalent as well. More than one in ten women said they had experienced rape by a man who was not their intimate partner at least once in their lifetime and one in ten in the last 12 months. Half of the women who said they had experienced non-partner rape had been raped on multiple occasions.

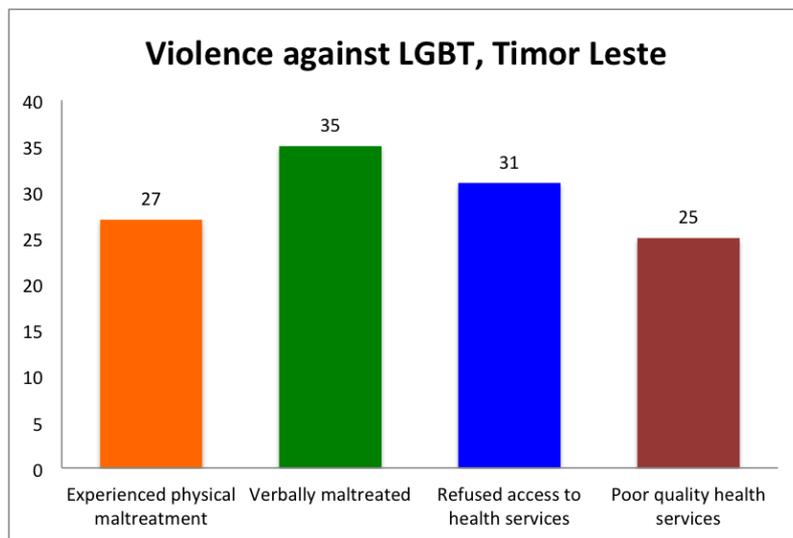
Sexual violence begins at an early age and reoffending is common. More than half of all men who had perpetrated rape did so for the first time when they were adolescents. This finding shows that men learn to use violence during adolescence and youth, and to pursue sexual entitlement over women as part of a dominant masculine identity.

Child abuse and trauma is also extremely pervasive in Timor-Leste. Approximately three in four women and men reported that they had experienced some form of physical or sexual abuse as a child. 80% reported that they experienced emotional abuse or neglect as a child. Approximately 60% of women and men reported that they did not have enough food to eat during their childhood. Moreover, corporal

punishment (or physical violence) as a way of disciplining children both at home and in school is widely practiced.

There is scant or no data on violence against people living with disabilities or the lesbian, gay, bisexual, and transgender (LGBT) community, although it is known that these groups are disproportionately affected. There is limited information detailing with specific incidents of discrimination and violence against LGBT persons. However, research in 2014 among 198 gay and transgender persons in Timor-Leste showed that 27% reportedly had experienced physical maltreatment, 35% had been verbally maltreated, 31% had been refused access to healthcare services and 25% were provided with poor quality health services. There are other reports of violence against LGBT persons in Timor-Leste, including assault in the street and, most commonly, abuse within the family home. Women living with disabilities are particularly vulnerable to sexual violence, and people living with disabilities are up to three times more likely to be physically or sexually abused than their able peers. At least 4% of people in Timor-Leste are living with a disability.

Figure 6: Violence against LGBT, Timor-Leste



ISEAN-HIVOS 2015

A majority of women (80%) and men (79% in Dili and 70% in Manufahi) believe that a husband is justified in hitting his wife in certain circumstances. They also think a woman should tolerate violence in order to keep her family together, indicating that maintaining the family is more important than the consequences for a woman's wellbeing and safety, and those of her children.

Factors contributing to high levels of violence in Timorese society include: (i) unequal gender norms, relationships, and sexual practices; (ii) attitudes that justify both violence and intimate partner violence; (iii) gendered norms related to men's dominance over women; (iv) polygamy and beliefs about the sexual availability of other women, which reflect an unequal dynamic within relationships; (v) transactional or commercial sex and other manifestations of male dominance; (vi) victim's and perpetrator's experiences of child abuse; (vii) perpetrator's experiences of trauma.

Health consequences of gender-based violence

The physical and mental health consequences of gender-based violence can be serious for the woman, and include injury, disability, unintended pregnancy, depression, suicidal thoughts, and impacts on her sexual and reproductive health. Physical violence during pregnancy was experienced by 14% of ever-partnered women who had ever been pregnant – over half of whom had been beaten during more than one pregnancy and, of those, one in three had been punched or kicked in the abdomen. In addition, women who had experienced partner violence had less control over reproductive health choices: they had lower rates of current contraceptive use; were more likely to have had partners refuse to use or stop them from using contraception; were less likely to make joint decisions (with their partners) about birth spacing; and were more likely to have had unplanned or unintended last pregnancies.

Moreover, most women who were injured during intimate-partner violence sustained injuries that required health care, with more than a quarter reporting they were injured at least once. Half of the women who had been injured from partner violence were injured severely enough to need health care, including for cuts, burns, sprains, broken bones and internal injuries. Yet one in three of these women did not receive the required medical attention, and only one in three women who received health care for a violence-related injury told the health-care worker the real cause of the injury.

Partner violence is also a significant issue for children. More than half of the women who experienced physical partner violence reported that their children had witnessed the violence on at least one occasion. There can be health consequences for children of women who have experienced violence, such as being more likely to experience emotional and behavioral problems.

Gender-based violence is a serious public-health issue in Timor-Leste, reflecting the global evidence that violence against women is an important public-health concern. Yet there is limited medical and psychological assistance to victims and a limited number of shelters for women and their children.

Laws and policies prohibit gender-based violence, yet there is low accountability

Gender-based violence is prohibited by law in Timor-Leste, which also has a National Action Plan on Gender-Based Violence (NAP-GBV). The Penal Code states that sexual assault, mistreatment of a spouse and mistreatment of a minor are public crimes, although there are no provisions specifically criminalizing marital rape or qualifying rape as a serious crime.

There is also a Witness Protection Law, which aims to protect witnesses in civil or criminal proceedings when their lives, physical or psychological integrity, freedom or assets are jeopardized. However, the Witness Protection Law has not been implemented due to insufficient resources. A government evaluation of the 2012–2014 NAP-GBV showed limited budget allocation and insufficient inter-ministerial coordination in implementing and monitoring the Law against Domestic Violence. The results of the evaluation will be used to develop the second phase of the NAP-GBV.

The Law on Domestic Violence has dramatically increased the number of domestic violence cases being brought before the courts. Under this law, the national police are now legally obliged to investigate a complaint, whether from the person who has experienced violence, another person, or by their own direct observation, and the officer must immediately prepare a report on the case for the public prosecutor. However, in practice, many cases of domestic violence are still referred back to the family or community for mediation or traditional justice.

There is a lack of accountability in Timor-Leste for several reasons. First, there is a general lack of awareness among women and men, including community leaders, of the criminal nature of gender-based violence, including domestic violence: this is particularly because such a large majority of people thinks it is acceptable in some circumstances. Indeed, agreement with the justifications for intimate-partner violence was a risk factor both for women's experiences and men's perpetrations of violence. Second, there is a low reporting rate – only about 25% of Timorese women who experienced violence sought help due to survivors' fear of stigmatization or revictimization (when a sexual-abuse survivor is sexually victimized again), and people's inadequate appreciation of the criminal nature of domestic violence. A large majority of women who had experienced intimate-partner violence did not report it to an authority or agency, with many saying that they perceived the violence as normal. The majority of cases of violence against children are not reported and those that are tend not to be adequately addressed in the judicial

The Law Against Domestic Violence defines domestic violence as:

Any act or result of an act or acts committed in a family context, with or without cohabitation, by a family member against any other family member, where there exists influence, notably physical or economic, of one over another in the family relationship, which results in or may result in harm or physical, sexual or psychological suffering, economic violence, including threats such as acts of intimidation, insults, bodily assault, coercion, harassment, or deprivation of liberty.

system. Traditional ways of resolving conflicts or crimes perpetrated against children are still very much the norm in Timor-Leste. Third, access to justice is difficult for survivors of violence. Survivors may not know where or how to seek help, as evidenced by the low percentage of women seeking legal aid.

Moreover, survivors may not see the point, given the limited accountability achieved through the justice system, with its low number of investigations, prosecutions and convictions for rape and sexual abuse, as well as lenient sentences in domestic violence cases and failure to issue protection orders. For the cases that do make it to court, there have been delays associated with the 13% decrease in the human resources available to the judiciary. Personnel are also not sensitized to the needs of survivors of violence, as there has been insufficient capacity building for the judiciary regarding gender equality, gender sensitivity and women's rights, as well as insufficient training of prosecutors, lawyers and police.

Timor-Leste's constitution provides for non-discrimination and equitable treatment for people living with disabilities. The Penal Code classifies the mistreatment of people living with disabilities by those who look after them as a crime punishable by up to six years of imprisonment, and the perpetration of sexual violence against people living with disabilities by up to 12 years of imprisonment. However, although some cases of rape against women living with disabilities are reported to the police, in other cases families and caregivers may discourage reporting. There is a National Mental Health Strategy 2010, but it is poorly implemented. An updated National Mental Health Strategy developed in 2015–16 has been submitted to the Ministry of Health Council of Directors to be approved before the end of 2017.

Recommendations to address gender-based violence in Timor-Leste

1. Raise awareness and facilitate prevention.
 - Strengthen awareness-raising and educational activities, targeted at men and women, traditional leaders, health-care and social workers, with support from civil society, to eliminate prejudices related to violence against women.
 - Encourage community-based programs aimed at preventing and addressing domestic violence, child abuse and neglect, including by involving former victims, volunteers and community members and providing them with training and support.
 - Continue efforts to integrate CSE, human rights and gender into the school curriculum and lesson plans to promote healthy and consensual sexual relationships, and address male sexual entitlement. Ensure there are sufficient resources to continue regular training for teachers to strengthen their knowledge and understanding of CSE.
 - Promote whole-community approaches aimed at transforming gender norms for a more equal and healthier notion of masculinity and femininity.
2. Laws and policies
 - Ensure that the NAP-GBV (2017–2021) is adopted expeditiously and is adequately monitored and resourced.
 - Recognize violence against women as a major public health issue.
 - Implement laws so that cases of domestic violence are prosecuted and perpetrators adequately punished, that women victims of domestic violence are encouraged to report such cases to the police, and that they are not directed to mediation by the formal or informal justice system.
 - Reduce the delays in prosecuting cases of domestic violence, ensure the safety of survivors in cases where suspension is necessary, issue and enforce protection orders whenever necessary, and award adequate compensation to survivors of domestic violence.
 - Address the current impunity of many sexual violence offenders and sexual predators.
3. Establish effective procedures and mechanisms to receive, monitor and investigate complaints, including through removing the requirement of a complaint by a child's parent or guardian in cases of sexual abuse of girls aged under 15 years; and ensure that the abused child is not victimized in legal proceedings and that his/her privacy is protected.
 - Establish an easily accessible mechanism for children and others to report cases of abuse and neglect, ensuring the necessary protection for such victims.
 - Establish a complaints mechanism for violence towards and harassment of girls attending

- school.
 - Ensure that all professionals and staff working with and for children are provided with the necessary training on how to prevent and monitor domestic violence as well as receive, investigate and prosecute complaints about such violence in a child- and gender-sensitive manner.
 - Establish mechanisms, procedures and guidelines to ensure the mandatory reporting of cases of child sexual abuse, exploitation and incest, and the speedy and effective investigation of those cases and prosecution of perpetrators.
 - Provide systematic training to law enforcement officials, social workers and prosecutors on how to receive, monitor, investigate and prosecute complaints in a child- and gender-sensitive manner that respects the privacy of the victim.
4. Other help for survivors:
- Strengthen assistance to and rehabilitation of women survivors of violence, including women in rural areas and women living with disabilities, through the establishment of a comprehensive care system for them, and take measures to ensure access to legal aid, medical and psychological support, shelters, counselling and rehabilitation services. Provide women survivors of violence with appropriate and sensitive health care that responds to their physical, psychosocial and safety needs.
 - Ensure that all child witnesses and victims of violence and abuse have access to adequate care, counseling and assistance with recovery and reintegration services.
 - Address child abuse and promote nurturing, violence-free family and school environments.
 - Facilitate the physical and psychological rehabilitation of child victims and ensure they have access to health services, including mental health services.

8. Conclusion

This Country Assessment on Sexual and Reproductive Health and Rights has identified key progress and challenges in relation to maternal and child health, family planning, reproductive health education, STIs and HIV, and gender-based violence in Timor-Leste. It has emphasized the value of a human rights perspective on sexual and reproductive health, identified the situation in Timor-Leste for each, and compared it globally; it has identified challenges and gaps, and the effort that the government and other organizations are taking to address the challenges. It has listed the existing strategies, plans and laws in place to support each of the key areas.

Some of the key recommendations have been to ensure that all women, including the young and rural, have timely access to quality emergency obstetric and newborn care services; to make systemic improvements in the information and accessibility to family planning services, to reduce the rate of unintended pregnancies and unsafe abortions; to promote comprehensive sexuality education universally, in a facility-specific, age-appropriate and gender sensitive way; to focus on HIV and STI prevention, testing and treatment, both for risk groups and the general community; and to strengthen awareness-raising and educational activities targeted at men and women, traditional leaders and health-care workers to eliminate prejudices related to gender-based violence.

The Country Assessment on SRHR has acknowledged vulnerable groups of people who have particular difficulty accessing SRHR, including poor, uneducated, rural women and girls; adolescents; unmarried people; people with disabilities; lesbian, gay, bisexual and transgender people; key populations at higher risk of HIV exposure; survivors of gender-based violence; and pregnant women and girls. The rationale to identify who is being left behind is that the SDGs will not be achievable without tailoring policies and programs targeted towards these groups.

Furthermore, the Assessment has highlighted key areas for action which will be necessary in order to achieve the SDGs in Timor-Leste, particularly in relation to health and well-being (SDG 3) and gender equality (SDG 5). The analysis will also feed into national reporting to international human rights mechanisms including the Universal Periodic Review, the CEDAW and the CRC.

Ultimately, the Country Assessment is an analytical tool which may be used by PDHJ, the government and civil society to monitor and advocate for the improvement of SRHR in Timor-Leste. The Assessment, as well as making specific recommendations for the improvement in each of the five key areas, also provides more general suggestions for the overall achievement of sexual and reproductive health and rights.

9. General Recommendations

The following proposals are to develop systems within the Ministry of Health and its programs, and to share information on SRHR in the broader community.

1. The SISCa program would increase in efficiency and be enabled to expand its reach to more areas if aspects of service delivery received attention.
 - Provide appropriate office space for SISCa to coordinate at suco and aldeia level, especially to direct a reproductive health education campaign in all areas.
 - Encourage SISCa volunteers or PSFs – *Promotores Saúde Familiar* (Family Health Promoters) – to perform more effectively by ensuring they receive incentives and establish minimum conditions for their work.
2. Develop systems to improve the delivery of medications and provision of facilities at every level.
3. Ensure that the relevant financial oversight occurs from the Ministries of Health and Finance through inspections and audits of budget execution and programming.
4. Advocate in favor of PDHJ signing a Memorandum of Understanding with the Ministry of Health and relevant organizations working in the area of reproductive health education to establish a coordinated plan for raising awareness of the importance of reproductive health issues in the community throughout the country.
5. Organise public discussions on TV and radio to debate the five thematic areas considered in the Assessment as part of an awareness-raising campaign on SRHR in Timor-Leste in collaboration with the relevant government institutions, NGOs and development partners, etc.

10. Annexes

A. Human rights and state obligations supporting sexual and reproductive health

Obligations are as set out in human rights norms and by United Nations Treaty Bodies.

<p>Right to Life</p> <ul style="list-style-type: none"> - Prevent maternal mortality and morbidity through safe motherhood programs; - Ensure access to safe abortion services when the life of the mother is at risk. 	<p>Right to Health</p> <ul style="list-style-type: none"> - Ensure adolescents have access to the full range of sexual and reproductive health-care services and information; - Ensure reproductive health services are available, accessible, acceptable and of good quality. 	<p>Right to Education and Information</p> <ul style="list-style-type: none"> - Ensure school curricula include comprehensive, evidence-based, and non-discriminatory sexuality education; - Ensure accurate public education campaigns on the prevention and transmission of HIV.
<p>Right to Equality and Non-Discrimination</p> <ul style="list-style-type: none"> - Prohibit discrimination in access to health care on the grounds of sex, age, disability, race, religion, nationality, economic status, sexual orientation, health status including HIV, etc.; - Do not deny access to health services that only women need. 	<p>Right to Decide the Number and Spacing of Children</p> <ul style="list-style-type: none"> - Ensure the full range of modern contraceptive methods are available; - Ensure women are given comprehensive and accurate information to ensure informed consent to contraceptive methods, including sterilization. 	<p>Right to Privacy</p> <ul style="list-style-type: none"> - Ensure the right to bodily autonomy and decision-making around sexual and reproductive health issues; - Guarantee confidentiality and privacy with regards to patient health-care information, including prohibiting third-party consent, such as spousal and parental, to sexual and reproductive health-care services.
<p>Right to Consent to Marriage and Equality in Marriage</p> <ul style="list-style-type: none"> - Prohibit and punish child, early and forced marriages; - Set the age limit for marriage at 18, equally for boys and girls. 	<p>Right to be Free from Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment</p> <ul style="list-style-type: none"> - Guarantee access to emergency contraception, especially in cases of rape; - Guarantee access to termination of pregnancy when a woman's life or health is in danger, in cases of rape and fatal foetal impairment. 	<p>Right to be Free from Sexual and Gender-Based Violence</p> <ul style="list-style-type: none"> - Ensure gender-based violence, including domestic and intimate-partner violence, is effectively prohibited and punished in law and in practice; - Prohibit and punish all forms of rape, in peacetime and in conflict, and including marital rape; - Prohibit and punish all forms of violence perpetrated because of sexual orientation.
<p>Right to an Effective Remedy</p> <ul style="list-style-type: none"> - Ensure effective mechanisms are in place for women who complain of sexual and reproductive health and reproductive rights violations; - Ensure women who are unable to afford a lawyer have access to effective counsel. 		

Timor-Leste has acceded to the following major international human rights treaties, which encompass the above human rights:

- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of all forms of Discrimination Against Women
- Convention on the Rights of the Child
- Convention Against Torture and other cruel, inhuman or degrading treatment or punishment
- International Convention on the Elimination of all forms of Racial Discrimination

- International Convention on the protection of the rights of all Migrant Workers and members of their families.

B. Human rights principles relevant for SRHR

Human rights principles applicable in the area of sexual and reproductive health and rights are summarized in the table below.

Duty of the state to respect, protect and fulfill human rights , including those human rights that interact with sexual and reproductive health and well-being.	
Respect	This obligation requires States to refrain from interfering directly or indirectly with the enjoyment of human rights. For example, regarding SRH, States have an obligation under international law to refrain from limiting access to contraceptives and from withholding, censoring or misrepresenting information about sexual health.
Protect	This obligation requires States to prevent third parties from interfering with the realization of these rights. Regarding SRH, this would include investigating and punishing practices by health-care providers that violate human rights such as forced sterilization or abortion.
Fulfill	This obligation requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to enable full enjoyment of rights. States must provide for sexual and reproductive health care and adopt related national health policy covering both the public and private sectors. The State must take active measures to deliver reproductive health services, including contraceptive services and provide these in a manner that respects women’s dignity, exercise of choice and autonomy.
Progressive realization	This obligation acknowledges that the full realization of economic, social and cultural rights may not be feasible in a short period of time or due to budgetary constraints. However, States must take active measures towards achieving those rights and must not regress on measures already taken. Moreover, steps towards that goal must be deliberate, concrete and targeted as clearly as possible, using all appropriate means—including the adoption of legislative measures and the implementation of national strategies with clear objectives, benchmarks, budgetary allocations and indicators to measure progressive achievement in accordance with available resources. Regardless of the resources available, States have certain obligations towards economic, social and cultural rights that must be implemented immediately. The enacting of anti-discrimination provisions and the establishment of associated enforceable rights with judicial remedies within national legal systems are but two examples.

C. Further human rights principles relevant for SRHR

Principle of participation	At all stages of decision-making, it is critical to ensure active involvement of civil society actors, individual participants and other key stakeholders in the development and monitoring of laws and policies, including budgets and use of public funds. Stakeholder voices are also important to accountability. Participation of populations most affected, and those facing significant barriers to their access to reproductive health services, ensures that their needs and priorities properly inform improvements in relevant laws and policies and in the delivery of services. International human rights law requires States to ensure effective accountability and participation processes, including in monitoring and evaluation and the availability of effective remedies. This obliges the participation of a wide range of stakeholders in the development and implementation of laws, policies and programs.
Principle of accountability	Where human rights have been violated in the context of sexual and reproductive health services, information or expression, States have an obligation to monitor and review the implementation of associated laws, programs and policies, and to establish appropriate remedies. At the national level, this entails a number of actions: <ul style="list-style-type: none"> • Ensuring effective human rights institutions are in place; • Providing access to information about accountability mechanisms;

	<ul style="list-style-type: none"> • Establishing effective monitoring and review mechanisms, developing rights-based indicators, collecting disaggregated data; • Strengthening birth and death (including maternal deaths) registration systems; • Providing judicial and non-judicial legal remedies; • Investigating and punishing violations as well as providing redress and reparations; • Providing access to legal aid, and removing barriers to justice and redress systems.
<p>Principles of non-discrimination and equality</p>	<p>Marginalized populations are often underserved. They can encounter significant barriers to realizing their SRHR, affecting their quality of health. For example, access to sexual and reproductive health information and services may be largely unavailable for these populations or of inferior quality due to factors such as physical or geographic barriers, absent or inaccurate or incomplete information, and discriminatory practices. Indigenous women and those belonging to minority groups, disabled women and HIV-positive women, and transgender people, for example, have been subject to coerced and forced sterilization. In some parts of the world, sex workers may be arrested for carrying a condom on the grounds that it is evidence of intent to engage in illegal sexual activity. Such practices reflect multiple forms of discrimination; violate the rights to privacy and health; and violate the right to determine the number, spacing and timing of children. Furthermore, they also violate the right to be free from inhuman and degrading treatment, and can be forms of violence against women.</p> <p>International human rights law requires special attention be given to populations living in situations of marginalization and disadvantage in policies, programs, budgets, service delivery as well as through other empowering measures to promote their active participation in public affairs and development processes affecting them.</p>

D. References consulted for each key theme

General references

Association for Disability Timor-Leste (2016). *Submission from Member Organisations of the Association for Disability Timor-Leste to the 26th Session of the Human Rights Council Universal Periodic Review Working Group*.

Committee on the Elimination of all forms of Discrimination Against Women (2015). *Concluding Observations on the combined second and third periodic reports of Timor-Leste*, CEDAW/C/TLS/CO/2-3, 20 November.

Committee on the Rights of the Child (2015). *Concluding Observations on the combined second and third periodic reports of Timor-Leste*, 30 October, CRC/C/TLS/CO/2-3.

General Directorate of Statistics (2010). *Timor-Leste Demographic and Health Survey 2009–2010*.

Ministry of Health (2015). *National Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health 2015–2019*.

PDHJ (2016). *Submission from the Office of the Ombudsman for Human Rights and Justice in Timor-Leste to the Universal Periodic Review*, March 24, 2016.

Timor-Leste Civil Society Coalition on UPR (2016). *Submission by the Timor-Leste Civil Society Coalition for the UPR*.

United Nations (2016). *Transforming our world: the 2030 Agenda for Sustainable Development*. Available at <https://sustainabledevelopment.un.org/post2015/transformingourworld>.

United Nations Country Team in Timor-Leste (2016). *Report for the Universal Periodic Review of Timor-Leste*, 26th Session of the UPR Working Group, October–November 2016.

1. Maternal and child health

General Directorate of Statistics and ICF (2017). *Timor-Leste Demographic and Health Survey 2016: Key Indicators*. Dili, Timor-Leste: GDS and Rockville, Maryland, USA: ICF.

General Directorate of Statistics and UNFPA (2010). *Mortality Monograph: Timor-Leste Population and Housing Census*.

Ministry of Health (2015). *Timor-Leste Second National Emergency Obstetric and New Born Care Assessment*.

Ministry of Health (2011). *National Health Sector Strategic Plan 2011–2030*.

UNICEF (2014). *Situation Analysis of Children in Timor-Leste*.

UNICEF (2014). *Violence Against Children in East Asia and the Pacific: A Regional Review and Synthesis of Findings*.

United Nations (2015). *The Millennium Development Goals Report 2015*.

WHO (2015). *Post-Natal Care for Mothers and Newborns: Highlights from the WHO 2013 Guidelines*.

WHO (2015). *Trends in Maternal Mortality: 1990–2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. 20 November.

2. Family planning

Belton S. et al. (2009). *Maternal mortality, unplanned pregnancy and unsafe abortion in Timor-Leste*. Alola Foundation, Dili.

Bertrand J.Y. et al. (2014). 'Contraceptive Method Skew and Shifts in Method Mix In Low- and Middle-Income Countries'. *International Perspectives on Sexual and Reproductive Health*, 2014, 40(3):144–153, doi: 10.1363/4014414.

Centre for Reproductive Rights and UNFPA (2010). 'Briefing Paper – the right to contraceptive information and services for women and adolescents'. Available at <https://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf>

Ministry of Health (2005). *National Family Planning Policy*.

Population Reference Bureau, USAID (2013). *The World's Youth: 2013 Data Sheet*.

Secretariat of State for Youth and Sports (2014). *Youth Situation Review Report*.

Singh, S. et al (2009). *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*. Guttmacher Institute and UNFPA: New York.

The Lancet (2014). 'Every newborn, every mother, every adolescent girl', *The Lancet*, Vol 383, Issue 9919, p 755–844, 27 February.

United Nations (2014). 'Report of the Secretary-General' distributed 12 February, A/69/62.

United Nations Country Team in Timor-Leste (2016), *Report for the Universal Periodic Review of Timor-Leste*, 26th Session of the UPR Working Group, October-November 2016.

UNFPA (2016), *Universal Access to Reproductive Health 2016*.

UNFPA (2015). *Girlhood not motherhood: preventing adolescent pregnancy*.

UNFPA (2014). 'Framework of actions for the follow-up to the Programme of Action of the International Conference on Population and Development beyond'.

UNFPA (2014). 'Report on Assessment for Reproductive Health Commodities and Services in Timor-Leste'.

UNFPA (2009). 'Youth Reproductive Health: Quantitative and Qualitative Analysis'.

UNFPA, SSYS and PLAN International (2017). 'Teenage Pregnancy and Early Marriage in Timor-Leste: Research on the Decision-Making Pathways of Young Women in the Municipalities of Covalima, Aileu and Dili'.

WHO (2012). *Safe abortion: technical and policy guidance for health systems*, second edition.

WHO (2006). *Defining Sexual Health: Report of a Technical Consultation on Sexual Health 28–31 January 2002, Geneva*. Sexual health document series. Geneva.

WHO (2004). *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets: Global strategy adopted at the 57th World Health Assembly*. Geneva. Available at http://whqlibdoc.who.int/hq/2004/WHO_RHR_04.8.pdf

3. Reproductive health education

Democratic Republic of Timor-Leste (2002). *Constitution of the Democratic Republic of Timor-Leste*.

Ministry of Health (2004), 'National Family Planning Policy'.

Ransom, E.I and Elder, L.K. (2003). 'Nutrition of Women and Adolescent Girls: Why it Matters', Population Reference Bureau.

Ruest-Archambault, E. (2010). 'Report of the Timor-Leste National Conference on Reproductive Health, Family Planning and Sex Education'.

UNESCO (2015). *Emerging evidence, lessons and practice in comprehensive sexuality education: A global review*.

UNESCO (2009). *International Technical Guidance on Sexuality Education: An Evidence-informed approach for schools, teachers and health educators*. Paris, UNESCO.

UNFPA (2014). *UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender*.

WHO (2006). *Defining Sexual Health: Report of a Technical Consultation on Sexual Health 28–31 January 2002, Geneva*. Sexual health document series. Geneva.

WHO (2004). *Reproductive Health Strategy to Accelerate Progress towards the Attainment of International Development Goals and Targets: Global strategy adopted at the 57th World Health Assembly*. Geneva. Available at http://whqlibdoc.who.int/hq/2004/WHO_RHR_04.8.pdf

4. HIV and sexual health

Fonner et al. (2014). 'School-based sex education and HIV prevention in low and middle-income countries: A systematic review and meta-analysis'. *PLoS ONE* 9(3): e89692.

General Directorate of Statistics (2012). *Timor-Leste Population and Housing Census 2010: A Census Report on Young People in Timor-Leste*.

General Directorate of Statistics and ICF Macro (2010). *2009–10 Timor-Leste Demographic and Health Survey: Key Findings on Youth*. Dili, Timor-Leste: NSD and ICF Macro.

HIV and AIDS Data Hub for Asia Pacific (2014). 'Timor-Leste Country Review@'. Available at <http://www.aidsdatahub.org/Country-Profiles/Timor-Leste>

Ministry of Health (2011). 'Timor-Leste National HIV and STI Strategy 2011–2016'.

Ministry of Health, HIV/STI Unit (2011). 'Results from the HIV/STI Integrated Biological and Behavioral Surveillance (IBBS) Survey in Timor-Leste', Dili.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (2014). *Concept Note for HIV in Timor-Leste: Investing for Impact Against HIV, Tuberculosis or Malaria*.

UNESCO and the Global Network of People Living with HIV (GNP+) (2012). *Positive Learning: Meeting the needs of young people living with HIV (YPLHIV) in the education sector*. Paris.

5. Gender-based violence

Committee on the Rights of the Child (2015). *Concluding Observations: Timor-Leste*, 30 October, CRC/C/TLS/CO/2–3.

Committee on the Rights of the Child (2008). *Concluding Observations: Timor-Leste*, 14 February, CRC/C/TLS/CO/1.

Democratic Republic of Timor-Leste (2010). Law No. 7/2010 on Domestic Violence.

Democratic Republic of Timor-Leste (2009). Law No. 2/2009 on Protection of Witnesses.

Democratic Republic of Timor-Leste (2009). Decree Law No. 19/2009, Penal Code.

Devries, K., Mak, J.Y.T., Garcia-Moreno, C., Petzold, M., Falder, G., Lim, S., Bacchus, L., Engell, R., Pallitto, L., Vos, T., Abrahams, N. and Watts, C. H. (2013). 'The Global Prevalence of Intimate Partner Violence against Women'. *Science* 340: 1527–28.

Fulu, E. and Kerr-Wilson, A. (2015). 'What Works to Prevent Violence against Women and Girls Evidence Reviews: Paper 2': *Interventions to Prevent Violence against Women and Girls. What Works to Prevent Violence: South Africa*.

Fulu, E., Warner, X., Miedema, S., Jewkes, R. and Lang, J. (2013). 'Why Do Some Men Use Violence against Women and How Can We Prevent It? Quantitative Findings from the United Nations Multi-country Study on Men and Violence in Asia and the Pacific.' Partners for Prevention: Bangkok.

Garcia-Moreno, C., Jansen, H.A.F.M., Ellsberg, M., Heise, L. and Watts, C.H. (2005). *WHO Multi-country Study on Women's Health and Domestic Violence against Women*. WHO: Geneva.

Garcia-Moreno, C., Pallitto, C., Devries, K., Stöckl, H., Watts, C. and Abrahams, N. (2013). 'Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence'. WHO: Geneva.

General Directorate of Statistics (2016). *Preliminary Results Population and Housing Census 2015*.

- ISEAN-HIVOS (2015). 'ISEAN-HIVOS Program (IHP) Baseline Research on MSM and TG experience of stigma and discrimination in Indonesia, Malaysia, Philippines and Timor-Leste: Final Report', April.
- Judicial System Monitoring Programme (2013). *Law Against Domestic Violence: Obstacles to Implementation. Three Years on*. JSMP: Dili.
- Noronha, J.M.D.R.C., State Secretariat for the Support and Socio-Economical Promotion of Women (2015). 'Evaluation Report, the National Action Plan on Gender-Based Violence', Dili, 10 December.
- Office of the Secretary of State for the Promotion of Equality (2012). *National Action Plan on Gender Based Violence 2012–2014*.
- Stöckl, H., Devries, K., Rotstein, A., Abrahams, N., Campbell, J., Watts, C.H. and Garcia- Moreno, C. (2013). 'The Global Prevalence of Intimate Partner Homicide: A Systematic Review'. *The Lancet* 382 (9895): 859–65.
- Taft, A. and Watson, L. (2013). 'Violence against Women in Timor-Leste: Secondary Analysis of the 2009–10 Demographic and Health Survey'. La Trobe University: Melbourne.
- The Asia Foundation (2016), *The Nabilan Health and Life Experiences Study, Fact Sheet 2: Health Consequences of Intimate Partner Violence Against Women in Timor-Leste*.
- The Asia Foundation (2016). *The Nabilan Health and Life Experiences Study, Fact Sheet 4: Sexual Violence Against Women by Someone Other than their Intimate Partner in Timor-Leste*.
- The Asia Foundation (2016). *Understanding Violence against Women and Children in Timor-Leste: Findings from the Nabilan Baseline Study – Main Report*. The Asia Foundation: Dili.
- The Asia Foundation (2015). *Beyond Fragility & Inequity: Women's Experiences of the Economic Dimensions of Domestic Violence in Timor-Leste*.
- UN Committee on Economic, Social and Cultural Rights (2000). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August. Available at <http://www.refworld.org/docid/4538838d0.html>
- UNFPA (2014). *A Guide in Support of National Human Rights Institutions: Country Assessments and National Inquiries on Human Rights in the Context of Sexual and Reproductive Health and Well-Being*.
- UNFPA and Center for Reproductive Rights (2010). *The Right to Contraceptive Information and Services for Women and Adolescents*. New York.
- United Nations General Assembly, Human Rights Council (2012). *Report of the Working Group on the Universal Periodic Review – Timor-Leste*. A/HRC/19/17.
- United Nations General Assembly (UNGA) (1993). 48/104. Declaration on the Elimination of Violence against Women', UN General Assembly: Geneva.
- United Nations Integrated Mission in Timor-Leste, OHCHR (2011). *Of Course We Can: Report on the Rights of Persons with Disabilities in Timor-Leste*.
- U.S. Department of State (2015). *Bureau of Democracy and Human Rights and Labour, Country Report on Human Rights Practices for 2014: Timor-Leste*.
- U.S. Department of State (2014). *Bureau of Democracy and Human Rights and Labour, Country Report on Human Rights Practices for 2013: Timor-Leste*.
- WHO (2014). *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*. WHO: Geneva.

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