



Situation Analysis of Children in Timor-Leste



MINISTÉRIO DAS
FINANÇAS



Situation Analysis of Children in Timor-Leste

The Situation Analysis of Children in Timor-Leste (SitAn) has been developed by the United Nations Children's Fund (UNICEF) and the SitAn Technical Committee led by the General Directorate of Statistics of the Ministry of Finance.

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Foreword

Timor-Leste's future relies on its children. The Situation Analysis of Children in Timor-Leste (SitAn) is a comprehensive report aiming to obtain an overall understanding of Timorese children – the current status of their basic rights, the causes of shortfalls and inequities, and the implications for children themselves and the country as a whole. The report also provides recommendations for future policies, programmes and actions.

This SitAn intends to offer solid evidence and baseline information to support the operationalization of the Timor-Leste National Strategic Development Plan 2011-2030, the current Government's five-year (2012-2017) Plan including the sectoral five-year development plans, and other key national and local planning documents and processes.

As the coordinating agency, the Ministry of Finance, in particular the General Directorate of Statistics, led the analysis with the support of UNICEF. An Inter-Ministerial Committee played a critical coordination and advisory role. The Committee is composed of key representatives of the Ministry of Finance, Ministry of Health, Ministry of Education, Ministry of Social Solidarity, Ministry of Public Works, Ministry of Justice, National Commission for the Rights of the Child, Secretary of State for Youth and Sports, and Secretary of State for Social Communication. The Ministry of Finance wishes to extend its sincere appreciation to UNICEF for providing technical, financial and administrative support for the analysis. I also would like to express my gratitude to the sectoral ministries, development partners and civil society organizations for their cooperation and support in completing the analysis.

The Government of Timor-Leste recognizes that the lives of children have remarkably improved over the past years, but significant challenges remain to be overcome. Malnutrition, insufficient quality of education, poor sanitation and inadequate child protection services, among others, impact severely not only on children's wellbeing, but also on the development of human capital and the country's long-term socio-economic development.

I therefore encourage all stakeholders to support the national efforts to enhance children's rights in Timor-Leste.



Ms. Emilia Pires

Minister of Finance

The Democratic Republic of Timor-Leste

Message from the Representative of UNICEF in Timor-Leste

The Situation Analysis of Children in Timor-Leste (SitAn) intends to inform planning, programming and decision making by pulling together and analyzing all available information and data on children in Timor-Leste from both national and international sources.

The Report captures the significant progress the country has made in enhancing children's survival, development and protection. For instance, Timor-Leste has largely reduced its child mortality rate from 125 deaths per 1,000 live births in 2002 to 64 in 2009. This is one of the biggest reductions in the world. Timor-Leste has also sharply increased primary school net enrollment rate from 64 per cent in 2005 to 94 per cent in 2009. These significant achievements show that in a peaceful and stable development environment, with strong political commitment and concrete actions, Timor-Leste can quickly enhance children's rights.

While congratulating Timor-Leste on the remarkable progress made, it is recognized that enormous challenges remain ahead. The Report reveals that huge gaps persist in improving children's nutritional status, particularly in reducing stunting among children under five years old, providing pre-school learning opportunities and improving the quality of basic education, expanding access to improved sanitation facilities, and enhancing hygiene practices. Unless urgently addressed, these gaps will undermine the country's future development potential and national competitiveness.

The Government of Timor-Leste is highly committed to the survival, development and protection of children. Human capital development is one of the four pillars of the National Strategic Development Plan 2011-2030 and the Fifth Constitutional Government Programme. This strong political commitment needs to be continuously translated into evidence-based plans, programmes and actions supported by sufficient public resources. In doing so, this report provides the evidence available up to date.

UNICEF, the United Nations Children's Fund, was very pleased to work with the Ministry of Finance in developing this Report. UNICEF also appreciates the excellent cooperation with all Government entities that have provided essential support for the development of this report, as well as development partners.

The path forward to sustainable development in Timor-Leste is to empower its children. Healthy and well-educated children will be better prepared and ready to lead the country forward.



Ms. Hongwei Gao
UNICEF Representative in Timor-Leste

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The Situation Analysis of Children in Timor-Leste (SitAn) has been jointly produced by the General Directorate of Statistics of the Ministry of Finance of Timor-Leste and the UNICEF Country Office in Timor-Leste.

The SitAn was developed through a participatory and collaborative process under the guidance of the SitAn Technical Committee led by Mr. Antonio Freitas, Director-General of Statistics, with the support of his team (Mr. Elias dos Santos Ferreira, National Director of Methodology and Data Collection, Mr. Silvino Lopes, National Director of System and Publicity, Ms Paulina Rita Viegas, National Director of Economic and Social Statistics, and Mr. Cesar Martins, Chief of the International Relationship Unit) and UNICEF. The Committee is comprised of representatives of representatives of social sector ministries (the full list of members of the SitAn Technical Committee is reported in Annex 4).

Under the overall direction of Ms. Hongwei Gao, UNICEF Country Representative for Timor-Leste, the team of Planning, Monitoring and Evaluation (Ms. Min Yuan, PM&E Specialist, Ms. Beatrice Targa, Social Policy Officer, Ms. Sachiko Matsuoka, M&E Officer, Mr. Joao da Costa, M&E Officer, and Maria de Araujo, Programme Assistant) worked closely with the technical working group from the initiation of the study, through analysing the data, drafting, organizing consultations, and finalizing the report.

Sincere thanks go to all UNICEF staff members and international consultants who contributed to the analysis and supported the validation process, as well as to all development partners who peer-reviewed the Report. Although not possible to mention everyone by name, special thanks go to Mr. Rene van Dongen, Deputy Representative, Dr. Hemlal Sharma, Chief of Health and Nutrition, Ms. Mayang Sari, Nutrition Specialist, Ms. Takaho Fukami, Chief of Education, Mr. Ramesh Bhusal, Chief of Water, Sanitation and Hygiene Promotion, Ms. Antonia Luedeke, Child Protection Specialist, Ms. Candie Cassabalian, Adolescent & Youth Participation Specialist, and Ms. Mary Ann Maglipon, Communication Specialist for revising and improving the Report.

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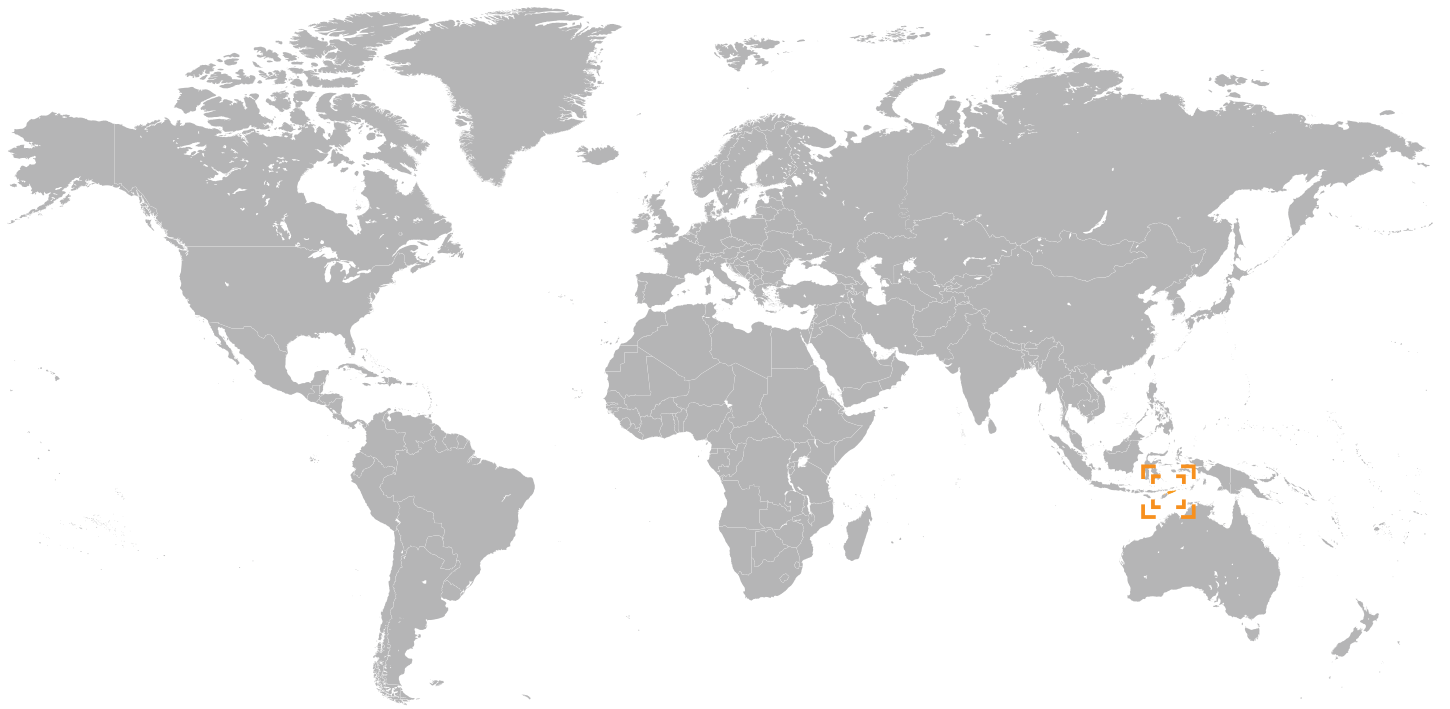
Abbreviations and acronyms

| | |
|---------------|--|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| ARI | Acute Respiratory Infection |
| ARNEC | Asia-Pacific Regional Network for Early Childhood |
| ART | Antiretroviral Therapy |
| AusAID | Australian Agency for International Development |
| BESIK | Be'e Saneamentu no Ijiene iha Komunidade (Community Water Supply and Sanitation Project) |
| BMI | Body Mass Index |
| CFTL | Consolidated Fund of Timor-Leste |
| CICL | Children in Conflict with the Law |
| CLTS | Community-Led Total Sanitation |
| CPNs | Child Protection Networks |
| CPOs | Child Protection Officers |
| CRC | Convention on the Rights of the Child |
| CSO | Civil Society Organization |
| CWD | Children with Disabilities |
| CWSDO | Community Water Supply Development Officers |
| DNSA | Direcção Nacional Serviço de Água (National Directorate of Water Supply Service) |
| DNSSB | Diresaun Nasional Serbisu Saneamentu Baziku (National Directorate for Basic Sanitation Services) |
| DPCM | Development Policy Coordination Mechanism |
| DPMU | Development Partners Management Unit |
| ECD | Early Childhood Development |
| ECE | Early Childhood Education |
| EFA | Education for All |
| EGMA | Early Grades Mathematics Assessment |
| EGRA | Early Grades Reading Assessment |
| EHD | Environmental Health Department |
| EMIS | Education Management Information System |
| EU | European Union |
| EVM | Effective Vaccine Management |
| FAO | Food and Agriculture Organization |
| FCJ | Forum Komunikaun Joventude |
| GDP | Gross Domestic Product |
| GER | Gross Enrolment Rate |
| GMF | Grupo Maneija Fasilidade (Water Supply Management Groups) |
| GNI | Gross National Income |
| GPE | Global Partnership for Education |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| HRBA | Human Rights-Based Approach |

| | |
|------------------|--|
| HSS | HIV Sentinel Surveillance |
| HWWS | Hand Washing With Soap |
| IMR | Infant Mortality Rate |
| INFORDEPE | Instituto Nacional de Formação de Docentes e Profissionais da Educação (National Institute for Teacher Training and Educational Professionals) |
| INTERFET | International Forces East Timor |
| IOM | International Organization for Migration |
| ITN | Insecticide-treated Mosquito Net |
| JMP | Joint Monitoring Programme |
| KOICA | Korea International Cooperation Agency |
| LLITN | Long Lasting Insecticide-Treated Net |
| MACR | Minimum Age of Criminal Responsibility |
| MAF | Ministry of Agriculture and Fisheries |
| MAGs | Martial Arts Groups |
| MCIE | Ministry of Commerce, Industry, and Environment |
| MDG-F | Millennium Development Goals - Achievement Fund |
| MDGs | Millennium Development Goals |
| MMR | Maternal Mortality Ratio |
| MNCH | Maternal, Newborn and Child Health |
| MoE | Ministry of Education |
| MoED | Ministry of Economy and Development |
| MoF | Ministry of Finance |
| MoH | Ministry of Health |
| MoJ | Ministry of Justice |
| MoPW | Ministry of Public Works |
| MSA | Ministry of State Administration |
| MSS | Ministry of Social Solidarity |
| MTCI | Ministry of Tourism, Commerce and Industry |
| NAR | Net Attendance Rate |
| NCRC | National Commission on the Rights of the Child |
| NDGs | National Development Goals |
| NDP | National Development Plan |
| NER | Net Enrolment Rate |
| NESP | National Education Strategic Plan |
| NGO | Non-Governmental Organisation |
| NHSSP | National Health Sector Strategic Plan |
| NIR | Net Intake Rate |
| NZAID | New Zealand Aid Programme |
| O&M | Operation and maintenance |
| OD | Open defecation |
| ODF | Open defecation free |
| OECD | Organisation for Economic Co-operation and Development |
| OHCHR | Office of the High Commissioner for Human Rights |

| | |
|---------------|---|
| OPAC | Optional Protocol on the Involvement of Children in Armed Conflict |
| OPSC | Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography |
| ORT | Oral Rehydration Therapy |
| PAKSI | Planu Aksaun Komunitade - Saneamentu no ljiene (Community-led total sanitation) |
| PDD | Decentralised Development Programme |
| PDID | Integrated District Development Planning |
| PID | District Investment Plans |
| PMTCT | Prevention of Mother to Child Transmission of HIV |
| PNDS | Programa Nasional Dezenvolvimentu ba. Sucos (National Suco Development Programme) |
| PNTL | National Police of Timor-Leste |
| PSF | Community Volunteers |
| RHF | Recommended Home Fluids |
| SAS | District Water and Sanitation Office |
| SBA | Skilled Birth Attendance |
| SDF | Sub-District Facilitator |
| SDP | National Strategic Development Plan |
| SEAMEO | South East Asian Minister of Education Organization |
| SGBV | Sexual and Gender Based Violence |
| SISCa | Serviço Integrado de Saúde Comunitária (Integrated Community Health Services) |
| STI | Sexually Transmitted Infection |
| TLSLS | Timor-Leste Survey of Living Standards |
| U5MR | Under-five Mortality Rate |
| UNFPA | United Nations Population Fund |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNICEF | United Nations Children's Fund |
| UNMIT | United Nations Integrated Mission in Timor-Leste |
| UNTAET | United Nations Transitional Authority in East Timor |
| UPE | Universal Primary Education |
| USAID | U.S. Agency for International Development |
| VIP | Ventilated Improved Latrine |
| VPU | Vulnerable Person's Unit |
| VSS | Victim Support Services |
| WASH | Water, Sanitation and Hygiene |
| WFP | World Food Programme |
| WHO | World Health Organization |
| WJU | Women Justice Unit |
| WSP | Water Safety Plan |

Location of Timor-Leste on World Map



Map of Timor-Leste with Districts



Key facts

Official Name

República Democrática Timor-Leste (RDTL)

Capital

Dili

Administrative Divisions

Timor-Leste is divided into 13 administrative districts (Ainaro, Aileu, Baucau, Bobonaro, Covalima, Dili, Ermera, Lautem, Liquica, Manatuto, Oecusse, Manufahi, Viqueque), which are subdivided into 65 subdistricts, 442 sucos (villages), and 2,228 aldeias (hamlets).

Population

1.066 million (in 2010)

Geography

The country consists of the eastern portion of the island of Timor and includes the enclave of Oecussi (also known as Ambeno; 2,500 square kilometres) and the islands of Atauro (144 square kilometres) and Jaco (8 square kilometres).

Part of the Malay Archipelago, representing the largest and easternmost of the Lesser Sunda Islands.

The area of the country is approximately 14,874 square kilometres, or 1,487,000 hectares with a total length of approximately 265 kilometres and a maximum width of 97 kilometres.¹

Currency

United States Dollar

Religions

Catholic (97 per cent), Protestant Christian (2 per cent), Other (including Muslim, Buddhist) (1 per cent), Animism (widespread general underlay to all religious groups).²

Languages

Tetun and Portuguese (official languages); English and Indonesian (working languages) and about 30 other local languages.

Life expectancy

62 years³

Government

The Constitution of the Democratic Republic of Timor-Leste provides for a Semi-Presidential System of government, with the President as the Head of State and the Prime Minister as the Head of the Government. The Legislature is a unicameral assembly, the National Parliament.

Current President

Taur Matan Ruak

Current Prime Minister

Kay Rala 'Xanana' Gusmão

Gross Domestic Product

GDP ⁴ (2011, nominal, billion): US\$ 5.8

Oil: US\$ 4.7 billion

Non-oil: US\$ 1.1 billion

1. Timor-Leste: Country Environmental Analysis, World Bank, July 2009

2. 2010 Census

3. Ibid

4. Timor-Leste National Accounts 2000-2011



Executive summary

Timor-Leste has changed dramatically. Since its independence of slightly more than a decade ago, it has moved from a post-conflict country to a lower middle income developing country. As the country experienced socio-economic and security-related progress in recent years, the situation of children in Timor-Leste has also gradually improved.

Nonetheless, there are major challenges still affecting children in Timor-Leste. A comprehensive situation analysis on children is imperative to ensure evidence-based actions that address the remaining challenges within the changing context of the country.

This Situation Analysis of Children (SitAn) provides an overview of children's rights to health and nutrition, water, sanitation and hygiene, education, protection, and participation, with a special focus on disadvantaged children and their families.

The analysis identifies key progress and persisting child deprivations, and explores the immediate and underlying causes of issues relating to supply, demand and quality of services which affect the equitable achievement of children's rights in Timor-Leste. The basic enabling environment for the improvement of children's lives is also discussed.

The SitAn aims to increase awareness and understanding of child development issues in the country and supports the implementation of the Fifth Constitutional Government's Programme (2012-2017), the National Strategic Development Plan (2011-2030) and other key national plans.

Key achievements in child development in Timor-Leste

Timor-Leste is one of seven high mortality countries⁵ that have already met the MDG on the reduction of under-five mortality rate by at least two-thirds since 1990⁶. **Timor-Leste has achieved a remarkable 50 per cent reduction in U5MR.** National household-based surveys found that the U5MR declined from 125 deaths per 1,000 live births in 2002⁷ to 64 in 2009⁸, which is well below the national MDG target of 96. Similarly, the infant mortality rate (IMR) - the probability of children dying before their first birthday, declined from 88 per 1,000 live births in 2002⁹ to 45 in 2009¹⁰, way below the target of 53.

Although Timor-Leste is still among the countries with higher levels of under nutrition among children under five years of age, **progress has been made to improve the nutritional status of the population.** Comparison between the 2009-2010 TLDHS data and the preliminary data from the 2013 Timor-Leste Food and Nutrition Survey shows that for children under five years of age, prevalence of stunting declined from 58.1 per cent to 51.9 per cent; wasting decreased from 18.6 per cent to 10.8 per cent; and underweight dropped from 44.7 per cent to 38.1 per cent.

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5. High mortality is defined as U5MR of 40 or more deaths per 1,000 live births in 2012. List of countries: Bangladesh, Ethiopia, Liberia, Malawi, Nepal, Timor-Leste and the United Republic of Tanzania.
 6. UNICEF (2013) *Committing to Child Survival, a Promise Renewed*, Progress Report 2013, New York: UNICEF.
 7. UNICEF (2003) *Multiple Indicator Cluster Survey 2002*, Dili: UNICEF Timor-Leste.
 8. Democratic Republic of Timor-Leste and ICF Macro (2010) *Timor-Leste Demographic and Health Survey 2009-2010*.
 9. UNICEF (2013) *Multiple Indicator Cluster Survey 2002*, Dili: UNICEF Timor-Leste.
 10. Democratic Republic of Timor-Leste and ICF Macro (2010) *Timor-Leste Demographic and Health Survey 2009-2010*.

Timor-Leste is on track to achieve the MDG target on improved drinking water. According to the 2010 Census, 66 per cent of the households had access to clean drinking water in 2010.

The global Joint Monitoring Programme (JMP) for water and sanitation estimated that by 2011, 69 per cent of population in Timor-Leste had accessed safe drinking water, a 15 per cent increase since 2000.

Significant progress has been made in access to basic education with the achievement of a primary (grade 1-6) net enrolment rate (NER) of 94 per cent with gender equality in 2010¹¹ as compared to only 64 per cent in 2005.¹² This is remarkable as the entire education system has been rebuilt from its foundations.

The establishment of a **National Commission on the Rights of the Child** with a clear mandate to promote and monitor children's rights is a critical step forward in advancing children's rights in Timor-Leste.

Major issues, challenges and disparities

Timor-Leste remains one of the countries with the highest prevalence of stunting among children who are under five years of age. Further, about 27.2 per cent of women in Timor-Leste have a body mass index (BMI) of less than 18.5, indicating under-nourishment,¹³ 15 per cent have short stature, and 21.3 per cent are anaemic, which perpetuate the cycle of under-nutrition.¹⁴

Child mortality is still high in Timor-Leste. Each year, around 1 in 16 children dies before his/her fifth birthday (64 deaths per 1,000 live births).¹⁵ Only two districts (Dili and Baucau) have an U5MR that is lower than the national average. Neonatal mortality (child death within 28 days after birth) is

high at 22 deaths for every 1,000 live births and has remained un-changed since 2003.¹⁶ Neonatal-related conditions, pneumonia, diarrhoea and malaria are major immediate causes of child deaths.

Moreover, with a maternal mortality ratio (MMR) of 557 deaths per 100,000 live births,¹⁷ **Timor-Leste is off track on the MDG target on maternal mortality.**¹⁸ About 42 per cent of all deaths among women aged 15-49 years were due to risks associated with pregnancy and child birth.

Timor-Leste is off-track to meet the MDG target on sanitation. The 2010 Census shows that only 39 per cent of households had access to improved sanitation facilities, an increase of only 2 percentage points since 2000. **About 8 per cent of urban households and 37 per cent of rural households still practice open defecation.**

Schools in Timor-Leste lack adequate WASH facilities. Nearly half (46 per cent) of the 1,259 primary schools in Timor-Leste do not have access to improved water sources and 35 per cent lack basic sanitation facilities.¹⁹ Likewise, the minimum standard for Health Posts requires 24-hour access to clean running water, but more than 50 per cent of rural Health Posts in Timor-Leste lack access to this basic facility.

High repetition rate, over-age and poor learning achievements are key challenges in education. About 30 per cent of students in grade one had to repeat the first year of school.²⁰ Children repeating the same grades, along with children who are never enrolled and children dropping out of school, constitute key challenges for achieving universal completion of basic education. Further, only 32 per cent of students were at the official school age when entering the first grade. The Early Grades Reading Assessment (EGRA) in 2010 also found that more than 70 per cent of students at the end of grade one could not read a single word of a simple text passage.

The lack of school readiness contributes to the existing challenges of students repeating grades or dropping out of school at primary levels.

School readiness can be increased through quality pre-school education. However, according to the preliminary data collected by the National Directorate of Pre-school Education, **the Gross Enrolment Rate of pre-school education is only about 14 per cent** as of February 2013.

Children with disabilities, adolescent mothers, working children and orphaned children face the greatest risk of not obtaining education.

Specifically, the 2010 Census indicates that only 59 per cent of children aged 6-14 years old with disabilities were attending school, as compared to 77 per cent among all children in this age group. Also, very limited inclusive education practices are exercised to support their learning. Further, almost half (47.9 per cent) of teenage mothers (15-19) years old in Timor-Leste had left school as opposed to only 12.8 percent of all young women. Only one-third (35 per cent) of working children (10-14) years old were still in school, as compared to 92 percent of all children aged 10-14 years old. Only 66 per cent of 10-14 years old orphans attended school while 87 per cent of children with parents did.

Domestic violence is widely recognized as a serious issue in Timor-Leste affecting women as well as children who are both witnesses and victims.

Data from the 2009-2010 TLDHS show that approximately 38 per cent of women aged 15-49 years and 30.8 per cent of women aged 15-19 years had experienced physical violence since the age of 15. About 3.4 per cent of women aged 15-49 years and 2 per cent of women aged 15-19 years reported that they had experienced sexual violence since the age of 15. Very limited information and reliable data is available on violence against children in Timor-Leste, However several studies have highlighted widespread practice of corporal punishment (or physical violence) as a way for disciplining children both at home and in school.

Children without parental care is another issue of concern. In 2009, nearly one in four (23 per cent) of households had orphans (1.6 per cent had no parents and 9.4 per cent had only 1 living parent) or foster children (17.4 per cent) under the age of 18.²¹ Kinship care is a widespread traditional practice in Timor-Leste. While generally a positive practice, especially if children are cared for by immediate family members, the limited monitoring by protection services renders children at risk of abuse and exploitation. Institutionalisation of children is the exception rather than the rule in Timor-Leste. However, there are 59 residential care facilities in Timor-Leste and none of these are formally licensed to provide care or protection to children.

Causes of deprivation

The limited coverage of quality basic social services is the main cause of deprivations of children and a major obstacle to child development in Timor-Leste.

Appropriate care for children is a continuum of support services that starts from pre-pregnancy until the child is 18 years old. It is along this continuum that key opportunities exist for the delivery of lifesaving interventions.

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11. 2010 Education Statistical Yearbook
 12. EMIS 2010
 13. BMI Categories: Underweight (<18.5), Normal weight (18.5–24.9) and Overweight (25–29.9).
 14. TLDHS 2009-2010
 15. Ibid.
 16. TLDHS 2003 and 2009-2010.
 17. TLDHS 2009-2010
 18. According to UN data (WHO, UNICEF, UNFPA and The World Bank, " Trends in maternal mortality: 1990 to 2010 estimates") MMR was 300 deaths per 100,000 live births in 2010.
 19. Democratic Republic of Timor-Leste (2012) National Stocktake of School Facilities and Equipment in Basic Education Schools in Timor-Leste, Dili: Ministry of Education.
 20. EMIS 2010
 21. TLDHS 2009-2010.

It is shown that the coverage of relevant interventions is still relatively low. For instance, according to the 2009-2010 TLDHS, only 22.3 per cent of women of reproductive age (15-49 years old) use contraceptives before pregnancy. Slightly over half (55.1 per cent) of pregnant women received professional antenatal care more than four times during pregnancy, and less than one-third (29.9 per cent) had skilled attendance during delivery.

Further, only one-third of mothers received professional postnatal care (31 per cent). Only a little over half (52 per cent) of infants less than 6 months of age are exclusively breastfed. Immunisation to protect infants from communicable diseases is a challenge with only around 60 per cent receiving a routine dose of measles vaccine; and about two-thirds (64 per cent) of children 12-23 months old receiving their third dose of DTP3 vaccination.

While primary school enrolment increased significantly, access to pre-school and secondary school education is still challenging. Out of 142 pre-schools available for the 2007/2008 school year, 53 are private or community-supported schools.²² Most of the existing pre-schools are concentrated in urban areas. There are only 85 secondary school facilities available in the country, also concentrated in urban areas.

Provision of direct services for children at risk or child victims of abuse, neglect, violence and exploitation is still limited. The overwhelming majority of service provision is based in Dili and is directed towards victims of domestic and gender-based violence. These programmes almost exclusively target women and girls. It appears that violence against boys is more widely tolerated and there are very limited specific services available to support them.

There are no targeted strategies or specialised services for children in conflict with the law in Timor-Leste. While a handful of NGOs provide minimum

support for children in prison, the case management role of the Child Protection Officers (CPOs) remains limited. Access to justice including courts and lawyers is not available in all districts.

Insufficient supplies and commodities, and inadequate supply management are key bottlenecks for quality service delivery.

A joint review supported by the UNICEF Regional Office in 2012 ²³ found that, as compared to existing needs, the stock available for essential commodities is only 20 per cent for assisted delivery and neonatal care, 10 per cent for Prevention of Mother-to-Child Transmission of HIV (PMTCT) and 5.6 per cent for oral rehydration salt with zinc. The Effective Vaccine Management (EVM) assessment conducted in 2011 identified weaknesses in procurement planning and supply chain maintenance. Shortage of essential drugs and ambulance fuel for transporting pregnant women to health facilities are reported frequently.

A shortage of classrooms is one of the most frequently voiced problems by school directors and teachers. Many schools with classroom shortages often schedule shifts to accommodate the students. Only 65 per cent of primary schools have toilet facilities and water is available in 54 per cent of schools.²⁴ School furniture such as desks and chairs is insufficient. Availability of textbooks, particularly in Tetun, is still very limited. Shortage of effective teaching aids and learning materials compound difficulties in effective teaching-learning.

Insufficient amount, skills and misdistribution of human resources and facilities result in poor quality basic social services.

The availability of nurses and midwives is only 50 per cent of what is required at the national level and even worse (estimated to be 10 to 15 per cent) in the low performing districts.²⁵ At the facility level, the misdistribution of doctors and nurses results in

the concentration of medical staff in urban medical facilities and insufficient staff in rural and peri-urban areas.²⁶

Nationally, only 40 per cent of teachers meet the national qualification standards.²⁷ There had been a significant number of volunteer teachers without adequate qualifications and training opportunities until 2013, who have been converted to temporary contracted teachers in 2014 to be paid by the government. Limited contact time between teachers and pupils and limited time on school tasks are some of the immediate causes of poor learning performance. Further, the lack of teachers' capacity in the official languages (Tetun and Portuguese) of instruction hampers the effectiveness of the teaching-learning process.

There are only 26 Child Protection Officers (CPO) at the district level and 64 Social Animators at the sub-district level. The CPOs are limited to dealing with only the most severe cases brought directly to them. They lack professional social work training to ensure the provision of adequate services to child victims of abuse, neglect, violence and exploitation. Although the Social Animators are stationed in the sub-districts, their capacity and scope for dealing with families at risk - and preventing escalation of problems - remains limited. The capacity of police to conduct investigations in cases of child abuse needs further attention and there are only limited child-sensitive judicial procedures in place.

Gaps in knowledge, attitude and behaviours influenced by social norms, culture and local practices contribute to the lack of demand for accessing social services.

The total fertility rate in Timor-Leste is among the highest in the world with a woman giving birth to 5.7 children on average during her lifetime.²⁸ The median number of months since the preceding birth is 29. Further, the 2009-2010 TLDHS indicates that 7.7

per cent of girls aged 15-19 had been married or in union, and about 7.2 per cent of them had already given birth or were pregnant with their first baby. Knowledge and skills of care providers and families are limited. The 2009-2010 TLDHS shows that only 52 per cent of infants aged 0-6 months are exclusively breastfed; and only 31 per cent of children 6-23 months receive timely and appropriate complementary feeding. Some adverse traditional health prevention, treatment, birth delivery and newborn care practices are still widespread.

Regarding sanitation, 80 per cent of the mothers dispose of babies' faeces unsafely,²⁹ and open defecation (OD) is widely practiced with 29 per cent of the population not using any kind of latrines. Hand washing with soap was reported at 20.4 per cent before preparing food and only 1.6 per cent after touching faeces.

There are perceived low returns on family investment in education and its links to employment. The current curriculum is not fully relevant and age-appropriate, and does not provide sufficient practical life- and livelihood-skills to meet the fast-changing demands of the modern world. Limited contact hours (four hours per day) and time on tasks, compounded by limited parents' support at home also hamper effective learning.

22. National Education Strategic Plan 2011-2030.

23. Joint review on bottleneck analysis in 2012, supported by the UNICEF EAPRO (Internal report), Dili: UNICEF Timor-Leste.

24. Democratic Republic of Timor-Leste (2012) National Stocktake of School Facilities and Equipment in Basic Education Schools in Timor-Leste, Dili: Ministry of Education.

25. Joint review on bottleneck analysis in 2012, supported by the UNICEF EAPRO (Internal report), Dili: UNICEF Timor-Leste.

26. Ibid.

27. EMIS 2010

28. 2009-2010 TLDHS

29. Knowledge Attitude and Practice (KAP) baseline survey (2011) for EU-UNICEF joint WASH Project.

Social practices, such as bride price and traditional systems of justice and conflict resolution, are impediments to protecting children against violence, exploitation and abuse. Family involvement in marriages and family pressure not to take issues of abuse and violence outside the family compound is an issue. Traditional ways of resolving conflicts or crimes perpetrated against children are still very much the norm in Timor-Leste.

Basic enabling environment

Timor-Leste is a small and a newly independent country with nearly half of its population (half a million) being children under 18 years. About 70 per cent of people live in rural areas.

The population growth rate decreased from 3.2 per cent in 2004 to 2.4 per cent in 2010,³⁰ but is still among the highest in Asia. At the current rate of growth, the population is expected to reach 1.2 million in 2015, 1.4 million in 2020 and double by 2039.

Timor-Leste inherited institutions of the state and society, local businesses and economy, and physical infrastructure in ruins when independence was restored in 2002. Enormous progress has been made since then with the country experiencing social and political stability since 2008, after years of conflict.

The National Strategic Development Plan (SDP) for 2011-2030 provides a long-term vision for the country's further development and focuses on four key areas: social capital; economic development; infrastructure; and institutional framework. The SDP also serves as the basis of the five-year government plan (2012-2017). The recently launched new Development Policy Coordination Mechanism (DPCM), led by the Prime Minister, aims at operationalizing the SDP and five-year

plan while ensuring maximum coordination among all stakeholders towards the achievement of the identified targets.

The Government has recently accelerated the **decentralization** agenda at the district level with the target of achieving administrative de-concentration by 2016. It is expected that the de-concentrated structure "will be better placed to deliver appropriate services to local citizens".³¹ Significant risks need to be carefully pondered and addressed, to be able to harvest the immense opportunities that decentralization brings about for the country.

Timor-Leste is currently a **lower-middle income country** with a GNI per capita of \$3,670 in 2012,³² aspiring to become upper middle-income by 2030. Rapid growth has been accompanied by high inflation, which has reached double-digit figures. Inflation in the price of certain goods, in particular food, reduces people's purchasing power, forcing them into cutting spending for basic services with negative implications for children's development and wellbeing.

Considerable oil revenues have allowed an expansionary fiscal policy since 2005. **The government's investment strategy has strongly focused on major infrastructure** to develop the non-petroleum economy and establish the basic foundation for the country's long term development.

In the past years, the actual amount of investment in key social sector ministries has considerably increased, tripling from less than US\$100 million in 2008 to almost US\$300 million in 2012, thanks to increasing oil revenues. However, in 2013 this amount reduced to US\$265 million. Further, **social expenditure has declined as a share of the total government budget** over time.

In 2014 the Ministries of Health and Education were allocated only about 4.8 and 9.2 per cent (CFTL and Infrastructure Fund) of the total national budget, among the lowest allocations in the East Asia and Pacific region.

The lack of employment still represents a critical issue in the country with only slightly more than half (54 per cent) of the labour force (15-64 years old) found to be economically active (i.e. either employed or seeking a job) in 2010.³⁴ Over 90 per cent of the economically active population was employed, with however a large share being considered “vulnerable”, i.e. 80 and 27 per cent in rural and urban areas respectively. Young people's unemployment rate is higher than the general labour force population (24 per cent of 15-24 against 9.5 per cent in the general population).³⁵

Child deprivations are still severe in Timor-Leste. While children living in rural areas and poor families with lower educated mothers are generally more disadvantaged, the SitAn found that for many development indicators, significant development challenges are common nationwide. For instance, even the children under five years of age belonging to the highest quintile suffer from high levels of stunting, wasting and underweight.

Children continue to be particularly vulnerable to the effects of natural disasters and climate change, ranging from direct physical impacts, due to heavy rains, extreme temperatures etc., to impacts on their education, psychological stress and nutrition. While these environmental challenges have been largely localised, these events typically have negative effects on the people of Timor-Leste and on children in particular as families rely heavily on domestic food production and the existing poor infrastructure.

Timor-Leste is party to most human rights and humanitarian law treaties. Reflecting the Government's commitment to the rights of children and the implementation of the Convention on the Rights of the Child (CRC) in September 2009, the National Commission on the Rights of the Child (NCRC) was established as the government agency responsible for promoting, protecting and monitoring children's rights under the Ministry of Justice. The combined 2nd and 3rd State Report on the CRC, OPAC and OPSC was submitted in November 2013.

Sectorial policies and strategies have been put in place but still require specific action plans for implementation. Some of the policies developed or being developed include the National Maternal, Newborn and Health Development Strategy; the National Nutrition Strategy; the National Framework for Pre-school Education; the National Basic Sanitation Policy, and the Child and Family Welfare System Policy. However, these policies require translation into costed action plans. Overall, the linkage between development planning targets and budgeting needs to be improved, and budget allocations to districts appear not to be based on solid evidence and thorough planning. Management and coordination mechanisms in social sectors all still need to be strengthened.

Monitoring and evaluation remains a challenge. Timor-Leste has developed significant capacity in conducting surveys and is implementing a comprehensive household-based survey plan under

30. Census 2010

31. Government Five-Year Plan 2012-2017

32. World Bank Development Indicators (2012).

33. Timor-Leste Budget Transparency Portal (data on executed expenditure).

34. Democratic Republic of Timor-Leste and UNFPA (2012) 2010 Timor-Leste Population and Housing Census: Labour Force Monograph, Dili, Timor-Leste: National Statistics Directorate (NSD) [Ministry of Finance] and UNFPA.

35. Census 2010.

the General Directorate of Statistics of the Finance Ministry, including the Timor-Leste Population and Housing Census, Demographic and Health Survey (TLDHS), Survey of Living Standards (SLS), Household Income and Expenditure Survey and others. These surveys have provided comprehensive and disaggregated data and analysis. The current challenge is how to make effective use of the information to support national planning, budgeting, monitoring and reporting.

The Government has showed increasing interest in collecting real-time data and information to support annual planning. Currently the Health Management Information System (HMIS), the Education Management Information System (EMIS) and other sectoral administrative data collection systems require significant improvement in terms of data quality and timely reporting. Significant capacity gaps in data analysis and use of data have been acknowledged and started to be addressed.

Opportunities for action

- **To put children at the core of national development to ensure a supportive environment for child development.** The specific needs of children should be considered a top priority in legislation, policy making and budgeting, as they directly link to human capital creation and long-term socio-economic development.
- **To take advantage of the ample fiscal space generated by the country's vast natural resource endowment to increase and improve investments in children in Timor-Leste.** Specifically, it is recommended to increase financing for social sectors; earmark budget for

child-related programmes and spending units at national and district levels; allocate budget based on the level of deprivation of children in different areas; and promote evidence-based and result-oriented planning and budgeting. Strengthening institutional capacity on executing financial resources in the social sectors is also paramount to improve the effectiveness and efficiency of public resources to produce enhancements in human and child development.

- **To implement high impact interventions for children.** Particular attention should be focused on improving nutrition, and maternal and child health. Pre-school education should also be a high priority to help reduce repetition and drop-out, and improve learning outcomes and the quality of education. Improving water and sanitation access at home, in the community, at school and in health facilities is paramount. Equally important is to further develop a comprehensive, integrated child and family welfare system and a child sensitive justice system.
- **To enhance the quality of social services through improved governance, institutional and human capacity development, and improvement of supply provision and management.** Institutional capacity assessment should be the basis for supporting human resource development. Training needs to be institutionalised based on competency and nationally-approved guidelines and training materials. Institutional human resource management should be strengthened including performance assessment and incentive mechanisms. The distribution of human resources and supplies should consider existing disparities and explicit policy and incentive measures should be introduced to fill in human resource gaps in rural areas.

- **To improve management and coordination among social sectors and improve institutional capacity on evidence-based planning, budgeting, monitoring and reporting.** The national level coordination among ministries, and the district and community level planning and monitoring needs to be integrated, strengthened and linked with the decentralisation process. Regarding the latter, management capacity for local authorities and service providers needs to be built.
- **To ensure a robust monitoring and information system is in place.** This will provide accurate and timely data and information as evidence for policy discussion, decision making, planning, budgeting, monitoring and reporting. Mechanisms for real-time data collection and use of new technologies have great potential to support the improvement of national systems. Capacity building of both national and local staff on data analysis and use of data requires more investment and will improve the effectiveness and efficiency of the national development programmes.
- **To increase public demand of social services through the promotion of optimal behaviour and practices on health, nutrition, sanitation, education, and child protection at all levels.** Further, the existing community-based approaches and mechanisms, such as Mother Support Groups in health, Community-Led Total Sanitation (CLTS) and hygiene promotion in WASH, and Parent-Teacher Associations and others need to be strengthened. Linkages among these community networks need to be established to maximise synergy and impact. There is also a need to enhance child care. Families and caregivers need to increase their knowledge, improve their attitudes and change their practices to ensure that best interests of children are met.
- **To encourage child and youth participation and develop proper mechanisms to allow their voice to be heard.** The Youth Parliament is a good practice and its value has been recognised regionally. Life-Skills-Based Education and civic education for adolescents and young people to mitigate risks of violence and develop responsive new generations for Timor-Leste should also be strengthened.

Introduction

The situation of children in Timor-Leste has improved although there are on-going challenges. Socio-economic and security-related progress indicates Timor-Leste's dynamic changing context that requires evidence-based action to address the remaining challenges affecting children in Timor-Leste. This is precisely why this comprehensive Situational Analysis of Children is important. The Analysis will increase awareness and understanding of child development issues in Timor-Leste, and support the implementation of the Fifth Constitutional Government Programme (2012-2017) and the National Strategic Development Plan (2011-2030).

Because Timor-Leste is strengthening social inclusion in its policies, programmes and advocacy agenda, this analysis has made efforts to utilise an equity perspective. Global experience indicates that the difficulty encountered in providing the most deprived population groups with basic services essential for their wellbeing and ensuring conditions that enable them to lead a life of dignity is detrimental to human rights and overall development. While the situation analysis aims to assist with the prioritisation of the most critical children's rights issues in policies, plans and programmes, the equity-focus seeks to identify the most deprived communities and children in terms of health care, water and sanitation, education, protection, and other essential services so that the causes and manifestations of deprivation may be addressed.

A children's rights agenda with an equity-focus is particularly relevant for Timor-Leste as the country seeks to strengthen its social development policies and infrastructure, and hasten the progress towards the Millennium Development Goals (MDGs).

Timor-Leste is a new nation of young people, having only gained independence in 2002 through a protracted and violent struggle after more than five centuries of colonisation and occupation. The socio-economic and political scenario of Timor-Leste changed drastically in the last few years, having an impact on the lives of people, particularly children who comprise 48 per cent of the population.³⁶ In looking at the situation of children, it is essential to acknowledge this history and its ramifications on society today. The country context shapes the lives of its children and determines their levels of vulnerability to deprivation. A fresh assessment of the progress made, the unfulfilled agenda and the challenges ahead are therefore called for.

The report is divided into chapters as follows:

Chapter 1: The rights of children and women are realized when the overall context is conducive. The first chapter reviews the demographic, political, social, and economic environments in Timor-Leste, which influence children significantly.

Chapter 2-6: These are the thematic chapters, devoted to analyse the key issues affecting children, namely maternal and child health (Chapter 2), nutrition (Chapter 3), water, sanitation and hygiene (WASH) (Chapter 4), education (Chapter 5), and protection (Chapter 6). Each chapter has the following components: situation overview, including status, progress and disparities; causality analysis; and opportunities for action.

Youth and adolescents are recognized as a crucially important group and therefore mainstreamed in the analysis. Further, Annex 1 is specifically devoted to this population group.

Finally, although the focus is on children (under 18 years), it is noted that children and women's issues are closely inter-linked and must be approached as such.

Methodology

The analysis follows a Human Rights-Based Approach (HRBA) to assess the current situation of children in Timor-Leste. In this light, the various sections of children's wellbeing are examined through equity focused-lens, as previously mentioned. Special attention is given to the poorest children and deprivations due to age, gender, disability, rural and urban residence and other inequities.

The HRBA applies to the analysis of the immediate, underlying and structural causes of shortfalls and disparities to identify restrictions affecting the following:

- Enabling environment (legislation and policy; social budgeting and expenditure; management and coordination, and social norms);
- Supply or provision of services (availability of essential supplies and inputs, and access to adequate staffed services, facilities and information);
- Demand (financial access; social practices and beliefs; and continuity of use of services); and
- Quality of services for children and women.

Gender equality analysis is mainstreamed to understand the influence of societal gender concepts and practices on the full realization of the rights of children.

The Situation Analysis relies primarily on secondary sources of information on children's rights in Timor-Leste, including the recently released data and monographs from the Population and Housing Census

2010, Demographic and Health Survey 2009-10, Labour Force Survey 2010, management information systems of ministries and qualitative information generated by recent studies. The unavailability of more recent data represents a limitation for the Analysis.

Wide participation was ensured through the engagement of relevant stakeholders, particularly through the Situation Analysis Technical Committee set up in December 2012. This brings together key government officials from all relevant ministries and is chaired by the Director General of Statistics of the Ministry of Finance (Annex 4). Involvement of development partners and civil society was ensured during the process, most notably through the peer review mechanism.

36. Government of Timor-Leste (2010) Timor-Leste Population and Housing Census, Dili: NSD, Ministry of Finance.

1

Country context

Timor-Leste is a young country with nearly half of the population below 18 years. As a significant component of the population, the issues and concerns of children affect the development agenda of the country.

Recognising that the rights of children can be essentially realised within the broader context of the state, society, community and family, the following chapter focuses on the demographic, political, social and economic environment in Timor-Leste.



1.1 Demography

Children, defined as individuals below the age of 18 years by the Convention on the Rights of the Child, constitute 48 per cent of the population in Timor-Leste. Out of a total of 515,000 children, over 150,000 are under five and 180,000 are primary school age children. Over 68 per cent of the population is under 30 years, with those aged 15-24 amounting to over 200,000 (Figure 1.1). The total population of Timor-Leste was 1.066 million in 2010, after an increase of 143,000 from 2004 and 279,000 from 2001.³⁷ Around 240,000 women are of reproductive age (15-49 years old).

The total fertility rate declined from 6.6 in 2004 to 5.7 births per woman in 2009-10³⁸, implying that on average a Timorese woman is expected to deliver 5.7 children during her life.

The population growth rate decreased from 3.2 per cent in 2004 to 2.4 per cent in 2010, but is still among the highest in Asia. At the current rate of growth, the population is expected to reach 1.245 million in 2015, 1.425 million in 2020 and double by 2039 (Figure 1.2).³⁹

Figure 1.1: Population pyramid

Source: Democratic Republic of Timor-Leste and UNFPA (2010) Timor-Leste Population and Housing Census 2009-10, Dili: National Directorate of Statistics (NSD) [Ministry of Finance].

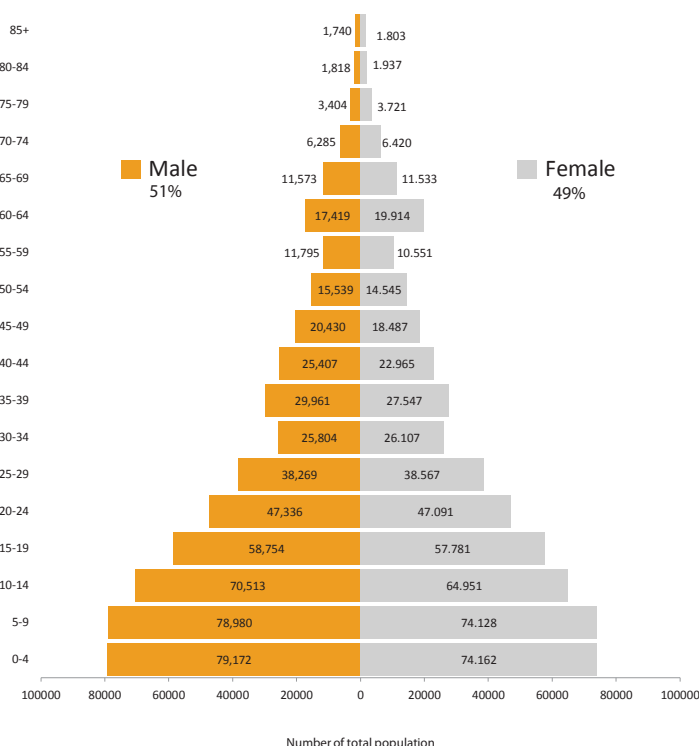
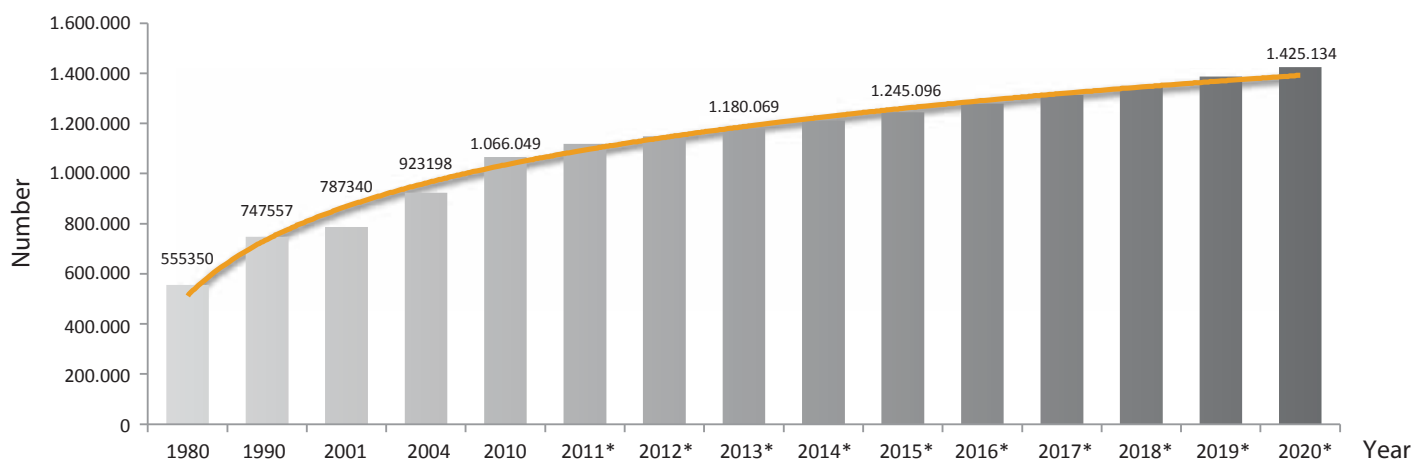


Figure 1.2: Population size (1980-2020)

Source: Democratic Republic of Timor-Leste and UNFPA (2012) 2010 Timor-Leste Population and Housing Census: Migration and Urbanization Monograph, Dili, Timor-Leste: National Statistics Directorate (NSD) [Ministry of Finance] and UNFPA. * Population data for 2011-2020 are projections.



Box 1.1:

Migration and Children in Timor-Leste

Migration, both internal and international, and urbanization are relevant not only as demographic processes but also as key elements for the country's economic development and social transformation.

According to the 2010 Census, 12 per cent of the population (or 128,142 persons) have moved from one district to another (internal migration rate) due to education, occupation or to follow the family, with marriage also being an important factor in rural areas. In-migrants mostly have primary (20.8%) or secondary level education (40.4%).

As for the overall sex ratio, there were 105 male for every 100 female migrants in Timor-Leste in 2010. International migration is also discernible in the country, which hosted a foreign-born population of 1.1 per cent of the total population in 2010. From a policy perspective it is important to receive international migrants who are educated and skilled so that they can contribute to the enhancement of human capital and the future development of the country.

Migration into Dili, Timor-Leste's capital, has been massive. Dili is said to have hosted about 85,200 in-migrants or 36.4 per cent of its resident population in 2010. In-migrants into Dili have increased by 37 per cent from 2004 to 2010. This heavy influx of migration into Dili has resulted in an increased population and changed structure, as well as in socio-economic and environmental effects due to rapid urbanization.

Between 2004 and 2010, the population in the capital increased by 4.6 per cent on average per year, which is much higher than the national average annual growth rate of 2.4 per cent. The population of other cities in the country also grew as a result of rural-urban migration and natural population growth.

Rapid urban growth strains the capacity of the government to provide even the most basic services such as water, electricity and sewerage. Policy makers and planners have formulated various options to address poverty and other socio-economic issues, such as unemployment (about 14 per cent of the migrants are unemployed) and livelihood difficulties, which reflect the migratory movements and urbanization in Timor-Leste.

Women in rural areas tend to have, on an average, one child more than urban women (6 compared to 5 births per woman).⁴⁰ While high fertility is prevalent in all age groups in rural areas, in urban areas the number of younger women (20-24 years) opting to have fewer babies is now growing. The rural-urban difference in fertility is most pronounced for women aged 20-24 (236 births per 1,000 women in rural areas versus 187 births per 1,000 women in urban areas). There are considerable differentials in fertility among districts, ranging from as low as 4.4 births per woman in Covalima to 7.2 births per woman in Ainaro.⁴¹

About 70 per cent of the population lives in rural areas and the urban population is mostly concentrated in the capital Dili.

Urbanisation is indicated by the increase in urban population from 25.9 per cent in 2004 to 29.6 per cent in 2010. The heavy influx of migration into Dili has resulted in its increased population and structure, and to effects on social, economic and environmental sectors. The population of Dili has increased at an average annual growth rate of 4.6 per cent, which is much higher than the national average annual growth rate of 2.4 per cent during 2004-2010.⁴²

The differences in population size and density among and within districts indicate an uneven distribution of population.

Dili, the capital city, has over 230,000 residents. Ermera and Baucau both have over 100,000 people. Manufahi, Ainaro and Manatuto each have a population of less than 50,000. The overall population density of Timor-Leste is 71 people per square kilometre. However, this is much higher in the districts of Dili (636), Ermera (152) and Liquica (109) and considerably lower in Manatuto (27), Manufahi (32) and Lautem (35). Even within these districts, some areas are sparsely populated due to their remoteness.

1.2 Political and civil context

1.2.1 Political situation

Timor-Leste inherited institutions of the state and society, local businesses and economy, and physical infrastructure in ruins when independence was restored in 2002. Enormous progress has been made since then with the country experiencing social and political stability since 2008 after years of conflict.

After almost five centuries, an attempted coup in 1975 led to the sudden departure of the Portuguese administration and Timor-Leste was left with an unfinished process of political transition and widespread civil conflict. Despite a UN resolution supporting Timor-Leste's right to self-determination, Indonesia occupied the territory, marking the beginning of 24 years of protracted and often violent struggle for independence.

Amidst increasing international pressure, a referendum coordinated and supervised by the United Nations was finally held in 1999 and almost 80 per cent of Timorese voters favoured independence. A large-scale military campaign by Timorese militias – supported by the Indonesian military – followed, which killed approximately 1,300 Timorese and further damaged or destroyed the majority of the country's infrastructure.

Independence was restored on May 20, 2002 with the support of the United Nations Transitional Authority in East Timor (UNTAET) – later the United Nations Integrated Mission in Timor-Leste (UNMIT) – and an Australian led International Force for East Timor (INTERFET). While still struggling with chronic poverty and displacement, Timor-Leste was again hit by civil unrest and violence in 2006, and a violent attack on the political leadership in 2008.

Opportunities for action - In-migrants in Timor-Leste are mostly young (over 40 per cent of lifetime net migrants are aged 15-29 and 13 per cent are in the age group 5-14) so efforts should be made to address their specific needs and vulnerabilities. Specifically, policies should enhance access to the potential benefits created by migration, while also providing protection for those who are vulnerable to its negative consequences. Effective migration policies should be accompanied by additional investments in health, education and social protection to address the risks faced by migrating children and adolescents. Governments, international organizations, and civil society stakeholders should collaborate to:

- Advocate for the rights of migrant children;
- Monitor and gather information on their wellbeing in migrant communities; and
- Promote awareness in sending and host communities to minimize risks of social exclusion.

Source: Whitehead, A. and Hashim, I. (2005) Children and Migration Background Paper for DFID Migration Team.

In 2012, Timor-Leste conducted orderly National Presidential and Parliamentary elections. Former military commander Taur Matan Ruak succeeded Nobel Peace Laureate José Ramos-Horta as President of the Democratic Republic of Timor-Leste, while Xanana Gusmão from the National Congress for Timorese Reconstruction was reconfirmed as Prime Minister. He formed a coalition with two parties, namely Fretilin and the Democratic Party, with the exclusion of FRETILIN, the major opposition party. As a result of the smooth and largely peaceful political transition, UNMIT formally closed at the end of 2012.

However, challenges related to the political environment and security remain. According to the **Fragility Assessment**⁴³ conducted by the Government of Timor-Leste as part of the New Deal initiative, the following are a few of the risk factors: political language used by some leaders

and/or some party members have the potential to create discontent among certain groups with related serious implications; national parliament's oversight role with regards to the executive body needs enhancement, with a clear mechanism that can ensure follow-up action by the executive yet to be established; conflict either among martial art groups at the community level or due to land disputes and; a high rate of unemployment, especially among the youth, which is usually accompanied by frustration and disillusionment.

The Government is making considerable efforts in addressing the above-mentioned issues and has achieved increased political stability and participation of the people in political processes. In addition, the ongoing decentralization process (please refer to Section 1.2.3) is expected to further stabilize the country and ensure representation of citizens living in the districts.⁴⁴

1.2.2 Policy framework

“The true wealth of any nation is in the strength of its people. Maximising the overall health, education and quality of life of the Timorese people is central to building a fair and progressive nation.”

- Timor-Leste, National Strategic Development Plan (SDP) 2011-2030

Socio-political stability and economic growth have enabled the Government to start facing the challenge of rebuilding state and society institutions, physical infrastructure and local economy. In 2009, the Government adopted the slogan ***“Goodbye conflict, Welcome development”***, later changed to ***“Be a good citizen. Be a New Hero to our Nation”*** in 2013.

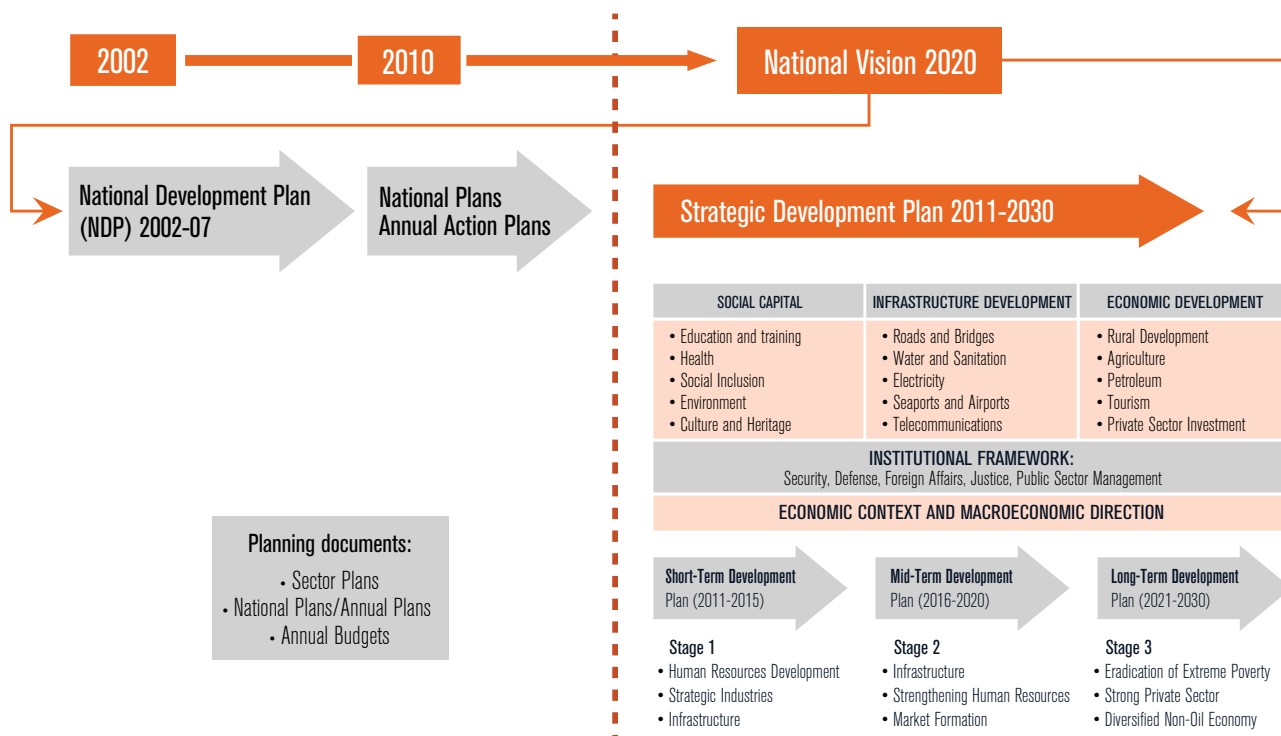
Intense efforts to develop a vision and strategy for poverty reduction and development began as early as independence. The first Timor-Leste Government, which assumed power in 2002, developed the **National Development Plan (NDP) – “Timor-Leste 2020: Our Nation Our Future”**, along with a Road Map and Stability Programme for its implementation identifying key priorities and Sector Investment Plans. Agency-level annual action plans linked to budgets provided the basis for policy implementation on an annual basis.

In a context of widespread poverty and deprivation, with one in five people living on less than one dollar per day and under-five mortality rate as high as 83 deaths per 1,000 live births⁴⁵, the NDP presented Timor-Leste's long-term vision up to 2020 and a poverty reduction strategy for the period 2002-2007. This strategy recognized the multiple dimensions of poverty and was translated into development goals, aligned with the MDGs, focusing on creation of economic opportunities; delivery of basic social services; provision of security for people and property; and community empowerment.

The national priorities identified by the Government every year allowed the country to steadily progress. This served as Timor-Leste's strategic planning mechanism.

In 2010, a summary Strategic Development Plan “From Conflict to Prosperity” was released and served as a basis for community consultations in all sub-districts across Timor-Leste⁴⁶ for inputs before the finalization of the **Strategic Development Plan (SDP) for 2011-2030**. The SDP provides a renewed long-term vision for the country's development and focuses on four key areas, namely: social capital, economic development, infrastructure, and institutional framework. The SDP provides a vision to 2030, a framework of action to 2020 and a public investment plan to 2015. It also serves as the basis for the **five-year development programme**

Chart 1.1: Staging the Timor-Leste Strategic Development Plan (SDP)⁴⁷



(2012-2017) launched by the Fifth Constitutional Government in August 2012. The SDP seeks the transformation of Timor-Leste into an upper middle-income country with a healthy, educated and secure population by 2030.

Agriculture, Tourism and Petroleum have been identified in the SDP as the growth-driving sectors. Specifically, the goals include the improvement of agricultural productivity to achieve food security by 2020; the implementation of strategies to leverage Timor-Leste's natural beauty, rich history and cultural heritage to develop the tourism industry; and the maximisation of local participation and shared benefits flowing from growth in the petroleum sector. New economic policy directions to support private sector development and build the finance industry are also provided by the SDP.

Infrastructure and the social sector are highlighted in the SDP as key enabling sectors for national development.

The recently launched new Development Policy Coordination Mechanism (DPCM), led by the Prime Minister, aims to operationalize the SDP while ensuring maximum coordination and synergy among ministries, development partners and civil society towards the achievement of the identified targets (Chart 1.2, see next page).

The national plans and programmes are also in line with the Peace-building and State-building Goals defined within the **New Deal for Engagement in Fragile States**, an international initiative driven by the g7+ group of 19 fragile and conflict-affected countries, in which Timor-Leste plays a prominent role.

Box 1.2:

What are the implications of decentralisation for the realisation of children's rights?

Risks

- Different sub-national financial and administrative capacities can deepen existing inequities: Administrative and financial decentralisation may put children in poorer remote areas at a disadvantage, due to the likely lower capacity of raising revenue and lack of skilled administrators as compared to wealthier urban districts.
- Inappropriately assigned administrative functions, loss of economies of scale and excessive duplication of functions can reduce the quality and reach of public services: For example, each sector has specific arrangements to ensure effective and efficient provision of services. In the case of education, local governments may effectively manage schools but curricula and standards should be defined and monitored nationally, and this division of responsibilities should be clearly articulated.
- New functions, responsibilities and obligations at the local level are not accompanied by the necessary increase in funding: This is likely to deteriorate the provision of essential services, negatively affecting the population at the sub-national level, including children.
- Local elites often appropriate the decision-making power created by decentralisation at the local level: This can limit the ability of central governments to implement policies benefiting the poor and disadvantaged, as well as increase rivalries at the local level.

Opportunities

- Inequities and inefficiencies may reduce: Delegation of responsibility may reduce bottlenecks, bureaucracy and inequity if poorer and remote areas benefit from capacity development interventions and equalising transfers of resources.
- Local decision-makers are in a position to better match interventions to local needs and are aware of the necessary targeting measures: In the presence of sound data collection and

The New Deal intends to promote a new development architecture and new ways of working, tailored to the situation and challenges of fragile contexts, as a pre-condition for meeting the MDGs. The Peace-building and State-building Goals are intended to be integrated into the global post-2015 agenda in supporting the achievement of sustained socio-economic development.

1.2.3 Decentralisation

Since 2003, the Government of Timor-Leste has been actively engaged in the process of honouring the country's constitutional commitment to decentralise and establish a system of democratic local governance, and has recently accelerated the decentralization agenda with the target of achieving administrative deconcentration by 2016.

Timor-Leste still has a centralized governmental structure with decision-making, planning, budgeting and implementation operating at central government level. District administration bodies, headed by politically appointed District Administrators, have limited functions in local governance.

The Government Five-Year Plan indicates that ***"The Government will introduce a new tier of municipal government. Existing administrative jurisdictions at the sub-district and district levels will be merged to form new consolidated and efficient administrative units with representative assemblies at the present district level. These units will be better placed to deliver appropriate services to local citizens and will have sufficient capacity to perform their functions."***

The suco (village) level elections were carried out in 2011 and put the lowest level of administration structure in place before the establishment of the

municipality-level governance. In the first half of 2013, Prime Minister Xanana Gusmão led a Governmental delegation to the country's 13 districts for disseminating and conducting consultations on the decentralization and local government policies.

The decentralization process will comprise three key stages: Administrative Pre-Deconcentration (Decree-Law No.4/2014) - the reorganization of central government local services through their integration into a common structure; Administrative Deconcentration - starting of public service delivery at the district level including health and education; and Administrative Decentralization - the establishment of separate legal entities from the State, administratively and financially autonomous with locally elected officials.

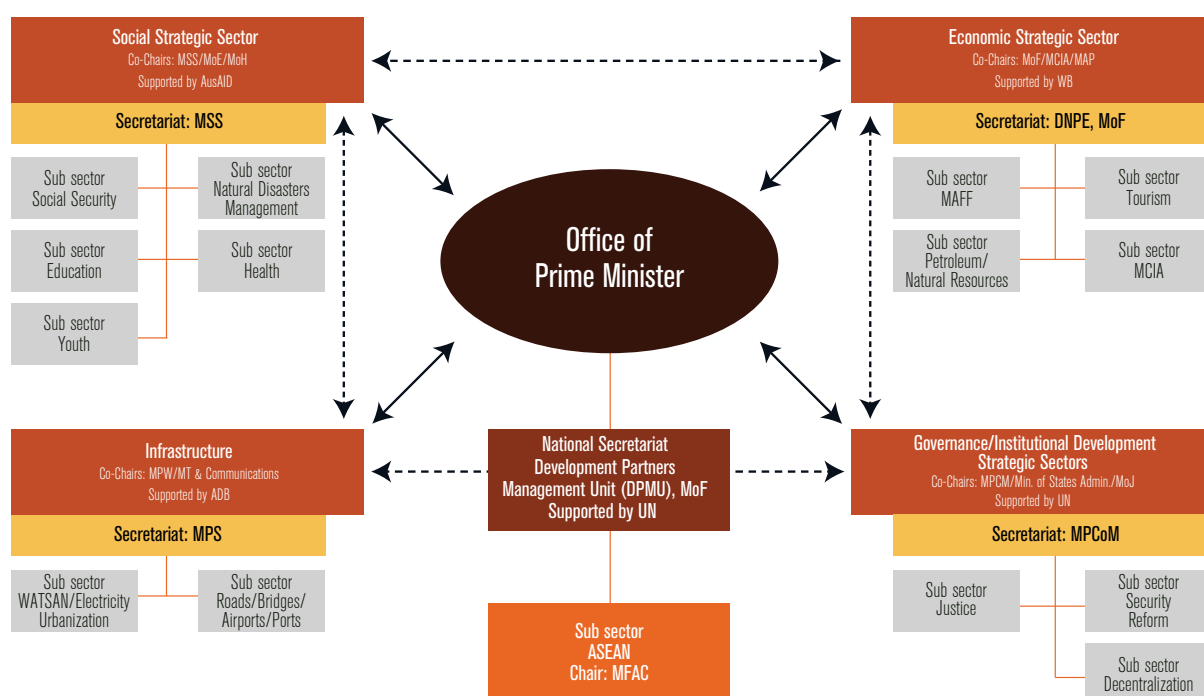
As pointed out in the Government Five-Year Plan, in order to complete this process, ***“There will be a critical need to develop human resources***

monitoring systems at sub-national levels, decentralisation may lead to needs-based and context-specific policies and policy implementation.

- Enhanced accountability, transparency, and response capacity of government institutions: As decision-making gets closer to rights-holders, they are motivated to play a more active role and reinforce the accountability of service providers, as well as decision-makers.
- Increased political stability and more inclusive political representation and participation in decision-making: Decentralisation allows citizens to better control public programmes locally, and encourages active involvement from a wider range of political, religious, and cultural groups, as well as children and youth.
- Innovation: Decentralised policy making and implementation may create fertile ground for new ideas leading to more creative and innovative programmes.

Source: Popic, D. and Patel, M. (2011) Decentralisation: Equity and Sectorial Policy implications for UNICEF in East Asia and the Pacific, Bangkok: UNICEF EAPRO, Social Policy and Economic Analysis Unit.

Chart 1.2: Government structure of Development Policy Coordination Mechanism



to effectively operate treasury and financial functions as well as develop, plan and monitor programs and service delivery at this level of government.”

Local development has become a priority for Timor-Leste, with the Government currently running various special programmes.

Specifically, since 2011 the Decentralised Development Programme⁴⁸ focuses on building essential infrastructure at the local level. Further, a Government-funded MDG Suco programme was established in the same year with the objective of building five new houses in each of Timor-Leste's 442 sucos. In 2013, the Government has started a new initiative, namely the National Programme for Suco Development (PNDS), with a planned allocation of US\$50,000 per year to each suco. Finally, the Government also established⁴⁹ Integrated District Development Planning (PDID)⁵⁰ to harmonise the implementation of district-level development programmes, and define the process for preparing the annual District Investment Plans (PID).

The local development programmes so far have had no thorough impact evaluation and are mostly focused on building infrastructure, with little emphasis put on other aspects of local development, therefore making it difficult to estimate any specific contribution to address children's issues at the local level. The Government has realised this and, through increased efforts towards the deconcentration of its functions, plans to improve the quality and accessibility of basic services, with the goal of directly affecting the wellbeing of people, especially children. However, as indicated in Box 1, significant risks need to be carefully pondered and addressed, whenever possible, to be able to harvest the immense opportunities that decentralization brings for the country.

1.2.4 Information and Media

The Timorese constitution guarantees the right to information and freedom of speech, and criticisms reported by the national daily newspapers have not earned retribution from the Government. The pending Media Law upholds these principles but also stipulates responsible journalism ethics. The Media Law, to help ensure that the sole national television station, which has budget allocation from the Government, becomes free from possible political interference, provides stipulations for the national television station to evolve as a private independent institution. The judiciary has respected the right of journalists to protect their sources of information. The Government does not restrict people's access to the internet nor monitor e-mail traffic or internet chat rooms.

This positive environment, nonetheless, remains under-utilised due to the limited reach of the mass media; and interactive and interpersonal channels appear to be the most utilised mode of communication.

The findings of the second nation-wide study of media use in Timor-Leste conducted in May 2010⁵¹ suggest that community leaders are still the most accessed (42 per cent) and most trusted source of information (33 per cent). About 16 per cent of the population does not access any form of media but still manage to obtain information about issues of concern from other sources, such as traditional leaders and through word of mouth.

Limited technological infiltration, adult literacy level at 58 per cent and preference for personalised information influence access to the media.

The 2010 Census found that only one-third (33 per cent) of households had a radio, one-fourth (24

per cent) of households owned a television, and over half (54 per cent) of households owned a telephone/mobile phone. Due to the high level of illiteracy, reading is yet to be a habit in Timor-Leste and the radio and TV remain as the most trusted media source for information.

Dili has significantly higher coverage of television and telephones/mobile phones than all the other districts. Mobile phones have become a major communication channel although information shared through mobile phone is still limited (Figure 1.3). The radio still has the highest reach of any individual medium but television is expanding rapidly.

Although radio is the main sources of news, the reception outside Dili and district capitals is still limited, and technical and/or resource constraints hamper regular access. Since the reach of national radio was extremely limited in the period after independence, community radios were set up at the district capitals in 2002 to serve as a conduit of much-needed information covering issues such as security and governance. However resources for regular maintenance and upgrading of equipment and radio studio facilities have been a challenge.

According to the previously mentioned 2010 study, no significant increase has occurred in access to newspapers and internet, which may be explained by the population's literacy profile, the cost of access, particularly in the case of internet, and other technological impediments.

In the last few years, increased competition resulting in a decrease in prices, free internet hot spots in the capital, and a decrease in energy prices are likely to have led to a non-negligible increase in media access although no data are available at the moment to support this assumption.

Tetun is the most used and preferred language for interaction across regions while local

languages are used within the communities.

According to the 2010 Census, over half (56 per cent) of population aged 10 and above is literate in Tetun. The literacy rates for Portuguese and English are both increasing (Figure 1.4).

Figure 1.3: Proportion of households owned radio, television and telephone/mobile

Source: Democratic Republic of Timor-Leste and UNFPA (2010) Timor-Leste Population and Housing Census 2009-10, Dili: National Directorate of Statistics (NSD) [Ministry of Finance] and UNFPA.

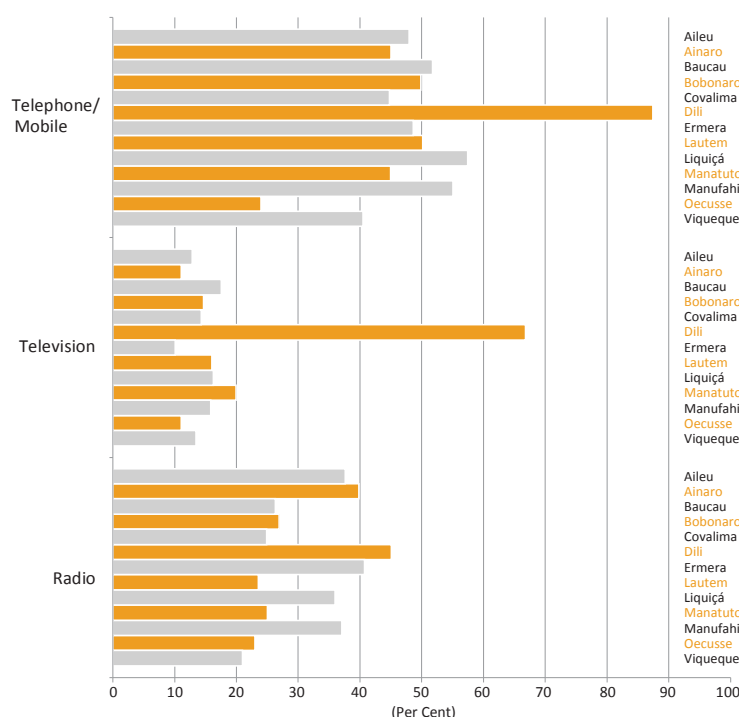
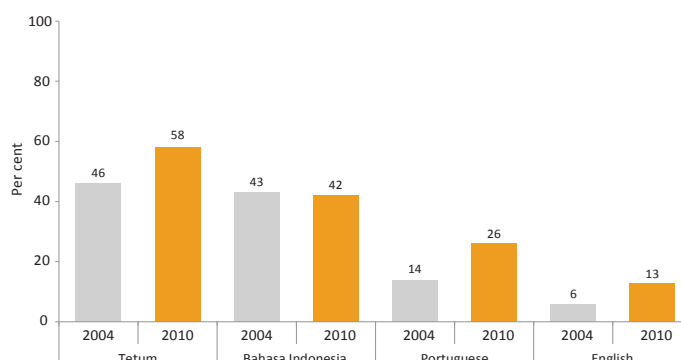


Figure 1.4: Proportion of population aged 10+ who are literate in each language, 2004 and 2010

Source: Democratic Republic of Timor-Leste and UNFPA (2010) Timor-Leste Population and Housing Census 2009-10, Dili: National Directorate of Statistics (NSD) [Ministry of Finance] and UNFPA.



1.2.5 Civil society and child development

Civil society in Timor-Leste enjoys a fair degree of freedom and is active, albeit still in the early stages of its evolution.

There is a relatively strong presence of international organisations in the country, while the national non-governmental organisations are beginning to find their space for public action. The relationship between governmental institutions and NGOs has generally been marked by cooperation. The Government continues to work with a large range of development partners and receives international assistance for child development from various partners, including civil society organizations.

Several local civil society organisations and NGOs are also working on various children's and women's rights issues but strong civil society organisation and NGO engagement with the wider children's rights discourse is yet to emerge.

Strengthening national organisations for championing the cause of children's rights in Timor-Leste needs to be a priority for development partners. Civil society should play an active role in highlighting critical child development issues, encouraging dialogue between people and the government on policies, monitoring and reporting on programmes that affect children both directly and indirectly.

1.3 Socio-economic development

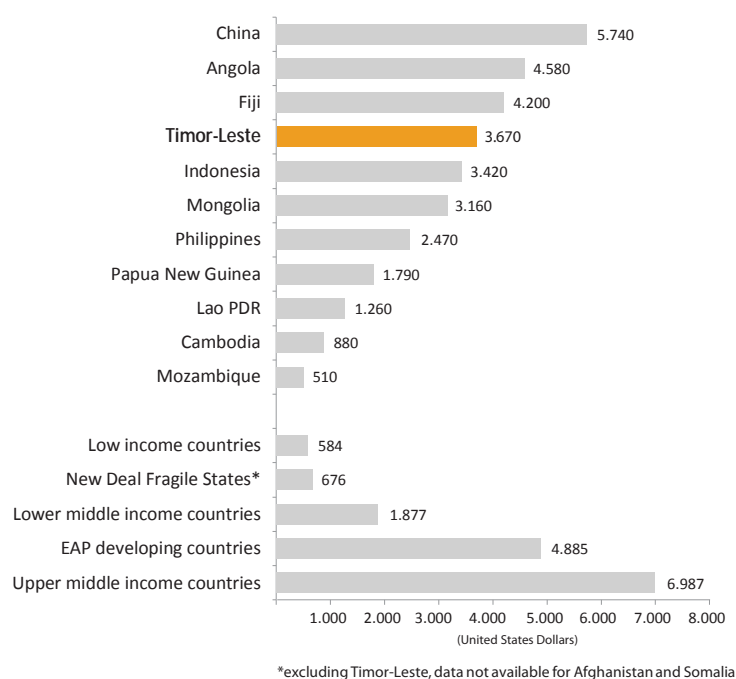
1.3.1 Economic growth

According to the World Bank's country classification based on the gross national income (GNI), **Timor-Leste is a lower middle-income country** (US\$1,026 to US\$4,035), aspiring to enter the upper middle-income category (US\$4,036 to US\$12,475) by 2030 as stated by the SDP (Figure 1.5).

Timor-Leste has experienced exceptional growth of its non-oil gross domestic product (GDP) since 2007, primarily driven by government expenditure funded by offshore petroleum revenues. If the period following the Timorese crisis of 2006 is considered, Timor-Leste's non-oil GDP grew at an impressive annual 12.1 per cent on average between 2007 and 2011 (Figure 1.6). East Asia and the Pacific's (developing only) economies and lower middle-income countries grew at 9.2 per cent and 6 per cent only per year in the same time interval.⁵² According

Figure 1.5: GNI per capita 2012, US\$ Atlas Method

Source: World Bank (2013) Development Indicators.



to governmental estimates, Timor-Leste's non-oil GDP is expected to grow at an annual average of 8 and 9 per cent in 2013 and 2014 respectively, effectively leading the region as the ASEAN's GDP growth equalled only 6 and 5 per cent in the same years.⁵³ On average, post-conflict countries take between 15 and 30 years, a full generation, to transition out of fragility and to build resilience.⁵⁴ In this light, the economic development in Timor-Leste can be considered remarkable.

In spite of its double-digit growth over the past years, **non-oil GDP⁵⁵ still accounts for less than one fifth of the overall economy**, which remains dominated by the petroleum sector. Construction, public sector and local trade account for the largest shares of the non-oil economy (Figure 1.7).

These sectors show a much smaller contribution if the overall economy is considered, namely 4 per cent or less each. **Over 90 per cent of the income of non-oil businesses was generated in Dili.**

Figure 1.6: Total, oil and non-oil GDP growth at constant 2010 prices, 2007-2011

Source: Democratic Republic of Timor-Leste (2000-2012) Timor-Leste's National Accounts 2000-2012, Dili: National Directorate of Statistics (NSD) [Ministry of Finance].

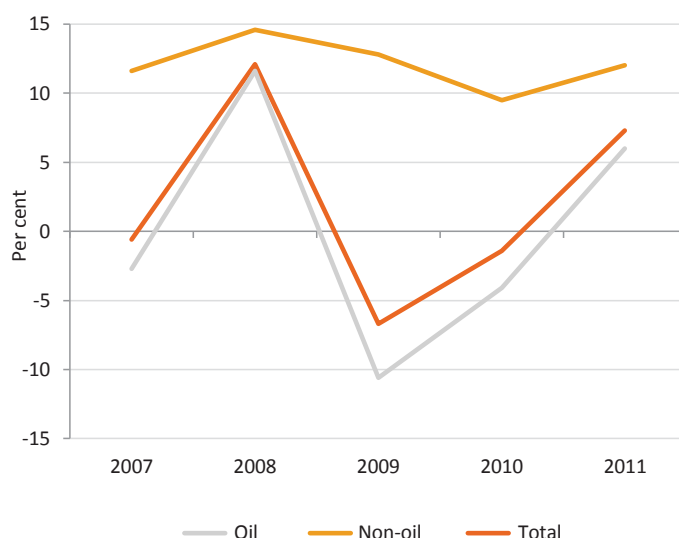
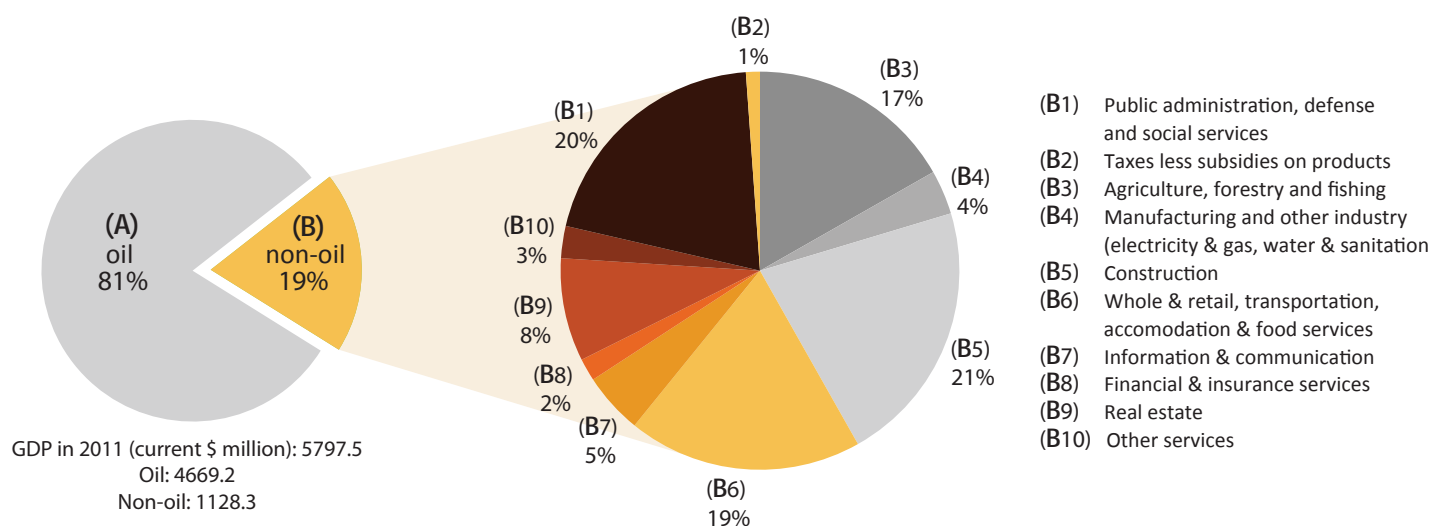


Figure 1.7: Composition of Timor-Leste's economy in 2011, based on current prices

Source: Democratic Republic of Timor-Leste (2000-2012) Timor-Leste's National Accounts 2000-2012, Dili: National Directorate of Statistics (NSD) [Ministry of Finance].



1.3.2 Inflation

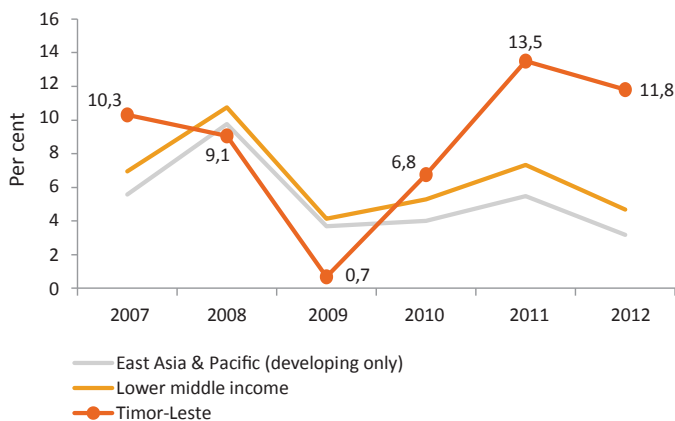
While growth in Timor-Leste has been remarkable, **the country has also experienced high inflation, which reached double-digit figures** peaking at 17.7 per cent in January 2012.⁵⁶ Inflation has since then stabilized to around 11 per cent but remains far above the Government goal of 4-6 per cent, diminishing local purchasing power as well as international competitiveness (Figure 1.8).

High inflation results from rising demand driven by expanding government spending in a small post-conflict economy characterized by limited absorptive capacity. The depreciation of the US dollar further worsened the problem, since in Timor-Leste both consumption and production rely heavily on imported goods and services. Such dependency also implies high vulnerability to fluctuations in international prices.

Inflation in the price of certain goods, in particular food, reduces people's purchasing power, forcing them into cutting spending for basic services with negative implications for children's development and wellbeing.

Figure 1.8: Inflation, consumer prices 2007-2012, annual %

Source: World Bank (2013) World Bank Development Indicators.



A study conducted by the Asian Development Bank⁵⁷ on the impact of food price increases on poverty in developing countries (using US\$1.25-a-day poverty line) indicates that a 10 per cent, 20 per cent and 30 per cent increase in food prices in Timor-Leste would generate a poverty increase of 2.2, 4.4 and 6.7 per cent respectively.

1.3.3 Public expenditure

Timor-Leste's economy and budget are largely dependent on the recent exploitation of gas and oil fields with assets in the Petroleum Fund. The oil revenue boom has lifted the Petroleum Fund balance to US\$14.6 billion as of September 2013⁵⁸ and allowed an expansionary fiscal policy since 2005. Except for 2013, during which the government used a large cash balance generated by lower-than-expected expenditure in 2012, significant withdrawals from the Petroleum Fund were made since 2009. Public expenditure, which continues to underpin non-oil economic growth, reached US\$ 1.8 billion in 2012, pushing demand and thereby generating inflation, especially in the case of recurrent spending. Due to this, along with issues related to budget execution, the national budget decreased to US\$1.6 billion in 2013 and further to US\$1.5 in 2014.

The government's investment strategy focuses strongly on major infrastructure to develop the shallow non-petroleum economy. The Infrastructure Fund absorbed 38 per cent of the total 2013 government budget despite declining execution rate in the previous years, 79 per cent in 2011 and merely 43 per cent in 2012.⁵⁹ Although the Infrastructure Fund still accounts for one forth of the entire national budget, its funding has declined in 2014 (Figure 1.9).

In the past few years, the actual amount of investment in key social sector ministries has considerably increased. Actual social sector spending tripled from less than US\$100 million in 2008 to almost US\$300 million in 2012, thanks to increasing oil revenues (Figure 1.10).

However, in 2013 this amount reduced to US\$265, mostly due to a lower allocation to the Ministry of Social Solidarity. Further, over time **social expenditure has declined a share of the total government budget.**

Figure 1.9: Government budget by ministry and fund in 2014, US\$ Million

Source: Timor-Leste Budget Transparency Portal, Ministry of Finance.

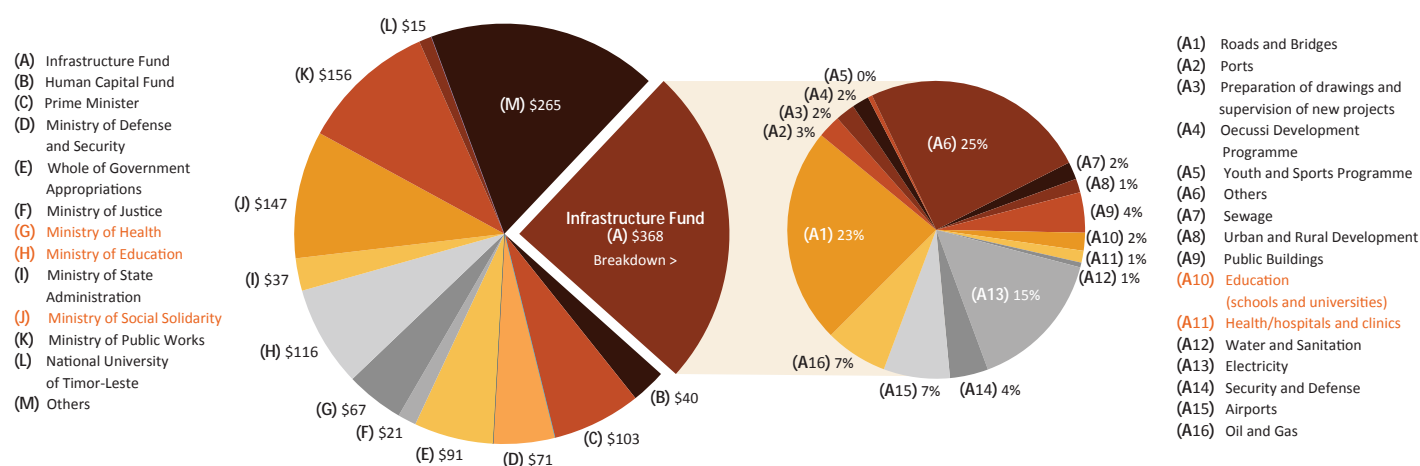
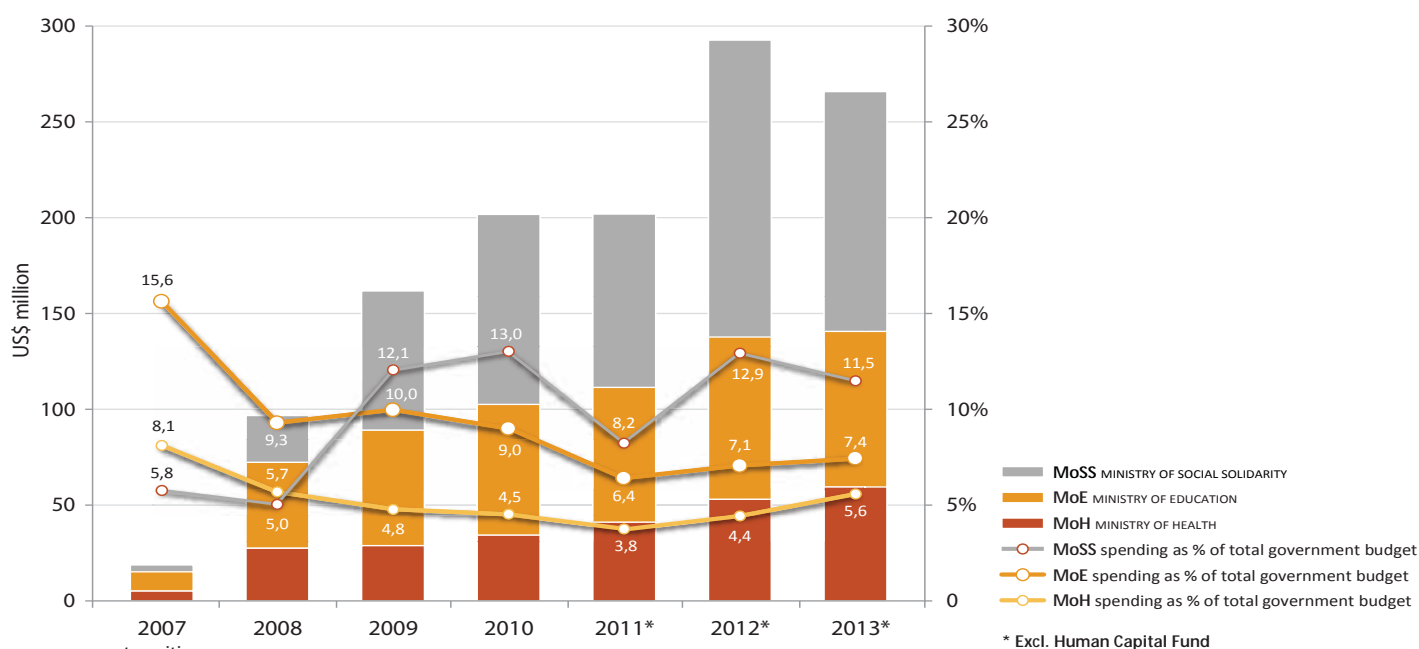


Figure 1.10: Government actual spending on key social sector ministries 2007-2013, US\$ Million and %

Source: Timor-Leste Budget Transparency Portal, Ministry of Finance.



Box 1.3:

Why an investment case for children?

The world of tomorrow will inherit the children of today. Whether nations grow and prosper will depend heavily on the survival, health, education and protection of their citizens, particularly the youngest. There are several compelling reasons to invest in children:

- Investing in children is fundamental to ensuring the realization of their rights. The 1989 UN Convention on the Rights of the Child sets out the legal obligations of national governments to realise children's economic, social, civil, political and cultural rights to the maximum extent of their available resources (Article 4).
- Childhood is a unique window of opportunity. Even temporary deprivations experienced by young children can have irreversible effects on their future capabilities and, in turn, a nation's future prospects. Interventions and policy choices made today will determine whether millions of children and youth are able to reach their full potential, or are left to face a future of worsening inequity and marginalization.
- The benefits far outweigh the costs. For example, a simulation on increasing pre-school enrolment in over 70 countries showed benefits in terms of higher future wages of US\$6.4-\$17.6 per dollar invested, as well as potential long-term benefits ranging from \$11 to \$34 billion.⁶⁰ Further, it was found that a one-year increase in the average years of schooling is associated with a rise in per-capita income of 3-6 per cent, or a higher growth rate of 1 per cent.⁶¹ Low cost investment during childhood can yield a lifetime of gains, not only for individuals, but also for societies and economies. Studies suggest simple interventions to reduce under nutrition in pre-schoolers - a subsidy for malaria combination treatment; expanded childhood immunisation coverage; de-worming of schoolchildren; and expanding tuberculosis treatment are highly relevant for children.

Source:

⁶⁰ Engle, P.L., Fernald, L. CH., Alderman, H., Behrman, J., O'Gara, C., Yousafzai, A., Cabral de Mello, M., Hidrobo, M., Ulkuer, N., Ertem, I., Iltus, S. and the Global Child Development Steering Group (2011) 'Strategies for reducing inequalities and improving developmental outcomes for young children in low-income and middle-income countries', *The Lancet*, vol. 378, no. 9799, pp. 1339-1353.

⁶¹ Sianesi, B. and Reenen, V. (2003) 'The Returns to Education: Macroeconomics', *Journal of Economic Surveys*, vol. 17, no. 2, pp. 15-200.

In 2014 the Ministries of Health and Education were allocated only about 4.8 and 9.2 per cent (CFTL and Infrastructure Fund) of the total national budget. The Government suggests that spending to the social sector will more sharply increase once the country's core infrastructure has been built.

However, insufficient investment in key social sector ministries generates deprivations that can have irreversible effects on the future capabilities of children, particularly the youngest. The inability of children and youth to reach their full potential translates into a heavy loss of the human capital that is critical to ensure sustainable growth and development in Timor-Leste.

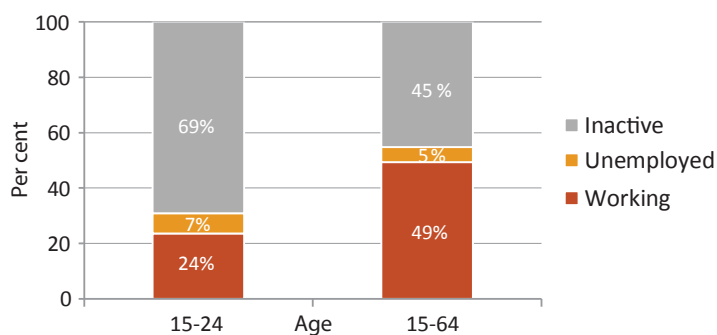
1.3.4 Employment

The 2010 Census classifies the employment status of the population into three categories: people at work (employed), people seeking jobs (unemployed) and economically inactive population (students, retirees, house workers, etc.).

In 2010, only slightly more than half (54 per cent) of the labour force (15-64 years old) was found to be economically active, i.e. either employed or seeking a job. About 45 per cent of the labour force population and 69 per cent of youth (15-24) were economically inactive (Figure 1.11).

Figure 1.11: Labor force and youth economic status, 2010

Source: Democratic Republic of Timor-Leste and UNFPA (2012) 2010 Timor-Leste Population and Housing Census: Labour Force Monograph, Dili, Timor-Leste: National Statistics Directorate (NSD) [Ministry of Finance] and UNFPA.

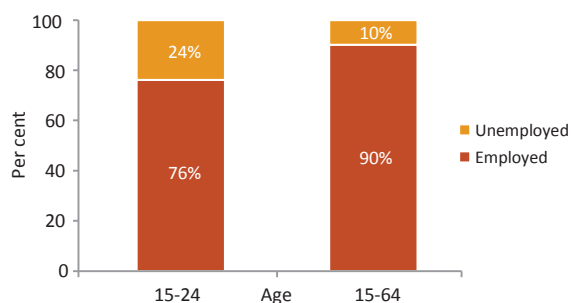


The unemployment rate was higher in urban areas –6.9 per cent compared with 2.2 per cent in rural areas. However, a **much higher proportion of people were in “vulnerable” employment** (i.e. “people who are classified as own account workers or contributing family workers. These people are unlikely to have any guaranteed salary each month, and will probably not have any job security”) – namely 80 and 27 per cent in rural and urban areas respectively. Over 70 per cent of economically active women and 64 per cent of active men fall within the vulnerable employment category.⁶² Jobs in Dili are less vulnerable than those in other districts (Figure 1.12). Limited natural resources (besides oil and gas), low productivity subsistence agriculture in rural areas, and a virtually non-existent industrial sector have contributed to this situation.

Young people suffer more than the general population from unemployment. The unemployment rate for young people is high: 24 per cent of 15-24 years olds versus 9.5 per cent in the general population (Figure 1.13). Unemployment is a more severe issue for males (with a 15-24 unemployment ratio of 8.9 per cent versus 5.8 per cent for females) and for urban youth, although in rural areas, most of the employment is in subsistence agriculture, only offering vulnerable employment. Nevertheless, young men are twice more likely to be employed than young women.

Figure 1.13: Labor force and youth employment rate, 2010

Source: Democratic Republic of Timor-Leste and UNFPA (2012) 2010 Timor-Leste Population and Housing Census: Labour Force Monograph, Dili, Timor-Leste: National Statistics Directorate (NSD) [Ministry of Finance] and UNFPA.

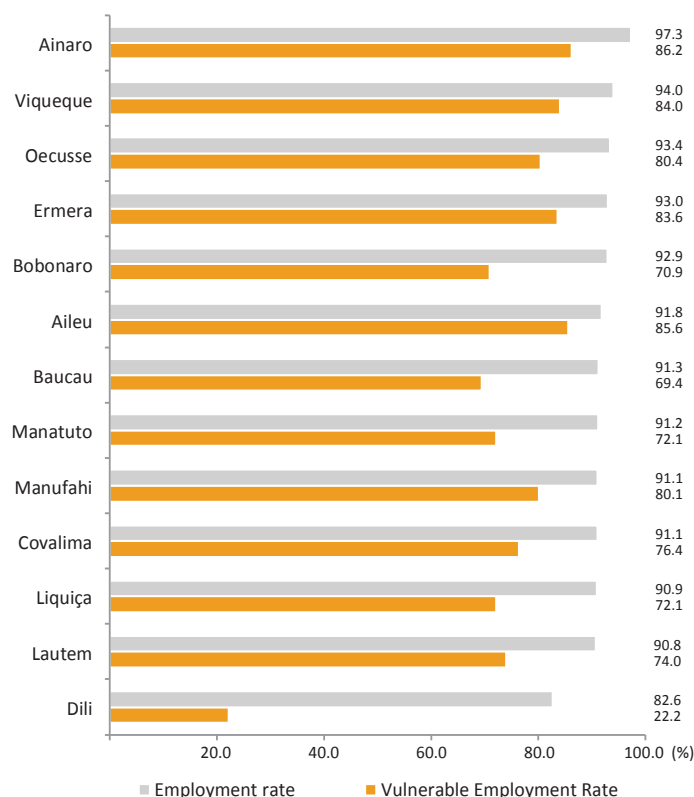


- Investing in children can help promote equitable, inclusive societies, allowing more people to effectively participate in their economic development. Because childhood is a unique window of opportunity, investments in poor children help create a level playing field.
- Children should have access to the essential health, educational, and nutritional requirements. Providing these will allow more equal access to better paying jobs later in life, as well as improve productivity. Furthermore, because the poorest and most vulnerable groups in society might be unable to make the most optimal investments on their own, there is a strong rationale for public investments in social sectors related to children – especially when aimed at those most in need.

Source: UNICEF (2012) Investing in Children: A brief review of the social and economic returns to investing in children, New York: UNICEF Division of Policy and Strategy Policy Advisory Unit.

Figure 1.12: Employment and vulnerable employment rates by district, 2010

Source: Democratic Republic of Timor-Leste and UNFPA (2012) 2010 Timor-Leste Population and Housing Census: Labour Force Monograph, Dili, Timor-Leste: National Statistics Directorate (NSD) [Ministry of Finance] and UNFPA.



Social norms are not supportive of young women participating in the workforce, even when asking young people. Fewer than one in five young men believe a woman should work after childbearing, and fewer than one in three believe she should work after marriage.⁶³

Youth unemployment remains a crucial problem faced by the Government. Three major causes were identified in the World Bank's 2007 study including lack of job opportunities due to the weak state of the non-oil economy; lack of appropriate skills when job opportunities become available; and lack of means for connecting employers with available job seekers.⁶⁴ These challenges largely remain. The prevalence of child employment remains a concern in Timor-Leste with about 6.2 per cent of children 10-14 years considered to be employed.⁶⁵

1.3.5 Poverty and child deprivation

In 2002, at the time of independence, Timor-Leste was one of the poorest countries in South-East Asia and the Pacific. It was characterised by a largely agrarian subsistence economy, with practically no infrastructure, and limited availability of financial resources and educated human capital. Poverty prevalence further increased between independence and 2007 in both rural and urban areas, mainly as a result of the 2006 crisis and the stagnation of the non-oil economy. In 2007, about half of the Timorese population was living below the basic needs poverty line of US\$0.88 per person per day (Fig. 1.14).

Despite rapid economic growth and increasing oil-funded public spending over the years, there is no strong evidence suggesting profound changes in poverty in Timor-Leste, due to high inflation and inequality between the capital and the districts, among other factors. In this light, Timor-Leste is unlikely to meet the MDG for poverty reduction by 2015.

The majority of Timorese families live in difficult conditions with limited household amenities.

The 2010 Census revealed that over 90 per cent of households own their dwellings, however the majority of them live in houses that are physically deficient in quality. The quality of housing and access to basic facilities portrayed a rather mixed picture with the majority of rural households lacking access to improved water, sanitation and clean energy for cooking and lighting (Fig. 1.15).⁶⁶

Children are affected the most by poverty.

The 2007 Timor-Leste Survey of Living Standards (TLSLS) estimated that children aged 0-14 years in poor households account for 49 per cent of the total poor (with a striking 21 per cent of the poor being constituted by children under five years).

Figure 1.14: Poverty rates 2001 and 2007

Source: TLSLS 2007.

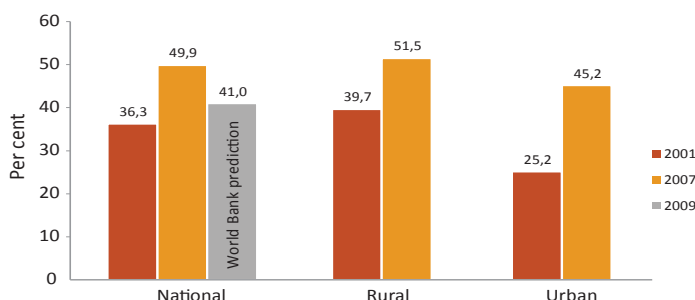
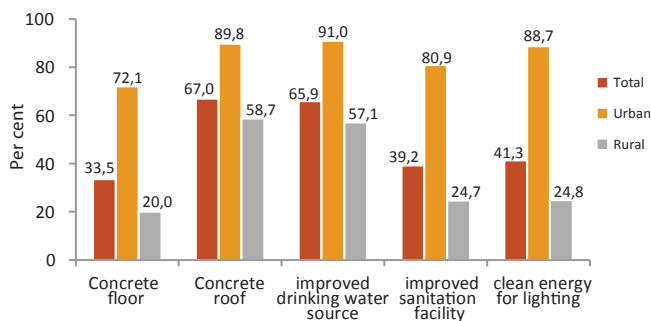


Figure 1.15: Proportion of households with quality housing facilities, by urban/rural, 2010

Source: Democratic Republic of Timor-Leste and UNFPA (2012) 2010 Timor-Leste Population and Housing Census: Labour Force Monograph, Dili, Timor-Leste: National Statistics Directorate (NSD) [Ministry of Finance] and UNFPA.



“Children living in poverty experience deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society.”

- The State of the World's Children, 2005

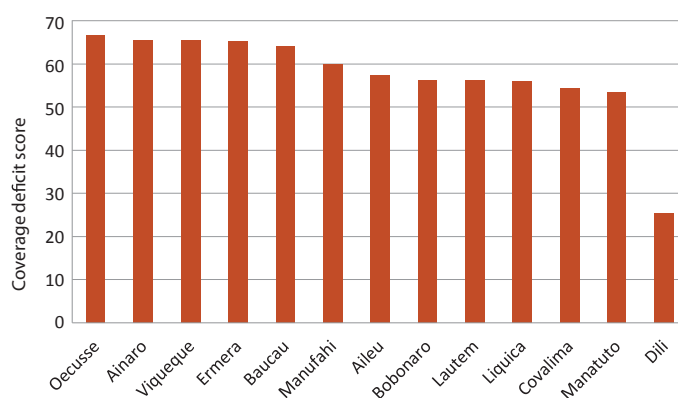
In the multi-dimensional approach to child poverty, linkages between child deprivations and the following critical areas are considered: education, health, nutrition, water and sanitation, shelter, information and income/consumption. A Child Deprivation Index⁶⁷ calculated using the 2010 Census data shows that the level of child deprivation is different among geographic locations (Figure 1.16). Children living in Oecusse, Ainaro, Viqueque, and Ermera districts are more deprived than those living in other districts in terms of their access to basic services and facilities. More generally, child deprivation appears high and widespread in all districts, with the capital Dili being the only exception. Similar results are also found if using the 2009-10 TLDHS data. If the suco level is considered, deprivation seems to be pervasive

with more than half of the country falling within the worst two categories of deprivation (i.e. 60-80 and above 80), with less deprived areas coinciding with Dili and district capitals (Map 1.1).

As child deprivation has inter-generational effects, investment in children, especially the disadvantaged, is considered critical for ensuring equitable and sustainable human development.

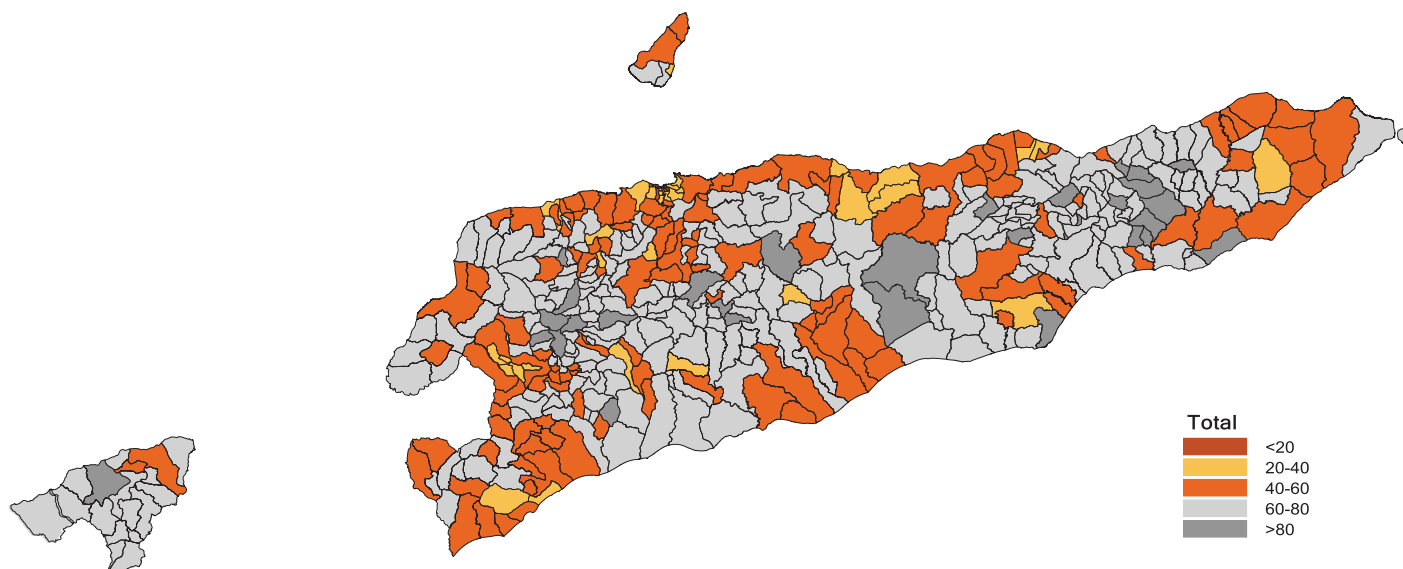
Figure 1.16: Child deprivation index

Source: Democratic Republic of Timor-Leste and UNFPA (2010) Timor-Leste Population and Housing Census 2009-10, Dili: National Directorate of Statistics (NSD) [Ministry of Finance] and UNFPA.



Map 1.1: Child vulnerability /deprivation by suco

Source: Democratic Republic of Timor-Leste and UNFPA (2010) Timor-Leste Population and Housing Census 2009-10, Dili: National Directorate of Statistics (NSD) [Ministry of Finance] and UNFPA.



Box 1.4:

Social protection and children

- **Equity and social protection:** Social protection enhances the capacity of households to care for their children and removes barriers in accessing services, while reaching the most vulnerable. There is strong evidence that social protection contributes to MDGs 1, 2, 3, 4, 5 and 6 - with stronger impacts for the disadvantaged.
- **Long-term returns from investing in social protection:** Evidence shows that the effects of social protection on children's development last far beyond childhood, improving adult productivity and contributing to reducing the inter-generational transmission of poverty.
- **Child-sensitive social protection helps all children to realise their rights and potential:** As recognised by the Convention on the Rights of the Child (CRC), children have a right to social security, including social insurance, and to an adequate standard of living. Social protection also plays a critical role in helping realise a broad range of rights, such as the right to survival and development or the right to education. By responding to the multiple and compounding vulnerabilities faced by children and their families, social protection is therefore a critical tool for them to reach their full potential.

HOW? Achieving child-sensitive social protection: Social protection does not have to explicitly target children in order to benefit them. Small nuances in how social protection is delivered have the potential to make a huge difference for children. Specifically, the Joint Statement on Advancing Child-Sensitive Social Protection (signed by 11 organisations in 2008), sets out the following principles:

- Avoid adverse impacts on children, and reduce or mitigate social and economic risks that directly affect children's lives.
- Intervene as early as possible where children are at risk, in order to prevent irreversible impairment or harm.
- Consider the age- and gender-specific risks and vulnerabilities of children throughout the life cycle.
- Mitigate the effects of shocks, exclusion and poverty on families, recognizing that families raising children need support to ensure equal opportunities.

1.3.6 Social protection

Poverty, hunger and child malnutrition remain critical development issues in the country. The Global Hunger Index, which measures national hunger as a percentage of the total population ranks Timor-Leste as sixth from the bottom among the 81 countries surveyed.⁶⁸ Social protection in Timor-Leste serves as an important catalyst in moving poor communities out of this cycle of poverty and benefits the whole society. It fosters inclusive economic growth, reduces inequality and improves security and political stability.

According to the Constitution of Timor-Leste
"Every citizen is entitled to social assistance and security in accordance with the law".

On the basis of this constitutional mandate, the Ministry of Social Solidarity of the 4th Constitutional Government of Timor-Leste, at the beginning of its mandate in 2007 designed several major social protection programmes – Older Person's Pension, Person With Disability's Pension, the National Liberation Combatants' Pension, and the Conditional Cash Transfer Programme (Bolsa da Mãe). The latter is targeted to families in a situation of high vulnerability living below the poverty line, on condition that their children attend school and are immunised. All programmes commenced implementation in 2008.⁶⁹

Although still underdeveloped, Timor-Leste is one of the very few countries in East Asia and the Pacific with significant formal safety nets, mostly for specific categories of the population.

The Government intends to further improve and integrate its social security system, as indicated in the SDP which states that by 2015 "A universal contributory social security system will be in place that guarantees all Timorese workers a pension", in case of retirement, disability or death.

As far as expenditure is concerned, **Timor-Leste has one of the highest commitments in social assistance among low income and fragile countries.** Timor-Leste spends about 15 per cent of non-oil GDP on social programmes, more than it directs to health, education or any other sector apart from infrastructure.⁷⁰ In preparing for a likely stagnation in budget growth over the next five years, the government will encounter increasing challenges to ensure universal coverage and sustainability of the system, and will need to prioritise among social assistance goals, and between social assistance and other national objectives. Further areas that will require the Government's attention to improve social protection include the coordination among relevant Ministries, the creation of a sound monitoring and evaluation system, the effective use of resources, the development of appropriate tools, and the strengthening of human resources capacity.

1.4 Disasters and climate change

1.4.1 Disasters

Geographically, Timor-Leste is exposed to several kinds of natural hazards, which include strong winds, heavy rains causing flooding and landslides, drought, as well as rarer events such as earthquakes and tsunamis. From 2001 to 2012, the major natural disasters were flooding and strong wind events that affected directly over 15,000 households.⁷¹

Fortunately, hazard events have been rather localised and have not had widespread devastating impacts historically. Nonetheless, these events typically have negative effects on the people of Timor-Leste

- Make special provision to reach children who are particularly vulnerable and excluded, including children without parental care, and those who are marginalized within their families or communities due to their gender, disability, ethnicity, HIV and AIDS or other factors.
- Consider the mechanisms and intra-household dynamics that may affect how children are reached, with particular attention paid to the balance of power between men and women within the household and broader community.
- Include the voices and opinions of children, their caregivers and youth in the understanding and design of social protection systems and programmes.

These principles are critical and need to be considered while building integrated social protection systems that are responsive to the local context, provide comprehensive packages of interventions along with appropriate supply-side investments, enhance inter-sectoral coordination, and frame strategies within a broader set of social and economic policies that promote human development and growth.

Sources: DFID, HelpAge International, Hope & Homes for Children, Institute of Development Studies, International Labour Organization, Overseas Development Institute, Save the Children UK, UNDP, UNICEF and the World Bank (2009) *Advancing Child-Sensitive Social Protection*. UNICEF (2012) *Integrated Social Protection Systems: Enhancing Equity for Children*, UNICEF Social Protection Strategic Framework.

as they rely heavily on domestic food production that can be affected by such hazards. Additionally, a low-probability but high-consequence event such as a major earthquake or tsunami can cause substantial damage to the country's infrastructure, as well as injury and fatality to residents who may not be prepared for such a disaster.⁷² It is found that Oecusse, Ermera and Ainaro Districts have the highest vulnerability to landslides due to heavy rainfall,⁷³ which exposes over 130,000 children to such risks.

To advance the prospects for child survival and development, governments and development partners globally are changing their approach

Box 1.5:

Climate change, Disaster Risk Reduction and children

The 'four pillars' of the Convention on the Rights of the Child – protection, survival, development and participation – establish the fundamental rationale to create opportunities for children's voices to be heard in research, advocacy and policy on climate change and Disaster Risk Reduction. Under this framework, children and young people in Timor-Leste should be in the forefront of climate change policy, advocacy and research. It is their right to participate in all matters that affect them. The increasing likelihood of disasters and the projected impact of climate change in the region indicate that children are especially vulnerable now and will bear the impacts of climate change over their lifetime.

Disaster preparedness, response and adaptation require an approach that is both child-centred and child-led. Growing consensus among development partners and research institutions strongly indicates that climate change policy should reflect the voice and perceptions of children and young people, since the decisions that are made today will have an impact on their lives tomorrow. If involved and empowered, children and young people can constitute effective agents of change in their respective communities to support the identification of an appropriate approach to fight and manage climate change.

Sources: Save the Children's Fund (2008), *In the Face of Disaster Children and Climate Change* and *The Children in a Changing Climate Research Programme* (2008), *Children, Climate Change and Disasters: An Annotated Bibliography*.

regarding disasters. It is recognised that constructive action is required to plan for hazards before they happen and ultimately to reduce the risk of harm for vulnerable population groups, especially children.⁷⁴ This requires making innovative investments in reducing risk as well as ensuring greater coherence between relief, reconstruction and development activities. There is a need to not only identify, but also understand the prevailing hazards, and the risks from disasters in the country.⁷⁵

Based on risk information, Timor-Leste can develop risk management strategies to reduce possible casualties and deepening of existing deprivations, especially for children. In addition, medium and long-term sectorial planning (such as land zoning, infrastructure development, and so on) can be based on risk information to reduce potential economic losses from future disasters and to build livelihood resilience.

1.4.2 Climate change

Timor-Leste already faces high levels of poverty, limited livelihood options and widespread degradation of natural resources. **Climate change is exacerbating the situation, with hotter dry seasons, shorter and more unpredictable rainy seasons, more frequent extreme rainfall events and seawater intrusion.** However, there is very little climate data or forecasts for Timor-Leste and what was not destroyed through conflict has been scattered across a number of countries and yet to be collated.⁷⁶

Children are particularly vulnerable to the effects of climate change, ranging from direct physical impacts, due to cyclones, extreme temperatures etc., to impacts on their education, psychological stress and nutrition. For instance, increasing temperatures have been linked to higher rates of malnutrition, cholera, diarrhoeal disease and vector-borne diseases like dengue and malaria. Children are at far greater risk of contracting these diseases and succumbing to their complications due to lower functional immunity and are also more likely than adults to be killed or injured during disasters.⁷⁷

The Constitution recognises the importance of environmental protection and climate change adaptation strategies; however, the country lacks a comprehensive environmental framework in terms

of legislation, regulation, and adequately resourced institutions. The existing environmental legislation is a legacy of the past and is not well recognised in current day Timor-Leste. In 2006, the government drafted two important environmental laws (i.e. on environmental impact assessment and pollution control), but they were not approved. In 2008, with the support from the World Bank, a new draft was prepared and presented to the Council of Ministers in February 2009.⁷⁸

Progress has been made to enhance the quality of the environment in Timor-Leste. International and local NGOs are working with communities to identify how the climate is changing in Timor-Leste, its impact, and developing community adaptation plans, which include planting trees to prevent erosion, conserving soil and water, and introducing organic farming methods. Efforts are also under way to improve the database for environmental management.⁷⁹

Several critical areas still require attention including: climate change policy and adaptation plans; gaps in environmental legislation and regulations; indoor air pollution; deficient water-quality and sanitation, and the very limited human resources and capacity available for effective implementation.

1.5 Legislation, child rights and development progress

Timor-Leste is party to most human rights and humanitarian law treaties, including the Geneva Conventions and Additional Protocols I and II; International Covenant on Civil and Political Rights; International Covenant on the Elimination of all Forms of Discrimination Against Women; Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment; International

Covenant on Economic, Social and Cultural Rights; Convention on the Rights of the Child; Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict; and the Rome Statute of the International Criminal Court.⁸⁰

Timor-Leste continues to make progress to uphold the rights of the child in all areas in response to its obligations arising out of the Convention on the Rights of the Child and its Optional Protocols, and other Human Rights instruments to which it is party.

The Government's commitment to this is reflected in the measures it continues to undertake to meet its treaty obligations since the submission of its Initial Report (CRC/C/TLS/1) to the Committee on the Rights of the Child in 2007. Timor-Leste's consolidated second and third report was endorsed by the Council of Ministers in 2013. The draft report outlines the key measures and initiatives undertaken by the Government in implementing the Convention covering the period 2007 to 2013, and identifies priorities for future concerted action to strengthen the implementation of the Convention. There still remains an urgent need to ratify or accede to other international child rights instruments, and their automatic incorporation into national law will provide an important basis for the national child rights framework. These include: the ILO Minimum Age Convention 138, and the Convention on the Rights of Persons with Disabilities. However, international instruments alone are not sufficiently detailed to create a national-level framework and to date there is no specific child protection law in place. The Ministry of Social Solidarity has prioritised the development of such a law, which is in draft and ready for consultation.

Reflecting the Government's commitment to the rights of children and the implementation of the CRC in September 2009, the National Commission on

the Rights of the Child (NCRC) was established as the government agency responsible for promoting, protecting and monitoring children's rights under the Ministry of Justice.

The NCRC has a role to defend and safeguard child rights by lobbying for "child-friendly" mechanisms and promoting children's rights throughout the country. The NCRC works in partnership with government ministries, NGOs, international organisations and civil society organisations. It operates at the national, regional, district and Suco (village) level.

The NCRC has the responsibility to review and comment on draft laws affecting children as well as monitoring and evaluating compliance of existing laws, regulations, decrees and policies on their implementation and harmonisation with the CRC. It also has a role in providing advice to the government with respect to all matters affecting children.

The Committee on the Rights of the Child in its 2008 concluding observations on Timor-Leste's State party report on the implementation of the CRC had recommended the adoption of a time-bound national plan of action for children.

It recommended it be rooted in the National Development Plan and the National Human Rights Action Plan, and cover in a comprehensive manner the rights of the child enshrined in the Convention, with due regard to the outcome document of the 2002 Special Session of the General Assembly of the United Nation's "A World Fit for Children" and "A World Fit for Children Plus 5 Declaration."

1.6 Opportunities for Action

- **To put children at the core of policy development.** The specific needs of children should be carefully considered in policy making and budgeting, as well as their link to human capital development, which is needed to trigger
- **To take advantage of the ample fiscal space.** The considerable natural resource endowment has created a fiscal space for increased investments in children in Timor-Leste. Strengthening institutional capacity on executing financial resources in the social sectors is also paramount to improve the effectiveness and efficiency of public resources to produce enhancements in human and child development.
- **To create a solid link between the on-going decentralization process and improved outcomes for children.** Decentralization is expected to bring improved basic social services closer to the most disadvantaged children and their families.
- **To consider inflation as a policy challenge.** In a context where no monetary policy levers are available, the economy and demand continue to expand, and the volatility of commodity and food prices in international markets continues, it is critical to focus on productive investments and the development of human capital in order to reduce supply bottlenecks, increase productivity and boost the local economy.
- **To create an integrated and child-focused social protection system.** The latter should address the challenges faced by the most disadvantaged children and their families, support them to overcome financial barriers, and establish a protective environment for children in Timor-Leste
- **Climate change should consider specific implications for children.** The protection of the natural environment and natural disaster preparedness should consider the particular effects on children and ensure that specific plans are put in place.

and sustain the non-oil economy and achieve human development for all.

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THE SITUATION OF CHILDREN'S RIGHTS IN TIMOR-LESTE

Children whose needs are greatest are also those who face the greatest violations of their rights. The most deprived and vulnerable are most often excluded from progress and most difficult to reach. They require particular attention to secure their entitlements. The rights of every child include survival; development to the fullest; protection from abuse, exploitation and discrimination; and full participation in family, cultural and social life. The CRC protects these rights by detailing commitments with respect to nutrition, health care, education, and legal, civil and social protection.

2

Maternal and child health

The health of children is interlinked with the health and social status of their mothers, and is a reflection of the socio-economic status of the household, community and society.

Article 24 of the CRC refers to every child's right to the "enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health." It urges States parties to "ensure that no child is deprived of his or her right of access to such health care services." The CRC commits States Parties to taking measures to reduce infant and child mortality; to ensuring the provision of health care to all children; to combating disease and malnutrition; and to ensuring appropriate prenatal and postnatal healthcare for mothers.

This chapter looks at the extent to which the right to health of children in Timor-Leste has been realised. The chapter also discusses the manifestations and causes of deprivation of their right to health and the opportunities for action.

2.1 Overview

Child mortality is a key indicator not only of child health and nutrition but also of the implementation of child survival interventions. More broadly, child mortality describes the social and economic conditions of society as well as the awareness and ability of the population to live in a healthy, hygienic and comfortable environment. MDG 4 aims to reduce the under-five mortality rate (U5MR)⁸¹ by two-thirds between 1990 and 2015.

The world has made substantial progress reducing the U5MR rate by 41 per cent, from 87 deaths per 1,000 live births in 1990 to 48 in 2012 and the East Asia-Pacific region recorded a 73 per cent decline in under-five mortality in 2011 as compared to 1990.⁸² The global number of under-five deaths has dropped from nearly 12 million in 1990 to 6.6 million in 2012. This means that about 17,000 fewer children died daily in 2012 than in 1990 and an estimated 90 million lives have been saved in the past 22 years. The global annual rate of reduction has steadily accelerated from 1.2 per cent between 1990 and 1995 to 3.9 per cent between 2005 and 2012.

Under-five deaths are currently reducing faster than at any other time during the past two decades. This is due to effective and affordable treatments, innovative ways of delivering critical interventions to the poor and excluded, and sustained political commitment. The interventions needed to save these children are, for the most part, known. Existing high-impact, low-cost interventions such as vaccines, antibiotics, micronutrient supplementation, insecticide-treated bed nets, improved breastfeeding practices and safe hygiene practices have already saved millions of lives. In recent years, the global community has learned a great deal about how to best provide mothers and children with quality health care.

This knowledge presents an unprecedented opportunity to save many more children.

Improving maternal health is one of the eight MDGs adopted at the 2000 Millennium Summit. A key target is to reduce the maternal mortality ratio (MMR)⁸³ by three-quarters between 1990 and 2015. **According to the UN Interagency maternal mortality estimates, the global maternal mortality ratio almost halved during the last two decades, from 400 in 1990 to 210 in 2010.**

Similarly, from 1990 to 2010 the number of maternal deaths dropped from 543,000 to 287,000 – a decline of 47 per cent.⁸⁴ Although there was significant progress in all developing regions, the average annual percentage decline in the global MMR was 3.1 per cent, short of the MDG target of 5.5 per cent. Therefore, while there is progress to celebrate, efforts to save lives must be accelerated.

About 42 per cent of all deaths among women aged 15-49 years were due to risks associated with pregnancy and childbirth. MMRs have declined by almost 20 per cent since 2000, but are currently two times higher than the level required to meet the MDG target. Maternal health and mortality rates have been linked with the socio-economic status of women in the household, community and society, which is reflected in their poor nutritional and education status; high fertility with short intervals; poor access, availability and utilisation of antenatal and postnatal care and essential and emergency obstetric services; and the authority to make decisions.

2.1.1 Health programming context

“Towards a Healthy East Timorese People in a Healthy Timor-Leste”

- National Health Sector Strategic Plan (2011-2030)

Health and medical care is a fundamental right of all Timorese guaranteed by the Constitution.

The commitment of the Government towards this constitutional obligation is reflected in the Timor-Leste National Health Sector Strategic Plan (NHSSP) 2011–2030 that was developed in line with the national SDP 2011–2030.

Structural and programmatic adjustments are being made in the Ministry of Health (MoH) and its network to enhance its effectiveness in meeting its obligations to the citizen.

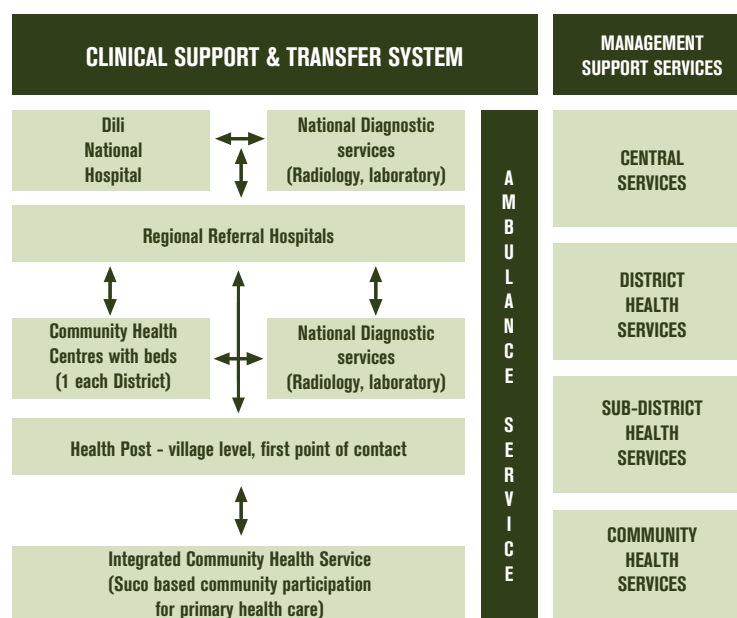
Health System

The current health system configuration is based on a broad definition of access to publicly financed and delivered primary care, with essential referral care being provided by regional hospitals and more specialised referral services by the only national hospital. In addition, the private sector provides care through these hospitals and numerous clinics, polyclinics and specialised centres. The hierarchical structure of the health sector provides a logical range of coverage of services (Chart 2.1).⁸⁵

The central office of the MoH designs, directs, manages and coordinates all Government health care and pharmaceutical policy and activities throughout the country. With the current initiative to decentralise, it is expected that some of these functions will be transferred to the district and municipal levels. As in many countries, the decentralisation of functions will take time to complete, so managers can anticipate some role uncertainties to arise.

Chart 2.1: Health Sector Structure

Source: Democratic Republic of Timor-Leste (2011) National Health Sector Strategic Plan 2011-2030, Dili: Ministry of Health.



Each of the 13 districts in Timor-Leste has a district health management team headed by the District Director of Health Services, who is responsible for managing the district health service.

For most families in Timor-Leste, the main contact with the health system is through primary health care services.

The primary health network provides a Basic Service Package that is comprised of basic curative services, immunisation programmes, maternal and child health care, nutrition programmes, and health promotion and education. It is provided through the District Health Service structure that includes Health Posts, mobile clinics and Community Health Centres. Community-based activities consist of the Integrated Community Health Services (called SISCa) in all villages and mobile services conducted at other sites such as schools and markets. The objective of the SISCa programme is to extend the reach of basic primary health care services to the community and household levels. It is community-based and provides the following services: family registration, mother and childcare,

nutrition monitoring, curative care and integrated vector control, and health promotion activities. SISCa posts have been established in all sucos. They are operated by health staff based in Community Health Centres, as well as by people from the community appointed by the Ministry.

At sub-district level, Community Health Centres provide a higher level of service than Health Posts, have a wider range of staff and provide technical and managerial support to Health Posts. Some Community Health Centres also offer dental services and laboratory testing for antenatal care, malaria and tuberculosis.

Health laws, policies and strategies

The **NHSSP** provides the overall vision, mission and objectives of the health sector. It specifies the governance structure, processes for improving the health system, and targets for health care delivery. The Plan guides Timor-Leste's health sector's programmes and projects.

Support to the health sector

Development partners and NGOs including faith-based organisations actively partner with the MoH in improving health services in Timor-Leste. Currently, the sector support project, NHSSP-SP, is funded by the Australian Agency for International Development (AusAID), the European Union (EU) and the World Bank through a multi-donor trust fund arrangement. The NHSSP-SP aims to improve the sector's performance in the following key areas: public financial management, pharmaceutical and drugs management, and sector coordination with the support of AusAID; and human resources capacity and health infrastructure facilities with the support of the EU. UN Agencies (WHO, UNICEF, UNFPA and WFP) support the MoH on health policy and

standards development, capacity building, basic service delivery and monitoring systems. The U.S. Agency for International Development (USAID), Cuba, and Indonesia are key bilateral partners in the health sector. National NGOs such as Alola Foundation and the Church-based organisation Pastoral da Criança play an important role in social mobilisation and behaviour change communication.

2.1.2 Key achievements

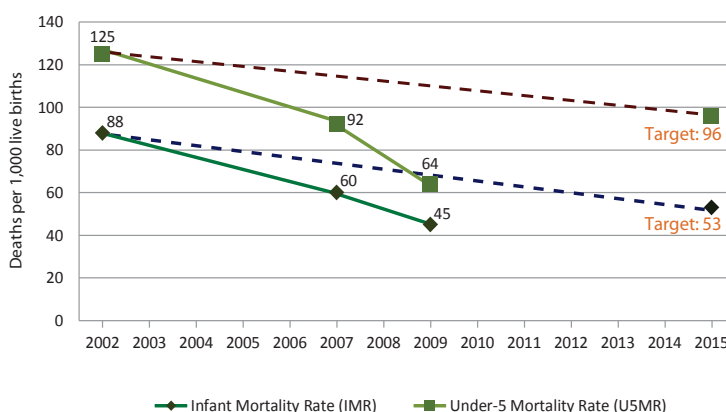
Timor-Leste is one of seven high mortality⁸⁶ countries that have already met the MDG on the reduction of under-five mortality rate by at least two-thirds since 1990.⁸⁷

Timor-Leste has achieved a remarkable 50 per cent reduction in U5MR. National household-based surveys found that the U5MR declined from 125 deaths per 1,000 live births in 2002⁸⁸ to 64 in 2009,⁸⁹ which is well below the national MDG target of 96.

Similarly, the infant mortality rate (IMR) or the probability of children dying before their first birthday declined from 88 in 2002 to 45 in 2009, way below the target of 53 (Figure 2.1).

Figure 2.1: Trends of IMR and U5MR (2002-2015)

Source: Democratic Republic of Timor-Leste Health Management Information System (HMIS) 2012, and Final Statistical Abstract: Timor-Leste Survey of Living Standards 2007.



Peace, stability and progress in socio-economic development and improvement in health indicators have jointly contributed to the decline in child mortality rates. Some of the key achievements that have contributed to the overall decline in child mortality are:

- The elimination of maternal and neonatal tetanus.
- An increase in exclusive breastfeeding for newborns (0 - 6 months) from 31 per cent in 2003 to 52 per cent in 2009.⁹⁰
- An increase in measles immunisation from 56 per cent in 2003 to 68 per cent in 2009 and full vaccination from 18 per cent to 46 per cent in 2009.⁹¹
- An increased level of antenatal care contact from 61 percent in 2003 to 86 per cent 2009.⁹²
- An increase in assisted delivery from 16 per cent in 2003 to 30 per cent in 2009.⁹³
- A reduction in the incidence of common communicable diseases such as diarrhoea, malaria, and acute respiratory infections and improvement in care seeking during illnesses.
- An increase in contraceptive use from 7 per cent in 2003 to 22 per cent in 2009, and a marked decline in the total fertility rate from 7.7 to 5.7 children per woman during a lifetime.⁹⁴
- Increased access to improved drinking water from 50 per cent in 2001 to 66 per cent in 2010.⁹⁵
- Adaptation and mainstreaming of implementation of evidence-based child survival and high impact nutrition interventions nationwide through the Basic Package of Services.

- The expansion of community health outreach, health volunteers and mother support groups, which are good practices leading to improvements in home and community care for children, such as exclusive breast-feeding.

2.2 Key issues – status, progress and disparities

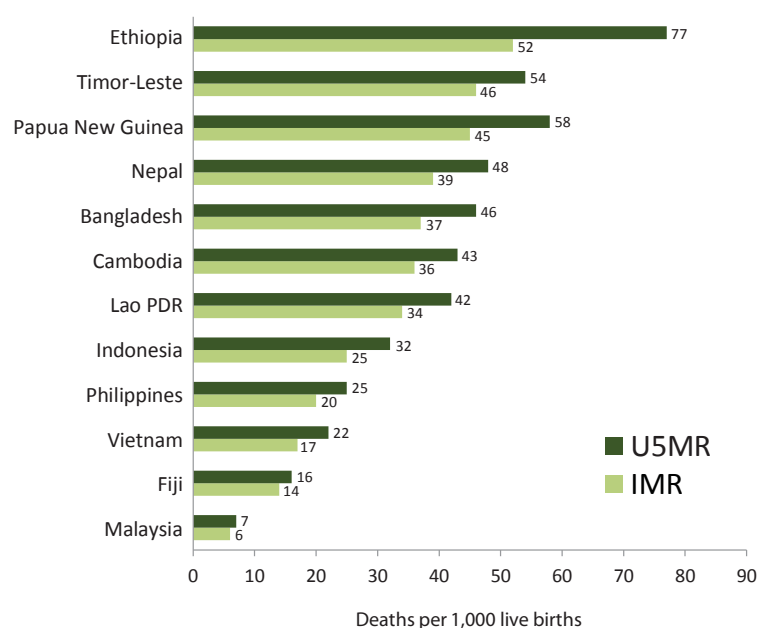
Child and maternal health are critical issues for Timor-Leste from the perspective of children's rights as well as for national development.

2.2.1 Child Mortality

Although the IMR and U5MR reached the country's MDG targets, the level of U5MR in Timor-Leste is still relatively high in comparison with other countries in the region (Figure 2.2).

Figure 2.2: IMR and U5MR in comparison with selected countries,

Source: Democratic Republic of Timor-Leste Health Management Information System (HMIS) 2012, and Final Statistical Abstract: Timor-Leste Survey of Living Standards 2007.



The TLDHS 2009-2010 reported an U5MR of 64 deaths per 1,000 live births, an IMR of 45 deaths per 1,000 live births and neonatal deaths and post-neonatal deaths of 22 and 23 per 1,000 live births, respectively.

Therefore, **1 in 16 children born in Timor-Leste dies before his/her fifth birthday. Over 70 per cent of deaths among under-five children occur during the first year of life.** Among under-five deaths, 34 per cent are neonatal deaths (occurring within the first month of life), 36 per cent are post-neonatal deaths (occurring within the first year but after the first month of life), and 30 per cent are deaths occurring between 1-4 years old (Figure 2.3).

Under-five children living in rural areas are more likely to die than their urban counterparts. The U5MR is 87 per 1,000 live births in rural areas and 61 deaths per 1,000 live births in urban areas. Inter-district differences are also evident with the lowest U5MR being in Baucau (42 deaths per 1,000 live births) and the highest in Ermera (102 deaths per 1,000 live births (Figure 2.4).

Neonatal mortality remains unchanged. The 2003 and 2009-2010 TLDHS data (Figure 2.5) show that post-neonatal mortality and child (1-4 years old) mortality reduced significantly but neonatal mortality remained unchanged at 21-22 deaths per 1,000 live births, indicating that programme efforts have not been effective in reducing new-born mortality.

Progress on child mortality reduction varies and only two out of 13 districts have U5MR below the national average. The TLDHS 2009-2010 data shows that only two out of 13 districts, namely Dili and Baucau, achieved U5MR below the national average.

All other districts still have a high U5MR. Specifically, the U5MR in Ermera, Liquica, Lautem and Ainaro is higher than the 96 per 1,000 live births required for reaching the MDG by 2015 (Figure 2.5).

Figure 2.3: Pattern of U5MR

Source: TLDHS 2009-2010, NSD and ICF Macro.

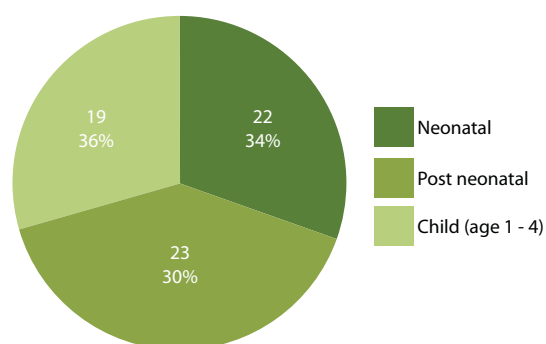


Figure 2.4: U5MR by district

Source: TLDHS 2009-2010, NSD and ICF Macro.

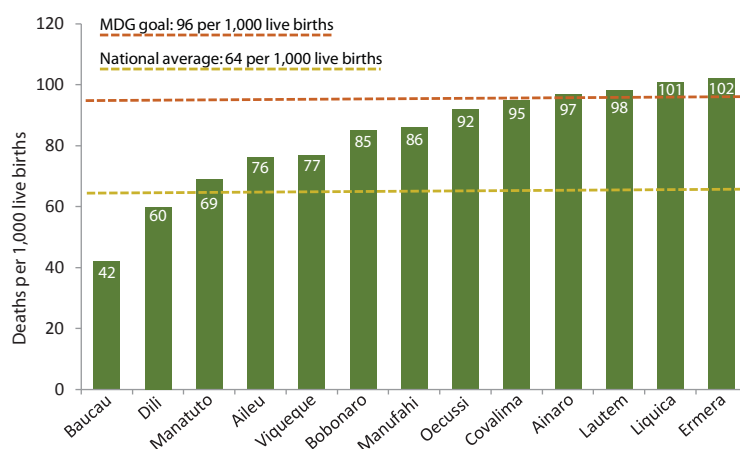
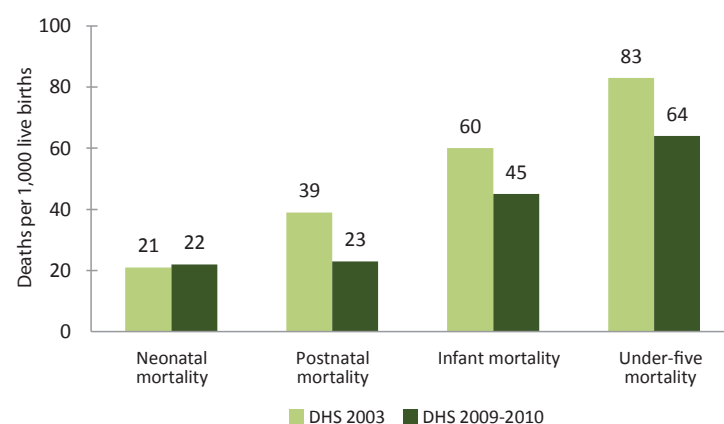


Figure 2.5: Trends in early childhood mortality rates in Timor-Leste (2003 & 2009-2010)

Source: TLDHS 2003, MoH; and TLDHS 2009-2010, NSD and ICF Macro.



Further, the IMR in Ainaro, Covalima, Ermera, Lautem, Liquica, Oecusse, Manufahi and Viqueque is higher than the MDG target of 53 per 1,000 live births to be achieved by 2015.

Children are also at greater risk of dying before the age of five if they are born in rural areas, among the poor, or to a mother with no basic education (Figure 2.6).

2.2.2 Maternal Mortality

Maternal mortality, which is closely linked to child survival and development, is extremely high in Timor-Leste. According to UN estimates,⁹⁶ the MMR was 300 per 100,000 live births in 2010.⁹⁷ However, TLDHS data depict a far worse picture. Specifically, the MMR declined from 660 per 100,000 live births reported in the TLDHS in 2003 but it remains high at 557 per 100,000 live births reported in the TLDHS for 2009-2010,⁹⁸ **putting the country off track to reach the MDG 5, Target 1 of reducing the maternal mortality ratio by three quarters by 2015.** While there are no disaggregated mortality figures, the maternal mortality rate is expected to be higher among poor, rural and illiterate mothers.

Maternal deaths are a subset of all female deaths and are associated with pregnancy and childbearing. A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.⁹⁹ The TLDHS 2009-2010 found that maternal deaths accounted for 42 per cent of all deaths among women aged 15-49 years. Therefore, more than two in five Timorese women who died in the seven years preceding the survey died from pregnancy-related causes.

2.3 Manifestations and causes of deprivation

Understanding the causes of child mortality and maternal mortality provides important public health insights and supports the development of high impact interventions.

2.3.1 Immediate causes

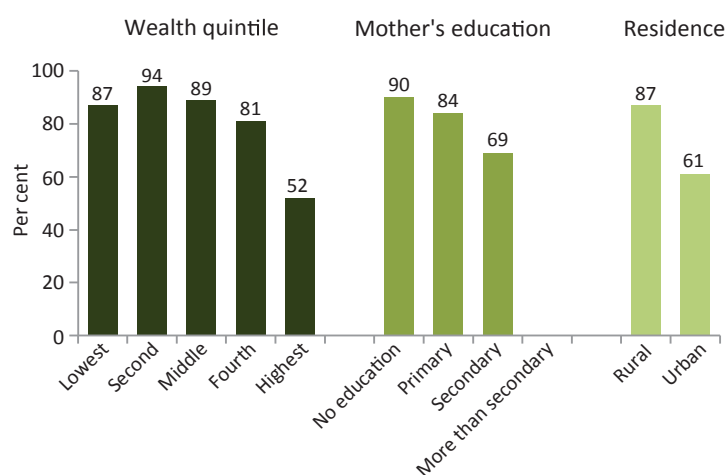
Immediate causes of child mortality

Worldwide, the leading causes of death among children under-five years of age include:

- Infectious diseases and conditions such as pneumonia (17 per cent), diarrhoea (9 per cent), malaria (7 per cent), meningitis, tetanus, HIV and measles. More than half of under-five deaths are caused by preventable diseases.¹⁰⁰
- Neonatal sepsis, meningitis and tetanus. Around 40 per cent of all under-five deaths occurred in the neonatal period, mostly due to preterm

Figure 2.6: U5MR by wealth quintiles mother's education and residence

Source: TLDHS 2003, MoH; and TLDHS 2009-2010, NSD and ICF Macro.



birth complications and intrapartum-related complications (i.e. complications during delivery).

- Malnutrition. More than one-third of under-five deaths are attributable to malnutrition.

In Timor-Leste, there is a data gap that limits the understanding of the immediate causes of child deaths. In the Health Management Information System (HMIS), a large portion of the causes of death (76 per cent) is classified as “others” or unspecified, as household surveys have not explored them. Available data shows that in 2010:

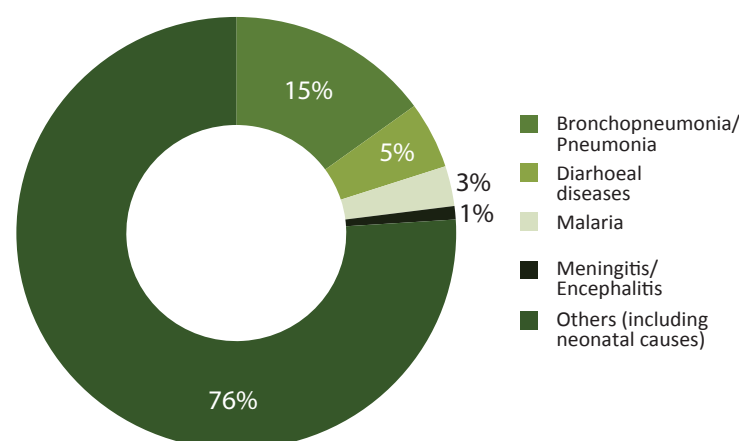
- About 15 per cent of under-five deaths were caused by pneumonia, 5 per cent by diarrhoea, and 3 per cent by malaria (HMIS 2010, Figure 2.7).
- Some 34 per cent of under-five deaths (22 out of 64) occurred during the neonatal period.
- Among neonatal deaths, the most common causes are birth asphyxia followed by preterm birth and neonatal sepsis.
- Malnutrition is the most serious health problem in Timor-Leste. According to the preliminary data from the 2013 Timor-Leste Food and Nutrition Survey, about 52 per cent of children under-five are stunted, 11 per cent wasted, and 38 per cent underweight. High prevalence of malnutrition contributes directly to high child mortality. More information on nutrition will be presented in Chapter 3.

Pneumonia

Acute respiratory infection (ARI) such as pneumonia is the leading killer of children under 5, causing 18 per cent of all child deaths worldwide, and 15 per cent of child deaths in Timor-Leste.

Figure 2.7: Causes of deaths in under-five children

Source: HMIS 2010, MoH



The TLDHS 2009-2010 reported that 2.1 per cent of children under-five had symptoms of ARI. The definition used (cough accompanied by short, rapid breathing) however, corresponds to the symptoms of pneumonia so the prevalence of ARI may be higher. Lautem has the highest ARI prevalence with 5.6 per cent and Viqueque has the lowest with 0.3 per cent prevalence. Some 71 per cent of children with symptoms of ARI were taken to a health facility or provider, and 45 per cent were prescribed antibiotics.

The prevalence of pneumonia is higher in urban areas (2.8 per cent) than rural areas (1.8 per cent), higher among children with higher educated mothers (3.9 per cent for mothers with education above secondary school) than those with less educated mothers (1.7 per cent in the case of uneducated mothers).

Further, prevalence is higher among children from wealthier families (2.3 per cent in the highest quintile) than those from poor families (1.5 per cent in the lowest quintile). This result may be related to the knowledge and awareness of the disease being higher among urban, rich and well-educated parents, which makes them more likely to report cases and seek services.

The survey also shows a link between ARI prevalence and smoking by mothers. Specifically, about 2.4 per cent of children with mothers who smoke reported symptoms of ARI as compared to 2 per cent among those of non-smoking mothers.

Diarrhoea

Dehydration caused by severe diarrhoea is a major cause of morbidity and mortality among young children in Timor-Leste. Diarrhoea is closely associated with poor living environments, malnutrition and lack of access to basic health services.

The prevalence of diarrhoea for children under-five was 15.6 per cent with significant geographic disparities ranging from 3.4 per cent in Ainaro district to 25.3 per cent in Liquica district. Similarly to pneumonia, children living in urban areas with more educated mothers and from wealthier families reported higher prevalence of diarrhoea.

Overall, 72 per cent of children with diarrhoea sought advice or treatment from a health facility or provider. Over 78 per cent of children with diarrhoea were treated either with Oral Rehydration Therapy (ORT) or Recommended Home Fluids (RHF). Zinc is normally given to children with diarrhoea along with ORT. However the TLDHS 2009-2010 shows that only 5.8 per cent of children with diarrhoea also received zinc supplements.

Malaria

Malaria remains a public health problem and is related to the climatic conditions in Timor-Leste. **Malaria and other illnesses that cause fever contribute to high levels of malnutrition and mortality.**

Fever is a symptom of malaria and other acute infections in children. The TLDHS 2009-2010 reported that 19.2 per cent of children had fever in the two weeks preceding the survey. Of this, only 5.7 per cent took antimalarial drugs and only 2.4 per cent took the antimalarial drugs on the same or following day.

A simple and relatively inexpensive way to control malaria is the use of long lasting insecticide-treated nets (LLITNs). The TLDHS 2009-2010 reported that 45 per cent of Timorese households own at least one mosquito net, 43.6 per cent of them own at least one untreated mosquito net, and 40.9 per cent of them use at least one insecticide-treated mosquito net (ITN). About 45 per cent of children under-five years of age slept under treated or untreated mosquito net and 41 per cent slept under an ITN.

Neonatal deaths

Neonatal deaths make up one-third (34 per cent) of all under-five mortality in Timor-Leste (Figure 2.3).

A study¹⁰¹ on neonatal morbidity and mortality indicated that over a quarter of new-born babies admitted to the neonatal unit of the national referral hospital in Dili weighed less than 2.5 kg (low birth weight) on admission. The most common reasons reported for admission were sepsis (38 per cent) and respiratory disease (22 per cent). Overall, mortality was 11.4 per cent, mainly attributed to prematurity (28 per cent), infection (26 per cent) and asphyxia (24 per cent).

Globally, the majority of neonatal deaths result from complications related to preterm birth (birth before 37 completed weeks of gestation) or from complications during birth.

Many mothers in the world's poorest countries deliver their babies at home rather than in a health facility; both they and their babies are therefore at greater risk if complications occur. Low birth weight (below 2.5 kilograms), caused by preterm birth and/or growth restriction, greatly increases children's risk of dying during their early months and years.

Birth weight or size at birth is an important indicator of the child's vulnerability to childhood illnesses and the child's chances of survival.

The TLDHS 2009-10 reported that only 26 per cent of infants upon birth were weighed in the preceding five years. Among them, 10 per cent were reported to have low weight (below 2.5 kilograms).

Nearly one-fifth (18 per cent) of deliveries in Timor-Leste are carried out by traditional birth attendants, 49 per cent by a relative or some other person, and 3 per cent without any type of assistance. As such, **very few new-borns have access to essential newborn care.** For example, a new or boiled blade was used in only one in five of the most recent non-institutional births, and 27 per cent of the non-institutional new-borns are bathed within the first hour of birth. Cord caring practices are also inadequate with 19 per cent applying ointment or powder, 10 per cent applying oil, 7 per cent applying ash, and 6 per cent applying traditional medicine (TLDHS 2009-2010).

A large proportion of neonatal deaths occur within the first few days following delivery. Postnatal care visits from a skilled health worker can be very effective in ensuring adequate care and preventing neonatal deaths. However, the majority of women (68 per cent) do not receive any postnatal check-up. Women in the highest wealth quintile are more than five times as likely to receive postnatal care from a health professional as those in the lowest wealth quintile (TLDHS 2009-2010).

HIV/AIDS

The 2013 review of the Health Sector Response to HIV/AIDS/STI in Timor-Leste reported that the HIV epidemic in Timor-Leste is evolving from 'low level' towards higher HIV prevalence.

The 2010 HIV sentinel surveillance (HSS) showed that overall national HIV prevalence ratio is 0.68 percent (extrapolated from the antenatal population).¹⁰² The number of confirmed HIV cases is still relatively low but increasing, from one case in 2003 to 211 accumulatively in 2010, 262 in 2011 and 317 in 2012.¹⁰³

Overall prevalence among antenatal mothers remains lower than 1 per cent but it reaches 1.05 per cent in Dili and goes above 1 per cent in risk population groups. Of the 17 children under 5 who were reported to live with HIV in 2012, 8 were boys and 9 were girls. Only 3 of them (17.6 per cent) had access to antiretroviral therapy (ART).¹⁰⁴

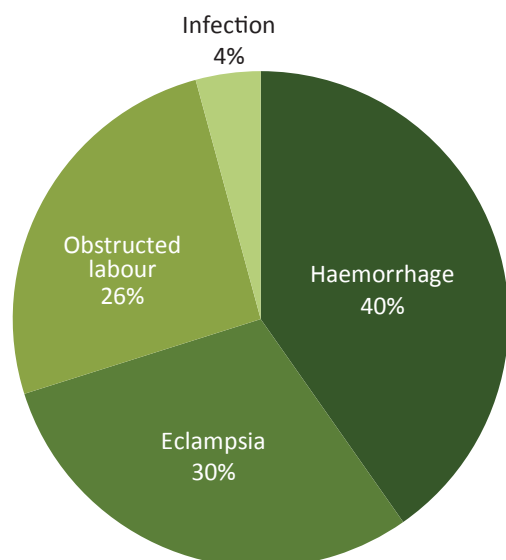
Immediate causes of maternal mortality

Worldwide, haemorrhage remains the leading cause of maternal death (38 per cent); followed by hypertension (18 per cent) and other indirect causes (such as malaria, HIV/AIDS and cardiac diseases).¹⁰⁵

The immediate causes of maternal deaths in Timor-Leste are unclear due to the inadequacy of data. In 2010, 47 per cent of the hospital-reported complications during pregnancy (N = 603) were due to haemorrhage, 27 per cent to obstructed labour, 21 per cent to eclampsia and 5 per cent puerperal sepsis (Figure 2.8, see next page).

Figure 2.8: Hospital reported complications of pregnancy

Source: HMIS 2012, MoH



2.3.2 Underlying causes

High rates of malnutrition

Globally, more than one-third of under-five deaths are attributable to malnutrition. Children weakened by malnutrition are more likely to die from common childhood illnesses such as pneumonia, diarrhoea, malaria, and measles, as well as from AIDS (if they are HIV-positive).¹⁰⁶

Malnutrition contributes to at least 20 per cent of maternal mortality by increasing susceptibility to infections, and reducing tolerance to blood loss during delivery. Malnutrition also heightens the risk of adverse pregnancy outcomes. A woman with poor nutritional status has a greater risk of obstructed labour, dying from postpartum haemorrhage, having a baby with a low birth weight, and experiencing illness for herself and her baby.

Timor-Leste has one of the highest levels of malnutrition in the world. The issues of malnutrition will be discussed in greater details in Chapter 3.

Gaps in maternal and child health service coverage

Tackling maternal and child health challenges does not require major advances in technology. Children and mothers are dying because services are provided piecemeal and those most at risk are not reached.

The continuum of care covers pre-pregnancy and childbirth through childhood up to the age of 5 and reflects key opportunities for the delivery of lifesaving interventions. The coverage of these interventions is still relatively low, as indicated by Figure 2.9, which highlights important gaps in quality maternal and child health service delivery.

Before pregnancy:

- Only 22.3 per cent of women of reproductive age (15-49 years) use contraceptives.

During pregnancy:

- Slightly over half of pregnant women (55.1 per cent) received antenatal care more than four times;
- Only 5 per cent of HIV-infected pregnant women received antiretroviral drugs for prevention of mother to child transmission of HIV/AIDS;
- 40.1 per cent of pregnant women slept under the ITNs; and
- 79.8 per cent of mothers were protected from tetanus during the last birth.

During birth:

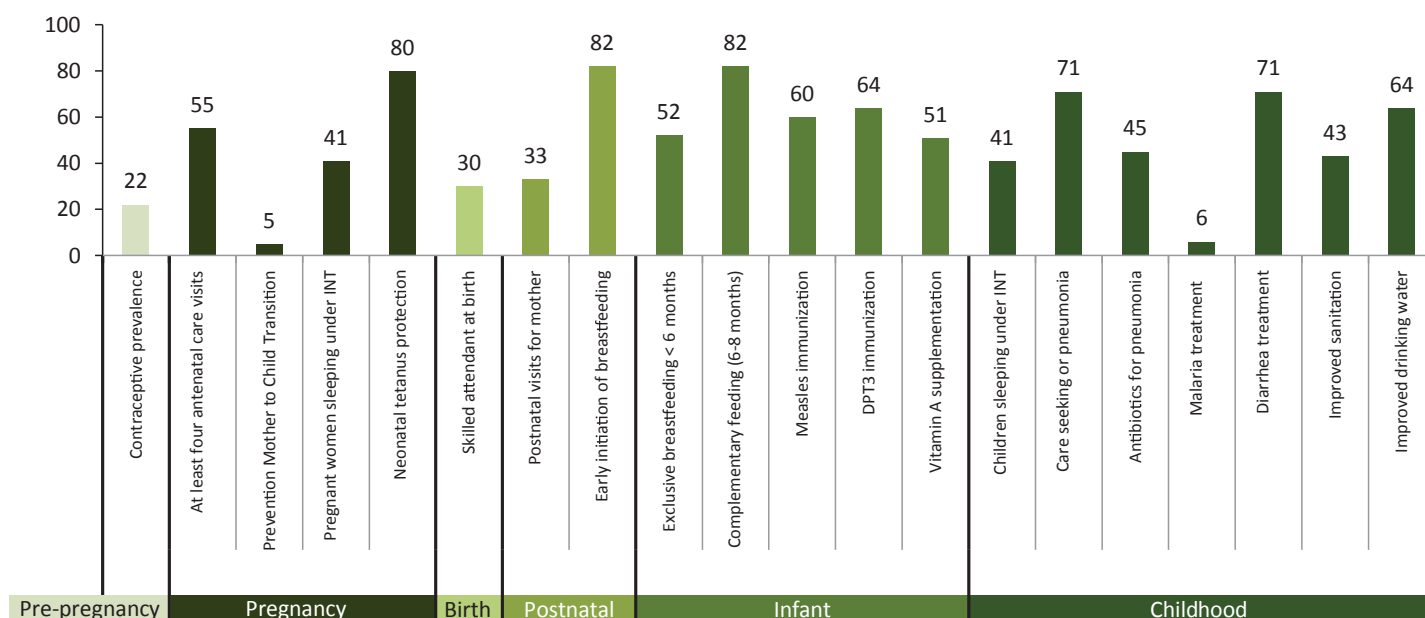
- Less than one-third (29.9 per cent) of pregnant women delivered babies supported by a skilled attendant.

Postnatal period:

- Only one-third (32.8 per cent) of mothers received postnatal visits; and
- 4 in 5 (81.7 per cent) of mothers had early initiation of breastfeeding within one hour of delivery.

Figure 2.9: Coverage of interventions across the continuum of care

Source: TLDHS 2009-2010, NSD and ICF Macro



Infancy and childhood period:

- Only half (52 per cent) of infants who are less than 6 months of age are exclusively breastfed;
- Over 80 per cent of children 6-8 months received supplementary feeding;
- 60 per cent received a routine dose of measles vaccine;
- About two-third (64 per cent) of children aged 12-23 months received their third dose of DPT
- Half (51 per cent) of children received two doses of Vitamin A.

Childhood period:

- 41 per cent of children under-five slept under the ITN;
- About 71 per cent of caregivers reported seeking appropriate care for suspected pneumonia;
- Antibiotic treatment was given for about 45 per cent of pneumonia cases;
- 71 per cent of children received oral rehydration therapy for diarrhoea treatment;
- 43 per cent of the population have improved sanitation facilities; and
- 64 per cent have improved drinking-water sources.

Disparities

Basic maternal and child health services are not distributed evenly throughout the country. However it is also noted that in general the access and quality of health services constitute a challenge for the majority of the population, except the richest quintile and those living in the capital city.

The TLDHS 2009-2010 suggests that children and women from families in the poorest quintile are less likely to receive high impact interventions than those in the richest quintile (Figure 2.10, see next page). An analysis of skilled attendance at birth (SBA), a critical determinant of maternal and newborn health outcomes, shows that the median coverage of the SBA was very close to the level of the lowest quintile. In another words, all quintiles except the richest have a low level of SBA coverage. Such low access is attributed to the shortage of human resources and has been termed “top-inequity” and “mass deprivation” by the WHO.¹⁰⁷

Figure 2.10: Coverage inequity by intervention

Source: TLDHS 2009-2010, NSD and ICF Macro.

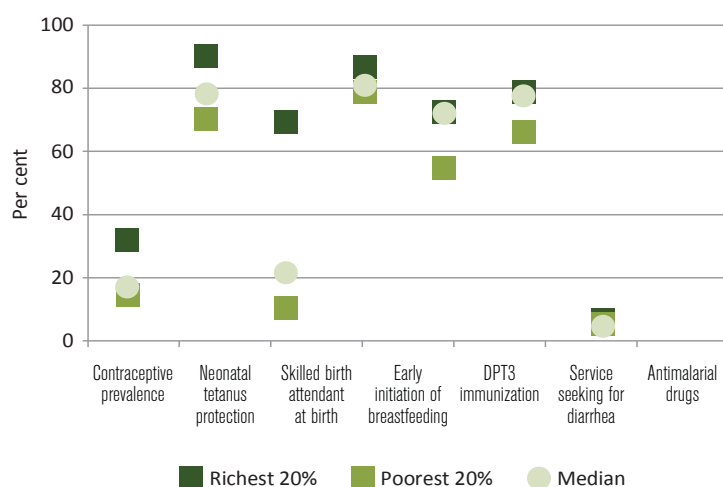
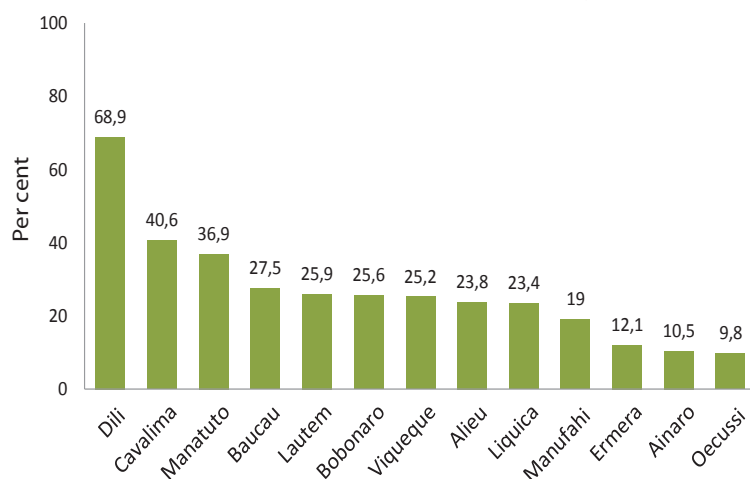


Figure 2.11: Skilled attendance at birth (%) by district

Source: TLDHS 2009-2010, NSD and ICF Macro.



Geographic disparities in health services coverage are significant. For instance, the SBA varies widely between Dili (68.9 per cent) and Oecusse (9.8 per cent). The analysis of SBA coverage by district shows that only Dili has over 50 per cent of SBA (Figure 2.11) indicating that access to newborn and maternal care is an issue nationwide.

Gaps in behaviours and practices

Early marriage and early pregnancy

Child marriage, defined as a formal marriage or informal union before the age of 18, is a reality for both boys and girls, although girls are the most affected. Child marriage increases health risks both for the girl and her children. Child brides are often less able to negotiate sexual relationships or contraceptive use, and are therefore at greater risk of unintended and frequent pregnancies, and sexually transmitted infections. Early marriage frequently leads to early childbearing, as marriage often marks the time in a woman's life when it becomes socially acceptable, or even expected, to have children. Pregnancy during adolescence undermines a girl's development by stopping her growth and increases the likelihood of complications or even death during delivery, for both the mother and child. Stillbirth and death are 50 per cent more likely for babies born to mothers younger than 20 than for babies born to mothers aged 20-29 years.¹⁰⁸ Children born to young mothers experience greater incidence of low birth weight¹⁰⁹ and are significantly more likely to suffer from stunting, wasting or other underweight conditions.

The TLDHS 2009-2010 found that 7.7 per cent of girls aged 15-19 were married or in a union, as compared to only 0.4 per cent of boys. About 3 per cent of women aged 20-24 reported being married before they were 15 years old and 18.9 per cent before they were 18 years. Data also shows that 2.7 per cent of them had their first sexual intercourse before they were 15 and 16.8 per cent before they were 18 years old.

According to the TLDHS 2009-2010, about 7.2 per cent of women aged 15-19 had delivered or experienced pregnancy. Rural women aged 15-19 years are twice more likely to have had a child than urban women. Further, teenage pregnancy is higher

among low educated women and women from poor families. In Oecusse, Bobonaro and Viqueque districts over 10 per cent of pregnant women are adolescents.

Frequent childbirths

The total fertility rate in Timor-Leste is among the highest in the world with a woman giving birth to 5.7 children on average during her lifetime. A birth interval is the length of time between two successive live births. Studies have shown that short birth intervals are associated with an increased risk of death of both the mother and the baby, particularly when the birth interval is less than 24 months.

The TLDHS 2009-2010 data shows that 29.2 per cent of mothers had their second baby less than 24 months after the previous birth, and 8.9 per cent of them had their second child after only 7-17 months of the preceding birth. **The median number of months since the preceding birth is only 29 months.**

Interestingly, young women (aged 20-29 years), living in urban areas and from wealthier families are reported to have more frequent births. Ainaro, Dili, Ermera and Liquica are the four districts with highest birth rates.

Social Practices and Beliefs

For preventive and promotive health care, mothers identify more with the traditional system of health promotion and disease prevention than with health messages from medical professionals. For example, a new or boiled blade is used in only one in five of the most recent non-institutional births and knowledge on the danger signs for new-borns is still low (TLDHS 2009-2010).

The full range of traditional newborn care practices and how they could be influenced is not fully known. Parents tend not to prioritise the need to seek preventive care for their children including immunisation and take their children to traditional healers for illness management such as pneumonia and diarrhoea.

There is inadequate and late care-seeking resulting from low knowledge on the benefit of maternity care and of the danger signs during the pregnancy, delivery and postpartum periods. Traditional household remedies are used in the event of difficult birth.

Low level of knowledge and skills of care providers and families

When caregivers do not have adequate information, knowledge and skills, the child is deprived of care, suffers growth faltering and is affected by the consequences of low resistance to infection. ITN use is promoted for malaria prevention but only 41 per cent of under-five children sleep under an ITN. Only 7.3 per cent of children having diarrhoea are given increased fluids and continued feeding.

Knowledge of danger signs during pregnancy and childbirth remains low among all quintiles. This could be a major contributor to delayed care seeking and high maternal mortality. Newborn care practices such as aseptic cord care and delayed bathing are low across all quintiles.

Inadequate sanitation coverage and hygiene practices

Timor-Leste has the third lowest rural sanitation coverage in the region, after Cambodia and Laos. Timor-Leste is on track for its rural water supply MDG but way off track for rural sanitation. Open defecation (OD) is widely practiced with 29 per cent not using any kind of latrines: only 8 per cent of people in urban areas practice OD compared to 29 per cent in rural areas. Improved hygiene practice plays a vital role in preventing diarrhoeal diseases: global evidence suggests that hand washing with soap alone can reduce up to 45 per cent of diarrhoea. Poor hygiene conditions worsen malnutrition and exacerbate pneumonia.¹¹⁰

Inadequate amount, skills and distribution of health human resources

Insufficient basic health staff and the misdistribution of professional staff such as doctors and nurses hamper service delivery at community, outreach and facility levels.

At the community and outreach levels, Timor-Leste relies on community volunteers, mothers' support groups, SISCa, midwives and nurses to provide health knowledge and basic preventive services including immunisation, antenatal care, and treatment of pneumonia and diarrhoea. However, a chronic shortage of human resources hampers their efforts in achieving universal coverage. For example, it is estimated that the availability of nurses and midwives is only 50 per cent of what is required at the national level and even lower (10 to 15 per cent) in the low performing districts.¹¹¹ Furthermore, the volunteers and outreach workers tend to lack motivation for better performance due to the absence of incentives, hardship allowances, and support such as schooling and housing.

In addition, at the facility level, the misdistribution of doctors and nurses results in the concentration of medical staff in medical facilities in urban areas and insufficient staff in rural and peri-urban facilities.¹¹² Rapid scale-up of the number of doctors is going on in the country. Cabral et al (2013) point out that the "choice of this scaling-up, with a relatively narrow focus on the medical workforce, needs to be assessed for its relevance to the health profile of the country, for its comprehensiveness in terms of other complementary measures needed to make it effective".¹¹³

As mentioned earlier in this chapter, mothers and newborn babies suffer immense deprivations and this calls for increased focus on training, deploying and retaining midwives in health facilities. The

Government has taken this need seriously and committed to deploy two midwives in each Health Post, although the way forward is yet to be clearly articulated.

Inadequate supplies and inadequate health care commodity management

Insufficient availability of essential medical commodities, equipment, and services in health facilities and hospitals remains a major bottleneck in service provision.

A joint review supported by the UNICEF East-Asia and Pacific Regional Office in 2012 found that the stock available for essential commodities is 20 per cent for assisted delivery and neonatal care, 10 per cent for Preventing Mother to Child Transmission of HIV (PMTCT) and 5.6 per cent for oral rehydration salt with zinc (TLDHS and programme reports, MoH).¹¹⁴ There are also problems with supply chain management from the central warehouse to district and sub-district facilities due to shortfalls in procurement and supply chain management.

In the case of immunisation, the country does not have the globally recommended level of institutional capacity to do self-procurement of vaccines. The Effective Vaccine Management (EVM) assessment conducted in 2011 led to the development of the EVM improvement plan. However, the EVM plan is yet to be implemented and shortages of vaccines happens frequently.¹¹⁵ Poor families sometimes travel long distances to reach the health facilities spending their limited resources for transportation and accommodation only to find that no providers or drugs are available. Shortages of essential drugs and shortages of ambulance fuel for transporting pregnant women to the health facilities are reported frequently.

In response to procurement issues, the National Procurement Commission has been bolstered considerably through decree laws and the establishment of chartered agencies to oversee specific areas of procurement.

To complement this, the Ministry of Finance (MoF) developed Best Practice Guidelines in an effort to improve and clarify procurement processes across all ministries in the Government. As the process of decentralisation continues, there is a need to specifically examine the effectiveness of the procurement reform agenda and the processes that have been adopted by ministries in the Government.

A recent external review by Deloitte has provided recommendations to improve supply management and procurement procedures as well as internal controls.¹¹⁶

2.3.3 Basic causes

A well-functioning health system comprises several building blocks that have multiple relationships and interactions, with people at the centre¹¹⁷ (Chart 2.2).

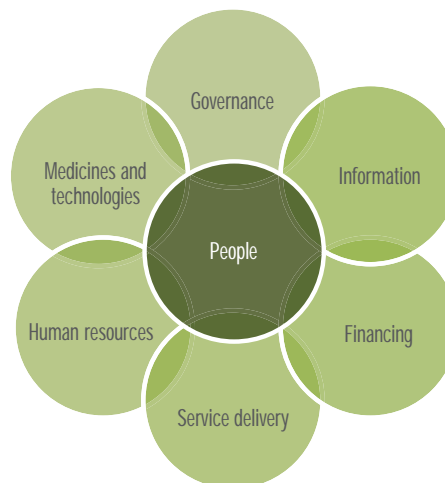
Two key issues in the health sector, namely governance and financing, are among the fundamental causes of the challenges experienced by Timorese children and their mothers in accessing quality basic health services.

Policy and legislation

The 2009 MDG report of Timor-Leste highlights the **need to further improve the health policy framework in order to enhance the adequacy and effectiveness of essential reproductive, maternal, new-born and child health (MNCH) services**, especially in the areas of spacing between

Chart 2.2: Health system

Source: Alliance for Health and System Policy and Research, 2010.



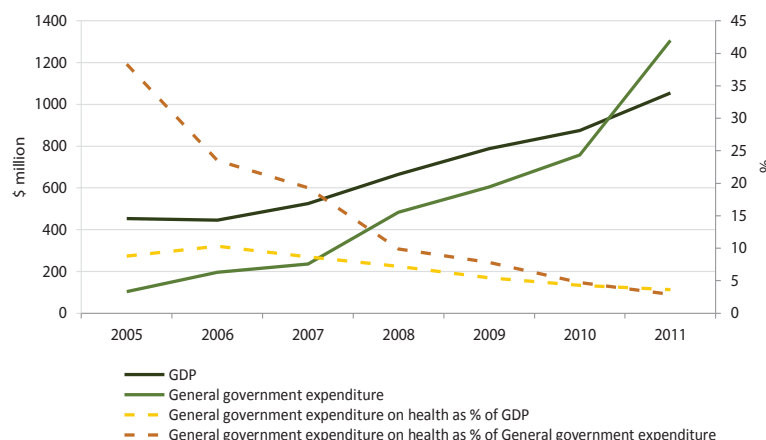
births, access to essential obstetric care and treatment of common childhood diseases, and care-seeking and care by mothers and service providers. The on-going development of a comprehensive national maternal, newborn and child health strategy, a National Nutrition Strategy, code for marketing of breast-milk substitute, and law on salt iodization is expected to improve the programming environment (Table 2.1). Efforts should also be put in developing policies on new-born and child health, health human resources, breast-feeding, and family planning and nutrition including food fortification.

Table 2.1: Status of Key MNCH Policies in Timor-Leste

| Key interventions | Status |
|---|---|
| International code of marketing of breast milk substitutes enacted | Draft |
| Maternity protection in accordance with ILO convention 183 | No |
| Midwives authorised to administer core set of life-saving interventions | Yes |
| Integrated management of childhood illness adapted to cover new-borns aged 0-1 week | Yes |
| Community treatment of pneumonia | Partial. (Community volunteers are not permitted to give antibiotics) |
| New oral rehydration salts formula and zinc for management of diarrhoea | Yes |
| Costed implementation plan for maternal, newborn and child health available | Yes |

Figure 2.12: Timor-Leste's GDP, public spending and health expenditure 2005-2011

Source: Global Health Expenditure Database, WHO.



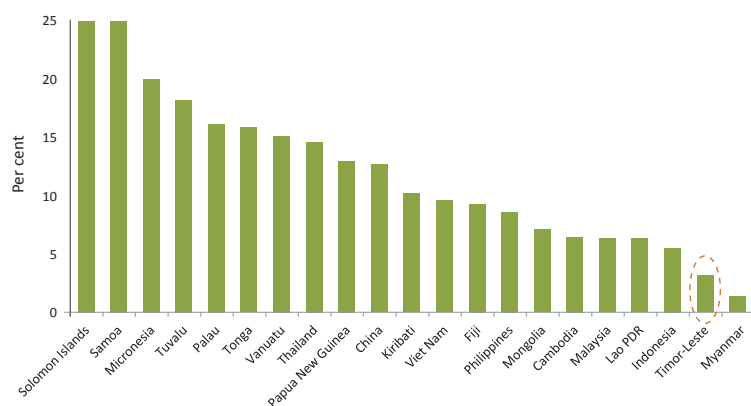
Health financing

According to the Constitution of Timor-Leste, ***“The State shall promote the establishment of a national health service that is universal and general. The national health service shall be free of charge in accordance with the possibilities of the State and in conformity with the law”.***

In absolute terms, the Ministry of Health's budget significantly increased in the past years and reached US\$67 million¹¹⁸ in 2014 from less than US\$17 million in 2005-06. Executed health expenditure also increased from about US\$12 million in 2005-06 to US\$58 million in 2014.¹¹⁹

Figure 2.13: Regional comparison of Timor-Leste's public spending in health 2011

Source: Global Health Expenditure Database, WHO.



Timor-Leste's total public spending and GDP also increased considerably over the years. However, the share of Government budget devoted to health against both total Government spending and GDP declined over time (Figure 2.12). In 2011, public health expenditure as a share of total government spending was only 2.9 per cent, which is among the lowest in the East-Asia and Pacific region and almost nine times lower than the leading country in the region (Figure 2.13).¹²⁰

Figure 2.14: Composition of Ministry of Health Actual Expenditure by Category, 2008-2013

Source: Timor-Leste Budget Transparency Portal, MoF.



The government expenditure on health also reduced as a share of the total expenditure on health in the country. Such reduction has been filled by non-profit institutions serving households, and to a limited extent, by out-of-pocket spending.¹²¹

The latter may therefore increase once donor-spending starts reducing. By looking at the sub-programmes, a declining allocation to the national directorate of community health (from US\$3.7 million in 2012 to US\$2.1 million in 2014) appears worrisome as all the critical maternal, newborn and child health and nutrition programmes are developed and costed by this directorate.

In terms of budget composition, the allocation to goods and services declined over 2008-2012 with greater shares going to transfers, salaries and wages (Figure 2.14). In the context of expanding the health care delivery network and range of services, squeezing operational expenditure could affect the effectiveness of the system in delivering services to the population.

Distribution of health funding to districts appears not to be based on needs. Districts where child mortality is higher are spending less per capita (Figure 2.15). For example, while Ermera and Liquica experience the highest under-five mortality in the country, they receive the lowest per capita public health expenditure (US\$6 and US\$8 respectively).¹²²

According to the World Bank,¹²³ “recent and forecast health spending is concentrated on expansion and rehabilitation of hospital capital works projects”. The fact that districts with hospitals receive higher per capita expenditure on health appears to corroborate this statement.

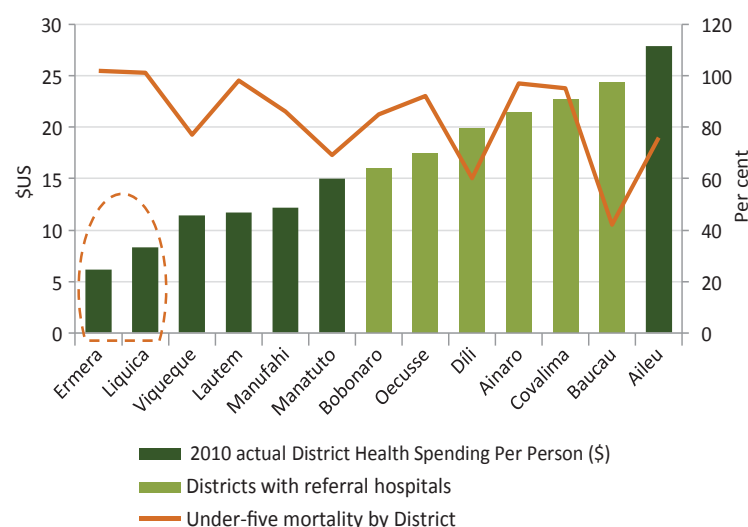
Further, there is a need to ensure adequate spending for child health and nutrition by earmarking national health budget and providing dedicated budget lines for child health and nutrition.

Finally, budget allocation decisions are yet to be based on sound evidence and thorough planning.

There is no effective mechanism to link district health plans with the MoH budget, sometimes leaving planned district level activities with no budget to implement them. Plans to decentralise management and budget functions will require an increase in financial management capacity at the district level. The ongoing Government initiative on district evidence-based planning and budgeting aims to address these gaps.

Figure 2.15: Under-five mortality and district public spending on health

Source: TLDHS 2009-2010, NSD and ICF Macro, and Budget Transparency Portal 2010, MoF.



Governance, management and coordination mechanism

In Timor-Leste, health service delivery is delegated by the Ministry of Health to the District Health Managers but the centralised structure of the government requires most decisions related to health policies, programmes and service delivery to be made at the central ministry level.

The district level officials provide health services based on instructions and guidelines from the central Government. Coordination and management units are established at the central level and the Ministry of Health and partners have formed a Maternal and Child Health Working Group and a Nutrition Working Group to analyse programmatic challenges and address them.

MoH and partners intend to adopt a sector-wide planning approach but this is yet to be put into practice. To address gaps in management skills, the MoH has made efforts to provide the district health management team with management training.

The WHO has facilitated the management training of health personnel and multiple donors. To further address some of the gaps in planning and budgeting, the MoH is working to adopt an evidence-based planning and budgeting approach and developing the capacity of district managers.

Illiteracy, poverty and gender issues

Timor-Leste's MDG report 2010¹²⁴ reported a national poverty rate of 49.9 per cent in 2007 with a 26 per cent decline in average consumption. The report states that poverty in some areas of the nation almost doubled between 2001 and 2007. As shown by the TLDHS 2009-2010, poorer segments of the population have a higher burden of diseases and less access to health care.

An educated mother is known to have better control of resources and ability to acquire knowledge and skills and translate them into self-care and care for their children, which are important determinants of good health status. The TLDHS 2009-2010 shows that a literate mother is less likely to have malnourished children and more likely to seek care for herself and her children. However, nearly three in ten women have no education compared with one in five men. Secondary or higher level of education among women is shown to be associated with reduced fertility, a key determinant of maternal and child survival. However, only 48 percent of women have secondary or higher levels of education as compared with 55 percent of men.

Women are the primary caregivers in the household and the way they carry out health related activities and control resources are important determinants of the nutritional status of themselves and their children. Timor-Leste is reported to have "strong remnants of the traditional patriarchal system.

Due to the dowry system, husbands adopt the strong view that their wives are their subordinate property." The patriarchal society grants lower status to women who get discriminated in the ownership of assets and participation in making decisions affecting their lives and that of their children.¹²⁵

2.4 Opportunities for action

- **To increase financing for the health sector and improve budget execution; earmark budget for child health in health spending units at national and district levels; allocate health budget based on the level of deprivation of children; and scale up district level evidence-based planning and budgeting.**

A costed evidence-based strategic plan (investment business plan) prioritising new-born care and emergency obstetrics must be developed at the central level as a tool for advocacy and political buy in.

The plan will be used for coordination among development partners to pool available resources to be prioritised according to the geographic level of deprivation (especially child mortality and malnutrition levels).

The current Ministry of Health-led initiative to strengthen district level planning and budgeting using bottleneck analysis and capacity building needs to be taken forward to enable districts to identify and address specific bottlenecks resulting in child deprivations.

- **To include support and capacity building of health management and staff in the interventions to strengthen health systems.**

There is a need to build up institutions of training, empowering professional associations, creating opportunities for contribution and management at national, district and suco levels, and networks of support for health staff working in remote areas.

To meet the clinical and public health gaps, there is a need for increases in the number and quality of doctors, midwives, and nurses, and development of systems of continuing professional development for health professionals. Involvement in local research, especially that contributing directly to critical issues in child health policy or strengthening national data systems help build capacity of management.

- **To prioritise policies and strategies to overcome bottlenecks in the areas of nutrition, maternal and child health, and water and sanitation.**

There is a need to review current work plans for better targeting and implementing evidence-based pro-equity strategies. The current strategies need to be evaluated and scaled up to more geographic locations and standard guidelines developed. Some of the strategies are at draft policy stage and should be expedited with accompanying action plans for implementation.

Strategies that may be new to the country such as mean tested social insurance are needed urgently to overcome financial bottlenecks. For that, the country needs to start out with advocacy, feasibility study and cost-effectiveness of possible approaches.

- **To put in place measures to increase the functionality of Health Posts and their capacity to provide basic MNCH and Nutrition services in a sustainable way.**

This requires putting in place basic facilities for delivery care, immunisation, nutrition screening etc. in health posts and filling in health human resource gaps, particularly the lack of skilled birth attendants, including through measures to incentivise and manage performance.

- **To promote and accelerate preventive health programmes.**

This will require promoting a continuum of care starting from the adolescent and pre-pregnancy period and continuing throughout pregnancy, delivery and childhood. Interventions should include proven, cost-effective ones such as community-based case management of common childhood illnesses, breastfeeding promotion and counselling, provision of folic acid supplementation in the preconception stage, maternal anthelmintic therapy, maternal and infant micronutrient supplementation, and maternal and infant use of insecticide-treated bed nets.

- **To promote optimal health and nutrition behaviour and practices at all levels.**

There is a need to improve home care practices and health care seeking to address determinants of women's and children's health and nutritional status through strengthened community engagement.

Scaling up and strengthening of existing community driven approaches should be pursued. This includes communication for development interventions, using behavioural change groups such as mothers' groups to accelerate social and behavioural change in childcare practices, and health and sanitation promotion through initiatives such as Community-Led Total Sanitation and Open Defecation Free.

- **To strengthen a robust information system as one of the components of quality health services.**

It is recommended to set up a real time monitoring using information technology to strengthen the Health Management Information System (HMIS) to enable the ministry to track changes in bottleneck reduction at different levels of the health system and to inform adjustment of programme strategies where needed. In addition, due to the critical importance of procurement in the delivery of government health services, a close monitoring of the progress in procurement within the MoH should be ensured.

Footnotes in Chapter 2

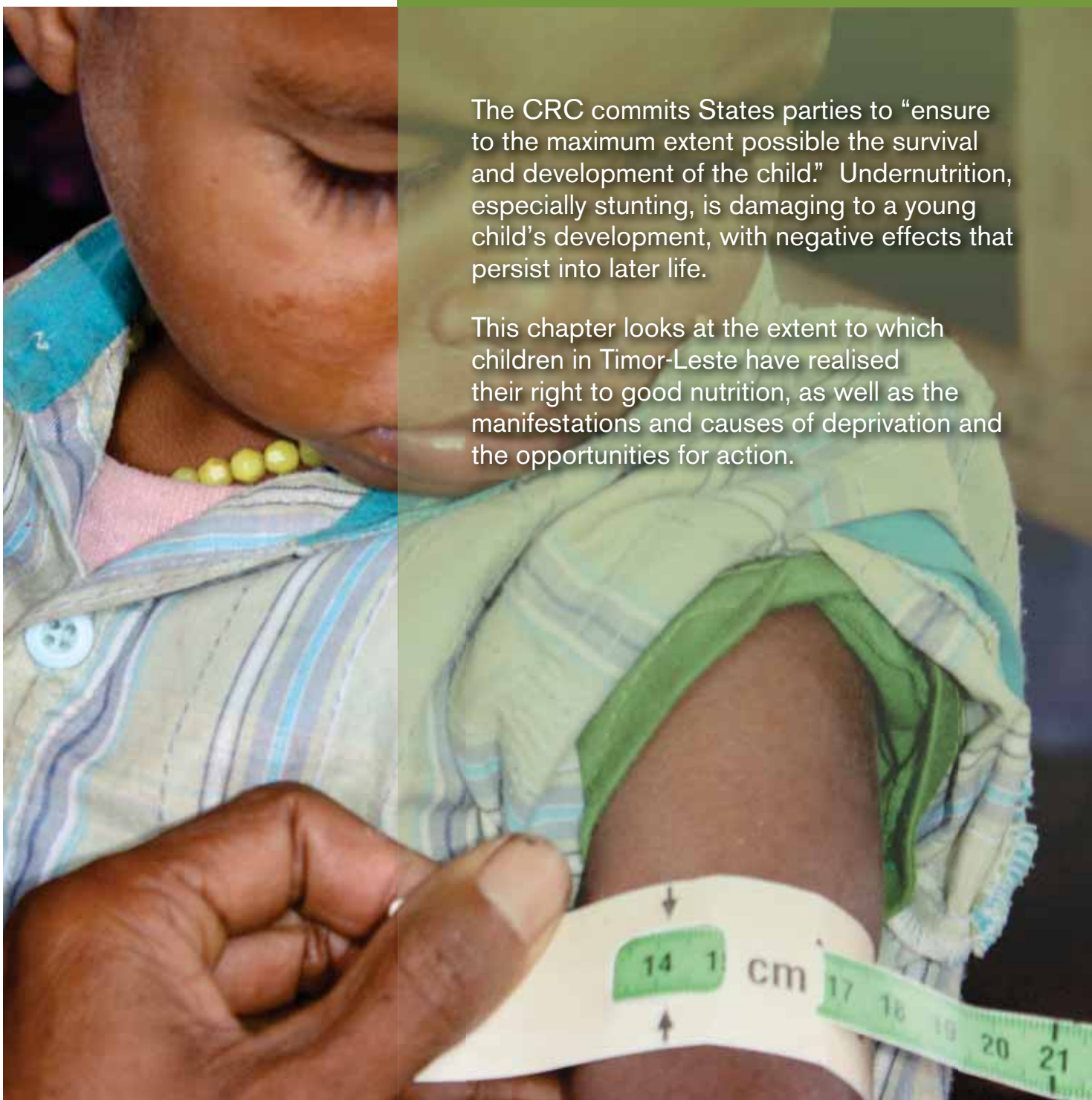
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3

Nutrition

The CRC commits States parties to “ensure to the maximum extent possible the survival and development of the child.” Undernutrition, especially stunting, is damaging to a young child’s development, with negative effects that persist into later life.

This chapter looks at the extent to which children in Timor-Leste have realised their right to good nutrition, as well as the manifestations and causes of deprivation and the opportunities for action.



3.1 Overview

Malnutrition “is globally the most important risk factor for illness and death”. Globally, about one in four children under five years old are stunted (26 per cent in 2011).

Malnutrition has serious consequences not only for child health, but also for the country's long-term social and economic development. It reduces a child's chance of survival, while also hindering optimal health and growth. Malnutrition is a major contributing factor to child mortality, disease and disability. For example, a severely stunted child faces a four times higher risk of dying, and a severely wasted child is at a nine times higher risk. Specific nutritional deficiencies such as vitamin A, iron or zinc deficiency also increase the risk of mortality. Malnutrition can cause various diseases such as blindness due to vitamin A deficiency and neural tube defects due to folic acid deficiency.

Stunting is associated with suboptimal brain development, which is likely to have long-lasting harmful consequences for cognitive ability, school performance, productivity, and future earnings. This in turn affects the development potential of nations. Stunting and other forms of undernutrition epitomize societal inequities and stunting serves as a marker for poverty and underdevelopment.

As stunted children enter adulthood with a greater propensity for developing obesity and other chronic diseases, the possibility of a burgeoning epidemic of poor health opens up, especially in transitional countries experiencing increasing urbanization and shifts in diet and lifestyle. This epidemiological transition could create new economic and social challenges in many low- and middle-income countries where stunting is prevalent, especially among poorer population groups.

A mother's nutrition and health status are important determinants of stunting. An undernourished mother is more likely to give birth to a stunted child, perpetuating a vicious cycle of malnutrition and poverty.

Focus on stunting prevention before the age of 2 years. In tackling child malnutrition, there has been a shift from efforts to reduce underweight prevalence (low weight for age) to prevention of stunting (short length/height for age). There is better understanding of the importance of nutrition during the critical 1,000-day period covering pre-conception, pregnancy and the first two years of the child's life, and of the fact that stunting reflects deficiencies during this period. The World Health Organization (WHO) has adopted a new target of reducing the number of stunted children under the age of 5 by 40 per cent by 2025.¹²⁶

Today's concerted focus on reducing stunting reflects an improved understanding of the importance of malnutrition during the most critical period of development in early life and of the long-term consequences extending into adulthood. There is now more emphasis on policies and programmes that support action before the age of 2 years, especially on maternal nutrition and health and appropriate infant and young child feeding and care practices.¹²⁷

Papers published in 2008 reported that globally, stunting, severe wasting, and intrauterine growth restriction together are responsible for 2.2 million deaths.¹²⁸ Deficiencies of vitamin A and zinc are estimated to be responsible for 0.6 million and 0.4 million deaths respectively.

Maternal short stature and iron deficiency anaemia increase the risk of death of the mother at delivery, accounting for at least 20 per cent of maternal mortality. Nutrition-related factors together are reported to be responsible for about 35 per cent

of child deaths and 11 per cent of the total global disease burden.

Malnutrition contributes to maternal mortality by increasing susceptibility to infections, reducing tolerance of blood loss during delivery and also heightens the risk of adverse pregnancy outcomes.

A woman with poor nutritional status, as indicated by a low body mass index (BMI), short stature, anaemia, or other micronutrient deficiencies, has a greater risk of obstructed labour, dying from postpartum haemorrhage and having a baby with a low birth weight and experiencing illness for herself and her baby.

Anaemia among women of reproductive age is associated with reduced work performance, low birth weight and higher risks of mortality during pregnancy. Anaemia is associated with greater morbidity and mortality and is a profound marker of poor health and nutrition for both women and children.

Anaemia in young children is associated with impaired psychomotor and cognitive development. Iodine deficiency leads to poor brain development and intellectual impairment.

Severe iodine deficiency during pregnancy can cause cretinism, severe mental and physical retardation and may cause stillbirth and miscarriage.

Poverty, through its causal link to malnutrition and economic loss as a consequence of malnutrition, is both a cause and an outcome of poor human development. Though there is no country-specific estimate of the economic burden of malnutrition in Timor-Leste as yet¹²⁹, the high burden of child malnutrition is expected to be causing substantial future economic loss. Therefore, investment in prevention of maternal and child malnutrition is a sound investment for the socio-economic development of the country.

3.1.1 Nutrition programming context

Good health is enshrined in the Constitution of Timor-Leste. All Timorese citizens are entitled to health care and the state has a duty to promote and protect the health of its citizens.

Nutrition policies and strategies

The government of Timor-Leste has committed to addressing malnutrition through a number of policy frameworks, statements and plans. These include:

- Timor-Leste's commitment to achieve the MDGs targets which are in line with the Seven National Development Goals (NDGs) of Timor-Leste;¹³⁰
- The 2004 nutrition strategy which is currently being implemented and revised to become the National Nutrition Strategy 2013-2018;
- The 2010 Comoro Declaration against hunger and undernutrition. This is a statement of policy commitment to address nutrition through concerted and joint efforts of seven line ministries: Ministry of Agriculture and Fisheries (MAF), Ministry of Finance (MoF), Ministry of Health (MoH), Ministry of Commerce, Industry, and Environment (MCIE) [formerly known as the Ministry of Tourism, Commerce and Industry (MTCI)], Ministry of Economy and Development (MoE),¹³¹ Ministry of Education (MoE), and Ministry of Social Solidarity (MSS);
- The Timor-Leste SDP 2011-2030 which aims to accelerate economic growth and reduce poverty, both of which are expected to have an impact on the basic causes of malnutrition; and
- The NHSSP (2011-2030), which emphasizes delivery of basic health services and health promotion. The NHSSP recognizes that tackling

malnutrition will require paying attention to the nutritional needs of women during pregnancy and of their children during the first two years of life.

Support to nutrition interventions and programmes

Most of the nutrition interventions currently being implemented by the Government of Timor-Leste are nutrition-specific interventions that address the immediate determinants of fetal and child nutrition and development—adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases.

The interventions include infant and young child feeding, micronutrient supplementation and fortification, treatment for acute malnutrition, and disease prevention and management.

A number of stakeholders and partners have been supporting the implementation of specific interventions, including NGOs such as Alola Foundation and church-based organizations (Pastoral da Criança), bilateral donors (AusAID, EU, Government of Japan, USAID, Spain, etc.), international financial institutions such as the World Bank, and global alliances such as the Spanish MDG Achievement Fund (MDG-F) and UN agencies (FAO, UNICEF, WFP, WHO).

The coverage and effectiveness of nutrition-specific interventions can be improved and complemented by implementing sensitive interventions that address underlying determinants of fetal and child nutrition and development - food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment.¹³² As such, nutrition-sensitive interventions are implemented by other sectors such as agriculture and food security; social safety nets; early child development; maternal mental health;

women's empowerment; child protection; schooling; water, sanitation, and hygiene; health and family planning services.

The linkages between nutrition-specific and sensitive interventions are still weak. Thus, there is a need to strengthen coordination among different sectors in order to tackle the complex problem of malnutrition.

The National Nutrition Strategy 2013-2018 that is currently being finalized highlights the requirements of multi-sectoral actions and support from health, agriculture, education, water and sanitation, and others to improve maternal and child nutrition in Timor-Leste.

3.1.2 Key achievements

Progress has been made to improve the nutrition status of children in the past years. According to the recently released preliminary results from the 2013 Timor-Leste Food and Nutrition Survey,¹³³ comparing with the TLDHS in 2009-10:

- **The prevalence of stunting among children under five years of age declined from 58.1 per cent to 51.9 per cent.** Among children of 0-23 months of age, this prevalence came down from 49 per cent to 38 per cent.
- **Wasting among children under five years of age came down from 18.6 per cent to 10.8 per cent.** Among children 0-23 months of age, this rate came down from 18.6 per cent to 11.9 per cent; and
- **Underweight among children under five years of age reduced from 44.7 per cent to 38.1 per cent.**

The Government has prioritized nutrition in its development agenda and declared its commitment to put an end to hunger and malnutrition through the 2010 Comoro Declaration as well as subsequent country policy and strategy documents highlighting the urgent need to address very high level of malnutrition;

Coverage of high impact nutrition interventions such as exclusive breastfeeding among children 0-6 months old improved from 30 per cent in 2003 to 52 per cent in 2009/10.

3.2 Key issues - status, progress and disparities

3.2.1 Stunting, wasting and underweight

Stunting reflects chronic malnutrition during the most critical periods of growth and development in early life. It is defined as the percentage of children aged 0 to 59 months whose height for age is below minus two standard deviations from the median of the 2006 WHO Child Growth Standards. Stunting often goes unnoticed and is sometimes referred to as 'silent malnutrition'.

Wasting reflects an acute situation of malnutrition. It is defined as the percentage of children aged 0 to 59 months whose weight for height is below minus two standard deviations from the median of the WHO Child Growth Standards. Wasting is a strong predictor of morbidity and mortality among children under five.

Underweight is a composite form of malnutrition that includes either or both stunting and wasting, without distinguishing between the two. It is defined

as the percentage of children aged 0 to 59 months whose weight for age is below minus two standard deviations from the median of the WHO Child Growth Standards.

Timor-Leste has one of the highest prevalence of stunting among children under-5 in the world.

More than half of children under five years old (58 per cent – 52 per cent according to the preliminary results of the 2013 Timor-Leste Food and Nutrition Survey) in Timor-Leste are stunted. Both underweight and wasting are also much higher than the average level of other countries in Asia, Africa and the Least Developed Countries (Figure 3.1).

Figure 3.1: Nutritional status of children under-five years, by region

Source: UNICEF, WHO and the World Bank, Joint Child Malnutrition Estimates, 2012; TLDHS 2009-2010.

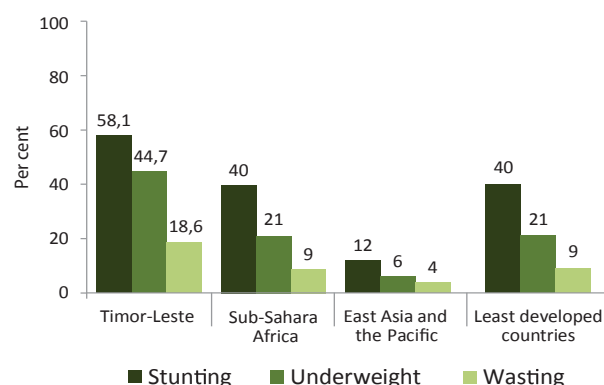


Figure 3.2: Trends in nutritional status of children under-5 years (WHO Growth Standards)

Source: TLDHS 2003, MoH; and TLDHS 2009-2010, NSD and ICF Macro, using data from 2003 recalculated using the WHO Child Growth Standard.

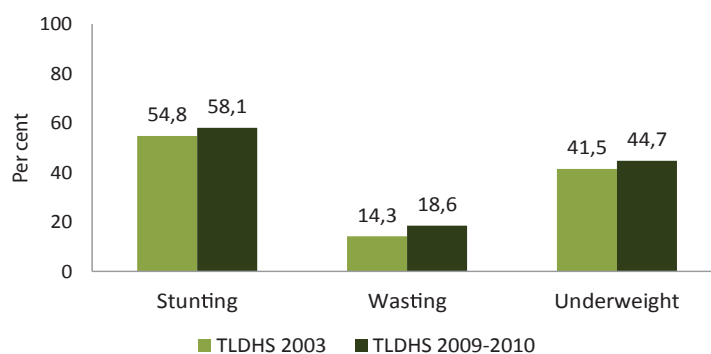


Figure 3.2 presents the comparison of results of surveys using the WHO Child Growth standards (with re-calculation of TLDHS 2003 data using WHO Child Growth standards) and indicates that chronic malnutrition (stunting) among children under the age of five years in 2010 was very high at 58.1 per cent.¹³⁴ Increases in wasting from 2003 to 2009/10 could be a reflection of seasonal variation as the TLDHS 2009-2010 took place during the food scarce dry season. The prevalence of stunting, wasting, and underweight malnutrition remain above the WHO defined threshold for considering it a severe public health problem.¹³⁵

The high level of malnutrition has put Timor-Leste off-track from the MDG 1 on the eradication of extreme poverty and hunger, and indirectly from MDG 4 on the reduction of child mortality, and MDG 2 on the universalization of primary education.

Figure 3.3 indicates that from 9-11 months, both stunting and underweight increased between 2003 and 2010. By 24 months old, children's malnutrition status remains the same or with little change. This clearly indicates that the 'window of opportunity' to address malnutrition and micronutrient deficiencies is before the child's second birthday.

Similar to all other countries, the economic status of the household influences the nutritional status of children. Children living in poor families have higher level of malnutrition compared with those from rich families. However, the TLDHS 2009-2010 suggests that malnutrition is a common problem in Timor-Leste, as the highest quintile also has high level of stunting, wasting and underweight (Figure 3.4. Note: Redlines are WHO thresholds for indicating a severe public health problem).

Malnutrition among districts is varied. With the exclusion of Aileu district, stunting prevalence is ranged between 43.9 per cent and 72.6 percent. Overall, all districts still have a very high stunting prevalence. Likewise, the prevalence of underweight in all districts is still defined as a severe public health problem according to the WHO threshold (Figure 3.5, see next page).

Figure 3.6 (see next page) using the indicator of stunting among children under five shows that boys have slightly higher malnutrition than girls. Children living in rural areas, or children whose mothers have lower education level, and/or children whose mothers are under-nourished are more likely to suffer from malnutrition.

Figure 3.3: Prevalence of malnutrition among children under-five years, by age

Source: TLDHS 2003, MoH; and TLDHS 2009-2010, NSD and ICF Macro.

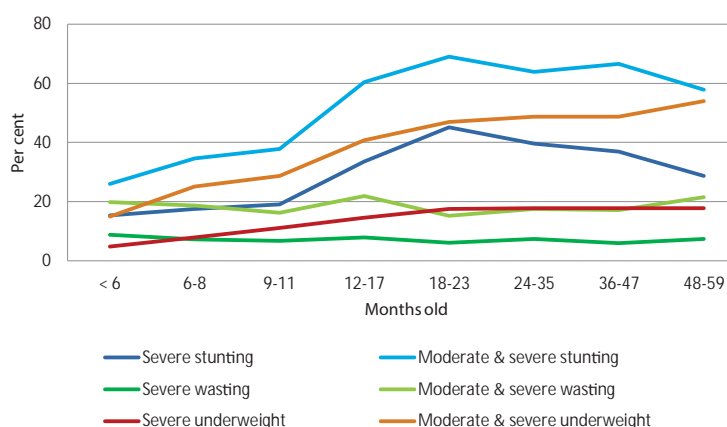


Figure 3.4: Undernutrition among children under-five years by socio-economic background

Source: TLDHS 2003, MoH; and TLDHS 2009-2010, NSD and ICF Macro.

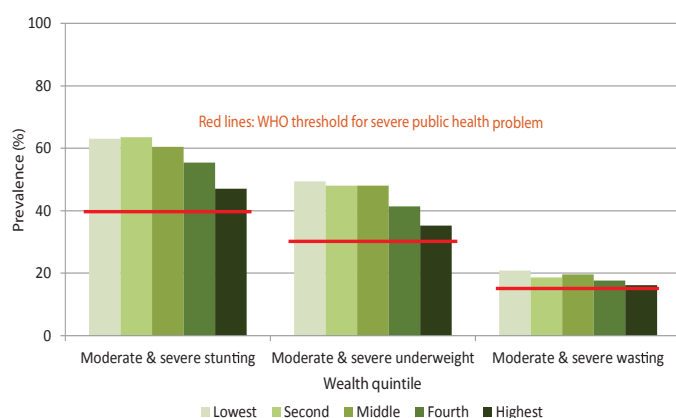
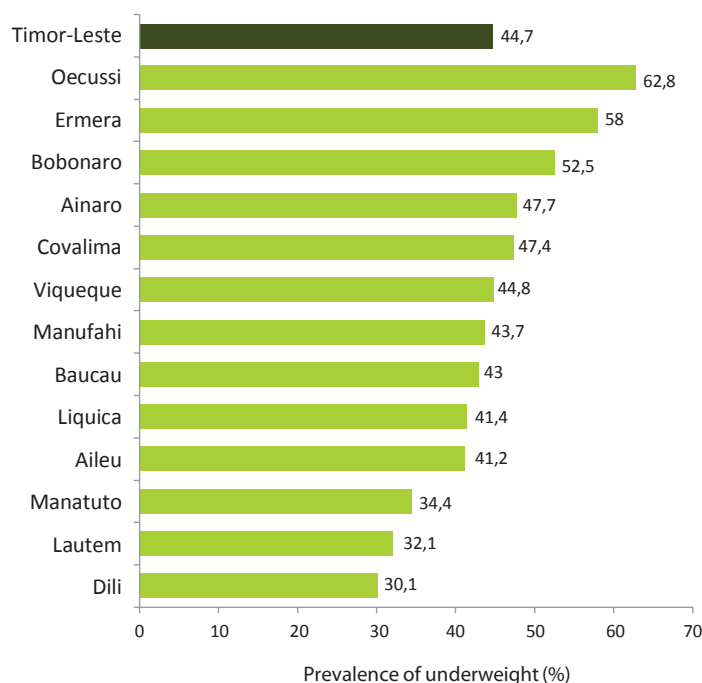


Figure 3.5: Prevalence of underweight by district

Source: HMIS 2010, MoH



3.2.2 Low birth weight

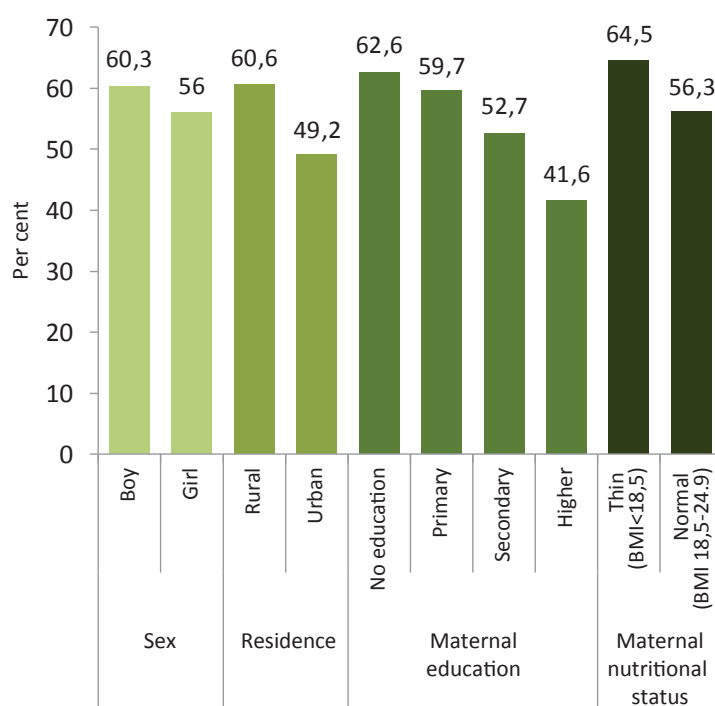
A child's birth weight or size at birth is an important indicator of the child's vulnerability to illnesses and the child's chances of survival. Children whose birth weight is less than 2.5 kilograms, or children reported to be "very small" or "smaller than average" are considered to have a higher-than-average risk of early childhood death.

Measurement of birth weight is still limited in Timor-Leste due to the low coverage of skilled birth attendance. Newborn weights and heights are not normally measured for children born at home.

Of the 26 per cent reported birth weight in the TLDHS 2009-2010, about 10 per cent of children were reported by their mothers to be smaller than average or very small at birth.

Figure 3.6: Prevalence of stunting among children under-5 years, by background characteristics

Source: TLDHS 2003, MoH; and TLDHS 2009-2010, NSD and ICF Macro.



3.2.3 Maternal nutrition

Nutritional status before and during pregnancy influences maternal and child health outcomes. Optimal child development requires adequate nutrient intake, provision of supplements as needed and prevention of diseases.

The high level of malnutrition among women perpetuates a vicious cycle of malnutrition leading to low birth weight and undernourished children. About 27 per cent of women in Timor-Leste have a BMI of less than 18.5,¹³⁶ 15 per cent have short stature and 21 per cent are anaemic, which perpetuate the cycle of malnutrition. In-depth analysis of the TLDHS 2009-2010 data (unpublished) revealed that mother's nutritional status was significantly associated with stunting among children regardless of urban or rural residence.

Children born to mothers with normal BMI (18.5 or higher) were less likely to be stunted, compared to children born to very thin mothers (BMI<18.5).¹³⁷

3.2.4 Micronutrient deficiencies

The high level of micronutrient deficiencies (particularly iron, vitamin A, zinc and iodine) among children and women in Timor-Leste is a determining factor in child mortality, morbidity and development. In 2009, more than one in three (38 per cent) Timorese children aged 6-59 months old and one in five (21 per cent) of Timorese women aged 15-49 years were detected with anaemia.¹³⁸

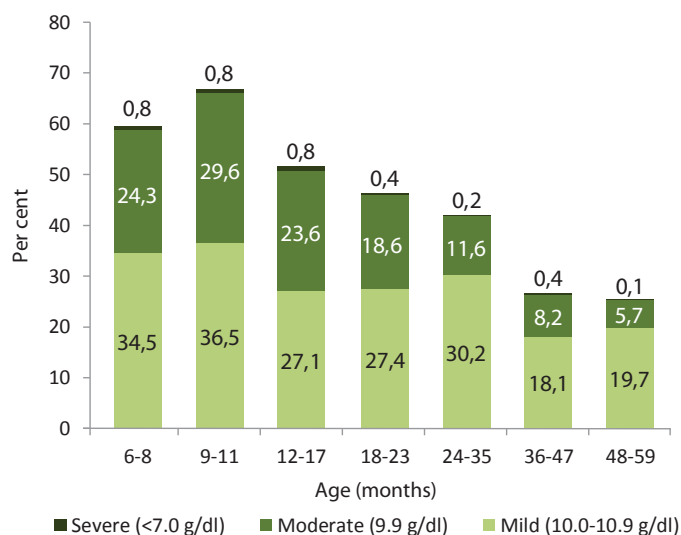
Iron-deficiency anaemia is an important underlying cause of maternal mortality, spontaneous abortion, premature birth and low birth weight, and poor school performance and lower intellectual quotient, especially among adolescent girls. It is caused primarily by inadequate dietary intake of iron, folate, vitamin B12, or other nutrients but can also result from malaria and parasitic intestinal infestation (e.g. hookworm, schistosomiasis and whipworm).

Among children with anaemia, 25 per cent had mild anaemia, 13 per cent had moderate anaemia, and less than 1 per cent had severe anaemia. The highest prevalence of anaemia among children was found in Manatuto district (68 per cent), and children in Ermera district have the lowest prevalence (15 per cent, Figure 3.7).

Among women, 17.5 per cent were mildly anaemic, 3.6 per cent were moderately anaemic, and less than 1 per cent had severe anaemia. Prevalence of anaemia was higher among pregnant women (28 per cent) than among lactating women (25 per cent) and women who were neither pregnant nor breastfeeding (19 per cent). The highest prevalence of anaemia was found in women with no education and from the lowest wealth quintile.

Figure 3.7: Percentage of children aged 6-59 months classified as having anemia

Source: TLDHS 2003, MoH; and TLDHS 2009-2010, NSD and ICF Macro.



3.3 Manifestations and causes of deprivation

Nutritional status is influenced by multiple factors with different levels of cause: immediate, underlying, and basic. The immediate cause of malnutrition is a result of a lack of dietary intake, or disease. This can be caused by consuming too few nutrients or an infection, which can increase requirements and prevent the body from absorbing those consumed. The interaction between malnutrition and infection creates a potentially lethal cycle of worsening illness and deteriorating nutritional status.

Whether or not an individual gets enough food to eat or whether s/he is at risk of infection is mainly the result of factors operating at the household and community level. These factors are classified as underlying causes, which can be grouped into three broad categories: food, care, and health. Optimal nutritional status results when children have access

to affordable, diverse, nutrient-rich food; appropriate maternal child-care and feeding practices; adequate health services; and a healthy environment including safe water, sanitation and good hygiene practices. The combination and relative importance of these factors to understanding the immediate and underlying causes of malnutrition in Timor-Leste is critical to delivering appropriate, effective and sustainable solutions and adequately meeting the needs of the most vulnerable people.

The third level factor contributing to malnutrition is basic causes. These refer to what resources are available (human, structural, financial) and how they are used (the political, legal and social factors).

3.3.1 Immediate causes

Inadequate dietary intake

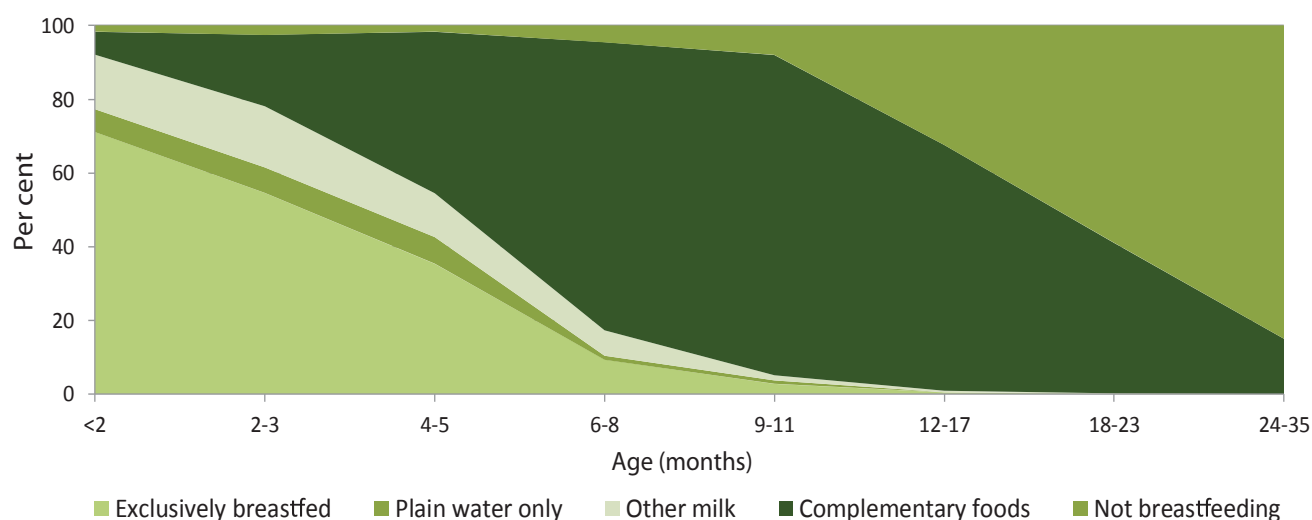
The TLDHS 2009-2010 showed that only 52 per cent of infants age 0-6 months are exclusively breastfed; and only 30 per cent of children age 6-23 months receive timely and appropriate complementary feeding (Figure 3.8).

TLDHS 2009-2010 reveals that nearly four-fifths (79 per cent) of last-born children aged 6-35 months consumed vitamin A rich foods, and 52 per cent of young children consumed foods rich in iron in the 24-hour period before the survey. Although there is an improvement in the coverage of vitamin A supplementation among children aged 6-59 months, it is still suboptimal where only 51 per cent of them received a vitamin A supplement in the six months before the survey. About 35 per cent of children aged 6-59 months received de-worming tablets in the six months preceding the survey.

Although the proportion of women who took iron supplements during pregnancy increased from 43 per cent in 2003 to 61 per cent in 2009-10, about 37 per cent of women did not take any iron supplements and only 16 per cent took the recommended dose for 90 days or more during their most recent pregnancy. In addition, 13 per cent of women received deworming medication during pregnancy, 31 per cent received supplementary food while pregnant with their last birth, and 29 per cent received supplementary food while breastfeeding their last-born child.

Figure 3.8: Infant feeding practices by age

Source: TLDHS 2003, MoH; and TLDHS 2009-2010, NSD and ICF Macro.



High prevalence of childhood illnesses

The TLDHS 2009-2010 reported 19 per cent of children under-5 years of age having had fever in the two weeks preceding the survey. This works out to each child having between 4-5 episodes of fever each year.

The incidence of diarrhoea among children under-five two weeks preceding the TLDHS 2009-2010 was 16 per cent. This, on average, is equal to each child having about four episodes of diarrhoea each year. The prevalence of Acute Respiratory Infection (ARI) in the TLDHS 2009-2010 was estimated by asking mothers whether their under-5 years age children had cough accompanied by short, rapid breathing, symptoms considered compatible with pneumonia during surveys.

The prevalence of pneumonia in the two weeks preceding the survey was 2 per cent. This, on average, is equal to each child having one episode of pneumonia every second year.

True incidence of ARI (fever plus cough) could be much higher. Malnutrition undermines the functioning of the immune-response mechanisms and lowers the body's ability to resist infection. This leads to longer, more severe and more frequent episodes of illness and these illnesses drain the nutrition status further aggravating malnutrition.

When a malnourished child falls ill the malnutrition worsens. Children who enter this malnutrition-infection cycle can quickly fall into a potentially fatal spiral as one condition aggravates the other.

3.3.2 Underlying causes

Household food insecurity

The TLSLS 2007 identified 72.9 per cent of households with “at least one month of low food consumption” and that the number of months in a year with low food consumption averaged 3.2 months.¹³⁹ A comprehensive vulnerability analysis and mapping conducted in 2005/06 revealed that nationally, 20 per cent of households are considered to be food insecure, 23 per cent to be highly vulnerable, 21 per cent to be moderately vulnerable, and 36 per cent to be food secure.¹⁴⁰

The food security situation has improved in recent years with efforts by the government to develop agriculture and provide subsidized rice. However, climate changes and frequent heavy rainfalls that resulted in flooding and landslides significantly affected agricultural production. During May to June 2013, a total 1,551 families in Covalima, Ainaro, Viqueque and Baucau districts were affected by the flooding and received food and non-food support from the MSS.¹⁴¹

Low level of knowledge and skills of care providers and families and poor caring practices for children and mothers

The TLDHS 2009-2010 reported 52 per cent of infants 0-6 months being exclusively breastfed and 30 per cent of children aged 6-23 months being fed according to the recommended infant and young child feeding practices. Multivariate regression analysis of the TLDHS 2009-2010 data (unpublished) showed that timely initiation of breastfeeding was significantly associated with a child's stunting status. Children who were put to

mother's breast within one hour of birth were less likely to be stunted in early childhood, compared to children who were put to breast later.

The association was consistent in both urban and rural areas. The analysis showed that in rural areas, children of average or above average size at birth were less likely to be stunted later, compared to children whose size at birth was below average.

While 82 per cent of newborns are breastfed within the first hour of birth and 96 per cent within the first day, 13 per cent are given harmful pre-lacteal feed in the first three days of life. An estimated 71 per cent of children with ARI symptoms, 60 per cent children with fever and 72 per cent with diarrhoea were taken to a healthcare provider; but only 10 per cent of children who suffered from diarrhoea were provided adequate fluids during the diarrhoeal episode; 12 per cent of them were given no fluids at all during the diarrhoeal episode; and only 7 per cent were given increased fluids and continued feeding as recommended.

Low level of knowledge and skills of care providers and families contribute to the feeding and care practices, and health seeking behaviours of caregivers. When caregivers do not have adequate information, knowledge and skills the child is deprived of care, suffers growth faltering and the consequences of low resistance to infection. Sub-optimal level of exclusive breastfeeding, inappropriate complementary feeding, inadequate home health care and care seeking during illness reported above indicate that the level of knowledge, awareness, and understanding of the importance of good nutrition are inadequate.¹⁴²

An educated mother is known to have better control of resources, higher ability to acquire knowledge and skills and translate them into self-care and care for their children, which are important determinants of good nutritional status. The TLDHS 2009-2010

reported that 32 per cent of Timorese women are illiterate. Stunting among children is higher (62.6 per cent) among those whose mothers are illiterate as compared to the national average (58.1 per cent). Women with secondary and higher level of education are less likely to be short compared to women who have no education.

Women are the primary nutrition caregivers in households and how they carry out nutrition related activities and control resources are determinants of both their nutritional status and of those under their care. Timor-Leste is reported to have "strong remnants of the traditional patriarchal system."¹⁴³ The patriarchal society grants lower status to women who are discriminated against in relation to the ownership of assets and participation in making decisions affecting their lives and those of their children.

Insufficient human resource for nutrition

There is insufficient capacity development and persisting gaps exist at all levels. Nutrition programme managers are mostly graduated from high schools with no nutrition preparation during their schooling year. Thus, continued efforts are required to strengthen nutrition capacity through pre-service education to produce qualified nutritionists as well as in-service trainings to orient and build upon current capacity on nutrition programming.

Inequitable access to and utilization of care and essential nutrition services, as well as preventive and promotive health services

Vitamin A supplementation is 44 per cent among the poorest and 59 per cent among the richest. Similarly, deworming medication among the poorest and richest group of children were 27 per cent and 47 per cent respectively.

Utilization of appropriate treatment for diarrhoea and fever remains low across all quintiles. Antenatal Care (ANC) offers an opportunity for providing nutrition interventions but has less than optimal coverage with the four recommended ANC visits being at 55 per cent.

Child immunization, the most widely accepted preventive health intervention, is fully completed by only 52.6 per cent of children aged 12-24 months.

Inadequate environmental conditions

Lack of access to safe water, poor sanitation and the unhygienic handling of food have significant implications for the spread of infectious diseases, notably diarrhoea and ARI which drain the nutritional status of children. An estimated 14 per cent of urban and 45 per cent of rural households have no toilet facilities, and less than 50 per cent of households reported hand washing after defecation.

Low sanitation coverage and high level of malnutrition in rural areas of Timor-Leste corroborates the symbiotic relationship between diarrhoea and malnutrition which in turn has a strong relationship with stunting; 25 per cent of all stunting in 24-month-old children is attributable to having five or more episodes of diarrhoea.

3.3.3 Basic causes

Poverty

Timor-Leste's MDG report 2010¹⁴⁴ reported a national poverty rate of 49.9 per cent in 2007 with a 26 per cent decline in average consumption. The TLDHS 2009-2010 reported higher prevalence of stunting among poorer households (63 per cent) as compared to the richer households (47 per cent),

and women in the highest wealth quintile are less likely to be below 145 cm than women in the lowest wealth quintile (8 and 17 per cent respectively).

Poverty limits access to adequate and nutritious food and also reduces access to other resources and choices needed for providing adequate care for children and women, such as home health care, access to health care, environmental sanitation etc.

High food prices, inflation and diminishing buying power of the poor

Timor-Leste is dependent on food imports and this dependency exposes Timorese people to the impact of global food price increases, making the imported food unaffordable to poor families. Inflation, as measured by the consumer price index, was as high as 13.5 per cent in 2011 and 11.8 per cent in 2012.¹⁴⁵

Nutrition financing

Spending in the overall health sector appears to be inadequate, in terms of both amount and quality, to meet the heavy challenges faced by the sector (please refer to section 2.3.3 for more details). The absence of earmarking for nutrition interventions and the line-item budget structure does not allow isolating and tracking of expenditure on nutrition.

Inadequate policy and programmes addressing the burden of malnutrition

There is a strong stated national commitment but there is as yet no explicitly defined National Nutrition Policy. The 2004 National Nutrition Strategy was not costed and the national budget does not have a nutrition specific budget line. There is as yet no breast-feeding policy that guarantees food security

for the 0-6 months old Timorese. Timor-Leste is yet to adopt a code for marketing of breast milk substitute that safeguards breast-feeding. There is no mechanism to monitor imported salt and there are no law and regulation regarding the production, importation and trade of salt, all essential for ensuring consumption of iodized salt. The country is dependent on food imports but is yet to have a programme to regulate food quality, including food fortification.

Inadequate nutrition information and management

Nutrition indicators routinely collected through the current Health Management and Information System are very limited and there are no linkages established between HMIS and the management information systems of other sectors such as agriculture and education. Nutrition information that allows monitoring of nutrition programmes to inform policy makers for decisions is not available and there is also an absence of nutrition surveillance and operational research.

Others basic causes

General isolation and lack of infrastructure, poor access to adequate irrigated farmland, and poor access to income generating activities outside of agriculture have been attributed as causes of food insecurity in Timor-Leste. The other basic causes of malnutrition are a) natural disasters adversely affecting crop yields; b) poor market access; c) rain-fed seasonal agriculture with inadequate food during the dry seasons; and d) rising unemployment that deprives families of income.

3.4 Opportunities for action

Interventions to reduce stunting should start well before pregnancy/conception, with the mother's prenatal care and nutrition, and continue up to when the child reaches the age of two years (Chart 3.1). The process of becoming a stunted child –called length growth faltering – begins in utero, up to two years of age. By the time the child is past two years of age, it is too late to undo the damage caused by malnutrition. The mother's health and nutrition status is, therefore, a crucial determinant of stunting in children.

Key opportunities for action include:

- **To increase nutrient intake by mothers and children by creating conducive policy and programming environment and by enabling mothers and families with knowledge and skills.**

This includes promoting micronutrient intake through micronutrient supplementation, food fortification and food-based approaches; and improving case detection and treatment for malnourished mothers and children through effective case follow up.

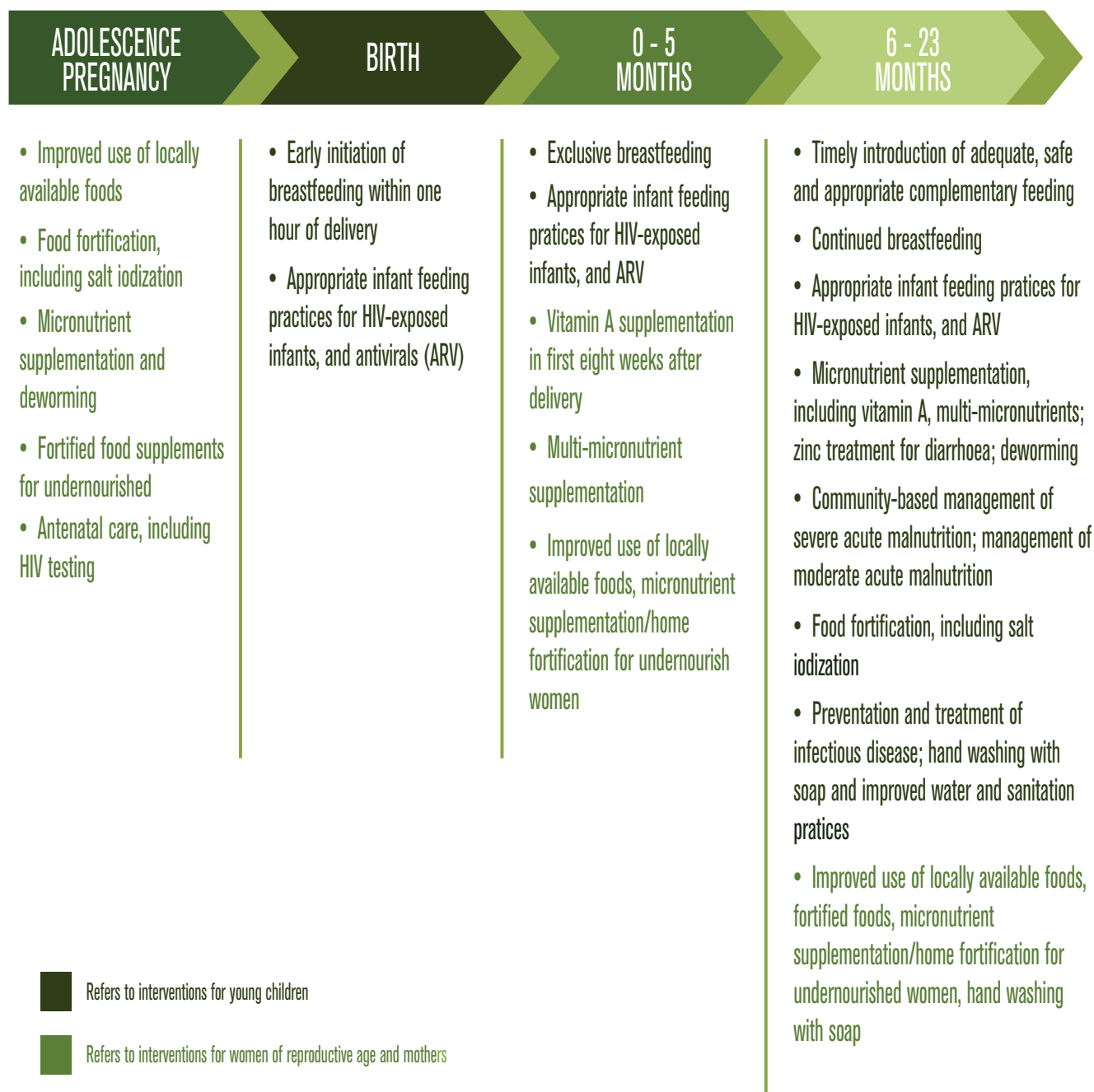
- **To improve home care practices and health care seeking behaviours to address determinants of women and children's nutritional status.**

The approach will be enhanced through strengthened community engagement in communication for behaviour change.

The interventions that need to be scaled up are: a) promoting safe motherhood; b) promoting community-led initiatives to improve home and community care for women and children;

Chart 3.1: Key proven practices, services and policy interventions for the prevention and treatment of stunting and other forms of undernutrition throughout the life cycle

Source: Adapted from Lancet Nutrition Series 2008 and 2010.



c) strengthening local capacity to improve maternal and child nutrition and food security education including health seeking behaviour and addressing food taboos; d) strengthening linkages between maternal and child nutrition with maternal reproductive health (i.e. birth spacing, fertility control, family planning, etc.); f) helminthic control; g) malaria, diarrhoea, pneumonia prevention and treatment; h) immunization; i) prevention and management of malnutrition associated with HIV/AIDS; and j) promoting linkages between nutrition and diet-related disorders/diseases, and other non-communicable diseases.

- **To improve food security at the household and community levels.**

This should be done by increasing the availability of food from animal sources at the household level; increasing consumption of animal foods by adolescent girls, young mothers and young children; enhancing opportunities for income earning for women, especially young mothers from the poorest households; increasing coverage of social protection schemes for children, adolescent girls and women from the poorest households and increasing overall and domestic food production.

- **To improve hygiene and access to water and sanitation.**

This should include ensuring that families, especially mothers and adolescent girls, use improved sanitation facilities, mothers and adolescent girls wash hands with soap, and families, especially mothers, adolescent girls and children under-5 drink treated water.

- **To promote optimal nutrition behaviour and practices at all levels through evidence-based nutrition social mobilisation and behaviour change communication.**

The areas of focus should be on developing a national nutrition communication strategy; influencing community norms for nutrition and health practices; developing and disseminating culturally appropriate nutrition and food security education materials; developing interpersonal and behaviour change communication skills of health workers, community volunteers and extension workers; and integrating nutrition education and messaging in education and other health and agriculture programmes.

- **To improve policies and capacity for multi-sectoral nutrition action.**

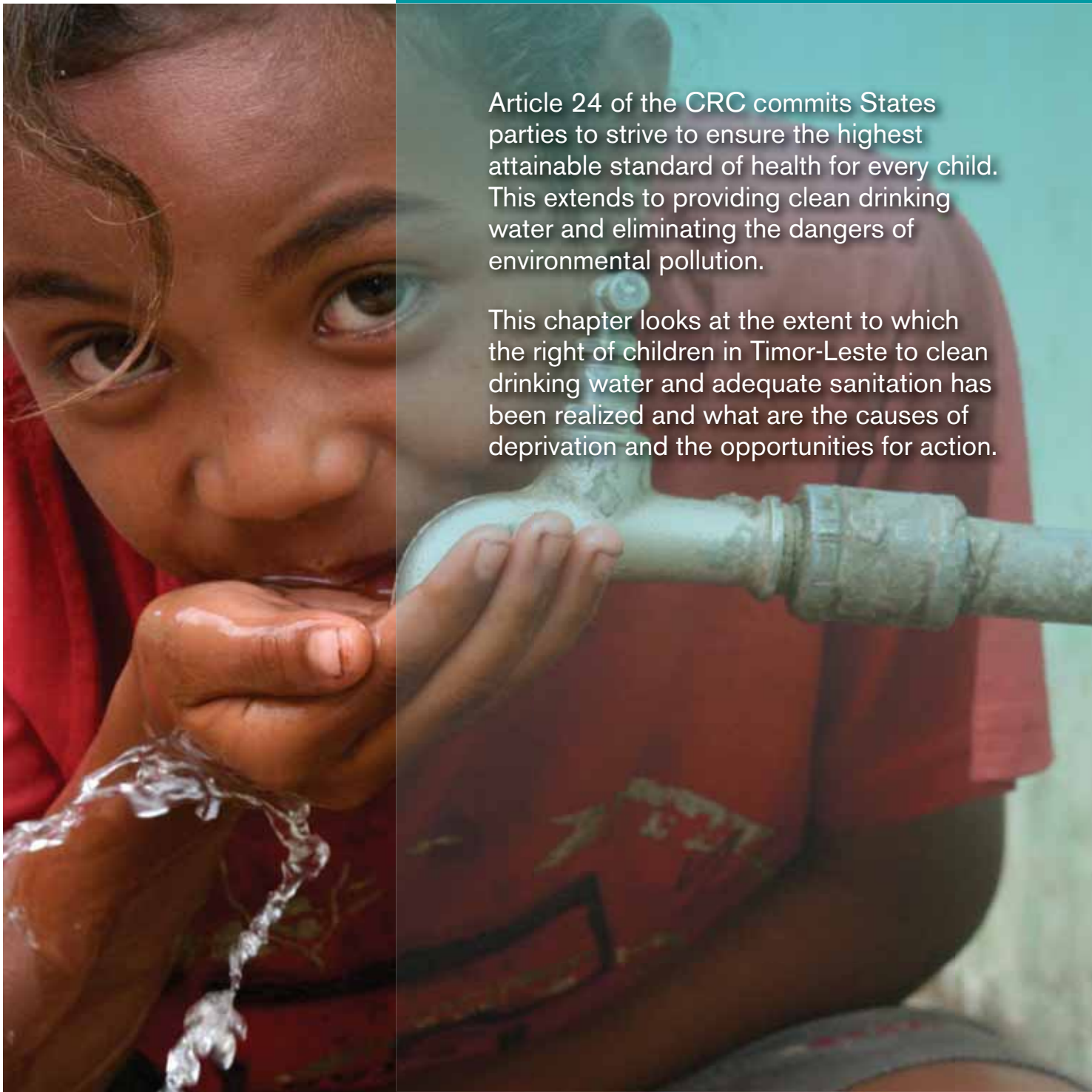
Specifically, this can be achieved by establishing, strengthening, and addressing the basic causes of malnutrition, including for example: establishing an effective multi-sector coordination mechanism; increasing investment in nutrition- specific and nutrition-sensitive interventions; putting in place institutional and legal frameworks as well as management structures; focusing on advocacy and coordination systems that integrate and mainstream nutrition and food security interventions across all relevant government sectors; improving nutrition-specific technical and management capacity; establishing nutrition surveillance; improving nutrition information management and increasing investment in nutrition. The information on the economic burden of malnutrition will support advocacy to increase budget allocations for nutrition interventions.

Footnotes in Chapter 3

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129. The estimation of the economic burden of malnutrition in Timor-Leste is currently being conducted by the MoH with the support of UNICEF and will be finalised by May 2014.
130. Democratic Republic of Timor-Leste and the United Nations System (2009) *The Millennium Development Goals Timor-Leste*, Dili: UNDP Timor-Leste.
131. MoED was abolished under the current government.
132. Ruel, M. T., Alderman, H. the Maternal and Child Nutrition Study Group (2013) 'Nutrition-sensitive interventions and programmes: how can they help to accelerate progress in improving maternal and child nutrition?', *The Lancet*, vol. 382, no. 9891, pp. 536–551.
133. Based on the press release of the Ministry of Health dated 18 November 2013 (unweighted data).
134. TLDHS 2003 data was recalculated using WHO Child Growth Standards (Source of converted/recalculated estimates: <http://www.who.int/nutgrowthdb/database/countries/tls/en/>).
135. Classification of nutrition indicators: Stunting: <20%: Low; 20–29%: Medium; 30–39%: High; ≥40%: Very high; Wasting: <5%: Low; 5–9%: Medium; 10–14%: High; ≥15%: Very high; Underweight: <10%: Low; 10–19%: Medium; 20–29%: High; ≥30%: Very high. WHO, Global Database on Child Growth and Malnutrition.
136. BMI Categories: Underweight (<18.5), Normal weight (18.5–24.9) and Overweight (25–29.9).
137. UNICEF (2011) *Determinants of Chronic Undernutrition among Underfive Children in Timor Leste: Findings of an indepth analysis using data from Demographic and Health Survey 2009–2010* (Draft), Dili: UNICEF Timor-Leste.
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4

Water, sanitation and hygiene

A close-up photograph of a young child with dark skin and hair, wearing a red shirt, drinking water from a public tap. The child's face is in the foreground, looking directly at the camera. The tap is a simple, weathered metal fixture. The background is slightly blurred, showing more of the child's face and the tap. The overall tone is warm and focused on the child's action of drinking water.

Article 24 of the CRC commits States parties to strive to ensure the highest attainable standard of health for every child. This extends to providing clean drinking water and eliminating the dangers of environmental pollution.

This chapter looks at the extent to which the right of children in Timor-Leste to clean drinking water and adequate sanitation has been realized and what are the causes of deprivation and the opportunities for action.

4.1 Overview

Safe drinking water, hygienic toilet facilities, and improved hygiene practices are important determinants of the health and wellbeing of children. Together they offer protection from diarrhoea and other water-borne diseases such as typhoid, cholera, dysentery, intestinal parasites and corresponding malnutrition. A clean living environment, including access to sanitary means for excreta disposal and adequate water supplies, reflects the overall living standards of the population and is linked to the dignity of families and communities.

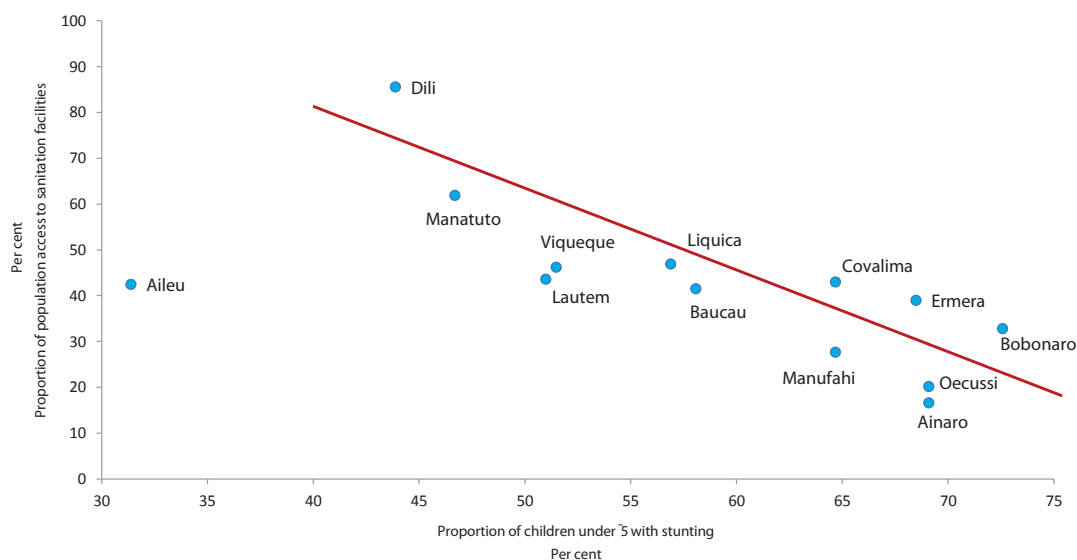
Unsafe water, poor sanitation and unhygienic conditions claim many lives each year. An estimated 1.2 million children die globally before the age of five from diarrhoea. In poor urban areas, where insufficient water supply and sanitation coverage combine with overcrowded conditions, the possibility of faecal contamination is maximised increasing the risk of spreading water-borne diseases including diarrhoea. In rural areas, widespread open defecation practices and the lack of awareness and practice of safe hygiene behaviours such as hand-washing with soap put the population at a high risk of faecal-oral diseases.

Low sanitation coverage and a high level of malnutrition in rural areas of Timor-Leste corroborate the symbiotic relationship between diarrhoea and malnutrition which in turn has a strong relationship with stunting (Figure 4.1).

As mentioned in the SDP 2011-2030, the economic consequences of poor sanitation on health, welfare services and tourism was the subject of a 2008 study of five neighbouring countries: Timor-Leste, Indonesia, the Philippines, Cambodia and Vietnam. This study shows an average loss of 2% of Gross Domestic Product across the five countries that could be recovered through improvements in sanitation alone. In Timor-Leste, this means that poor sanitation is costing at least US\$11 million every year – and rising as the economy expands. Other studies have shown that investment in sanitation is an investment in health, education, the environment and poverty reduction. Improved sanitation typically yields about \$9 worth of benefits for every \$1 spent, based on a reduction in direct and indirect health costs, better education, improved quality of water supply and increases in tourism.¹⁴⁶

Figure 4.1: Relationship between stunting and access to sanitation facilities

Source: TLSLS 2007, NSD, and TLDHS 2009-2010, NSD and ICF Macro. *Note: The stunting data for Aileu District in the TLDHS 2009-2010 is questionable.



4.1.1 WASH programming context

“A vitally important element in the economic and social development of Timor-Leste – and in the health and wellbeing of our people – is access to safe drinking water and sanitation systems.”

- SDP 2011-2030

The SDP 2011-2030 clearly states the short, medium and long-term targets for improvement of access to safe drinking water and sanitation facilities in Timor-Leste.

There is growing recognition that access to and utilisation of WASH facilities must be improved for achieving the MDG targets with equity. The government announced its commitment to prioritising water and sanitation and increasing funding for the sector at a high level meeting held in Washington in 2010. Since then, water supply infrastructure has been a priority supported by the national Infrastructure Fund.

The National Water Supply Policy, formulated by the National Directorate of Water Supply Services (Direcção Nacional Serviços de Águas – DNSA) in the Ministry of Public Works (MoPW), is being finalised. The draft is being reviewed by stakeholders and will be submitted shortly to the Council of Ministers for approval. With support from the AusAID funded Community Water Supply and Sanitation Project (BESIK), the MoH has drafted the National Strategic Sanitation Development Plan for 2013-2020 in line with the SDP 2011-2030 and the National Basic Sanitation Policy of Timor-Leste 2012. The strategic sanitation plan aims to achieve an ODF Timor-Leste by 2020 by scaling up the CLTS approach to create demand for improved latrines.

The strategic plan, which is known as PAKSI (Planu Asaun Komunitade - Saneamentu no Ijiene) in Tetun language is a comprehensive package that includes ODF community, improved sanitation, improved hygiene, liquid waste management and solid waste management. The plan also entails a provision of a sanitarian in every sub-district for community mobilization and progress monitoring. Currently BESIK is supporting a pilot of the programme with 15 sanitarians in 3 districts. The MoH has plans to support an additional 15 sanitarians in 2014.

Chart 4.1: Targets for improvement of water and sanitation facilities in the SDP 2011-2030

Targets

By 2015:

- The MDG of 75% of Timor-Leste's rural population having access to safe, reliable and sustainable water will have been exceeded
- Improved sanitation facilities will be available in 60% of district urban areas
- The improved operation and maintenance of the Dili drainage system will result in a cleaner city and reduced flooding

By 2020:

- All government schools will be connected to clean piped water
- There will be appropriate, well operated and maintained, sustainable infrastructure for the collection, treatment and disposal of sewage in Dili
- Drainage will be improved in all districts

By 2030:

- All sub-districts will have improved drainage systems
- All districts and sub-districts will have appropriate sewerage systems

There are two coordination mechanisms currently in place: the WASH Forum and the Sanitation Working Group. The WASH Forum deals with information sharing and exchange of ideas on water supply in communities and institutions, water quality and emergency preparedness and response. It also addresses issues around community management of water systems, and subsequent government support. The Sanitation Working Group focuses on rural sanitation and hygiene. These groups are respectively led by the National Directorate of Water Supply and the National Directorate of Basic Sanitation.

Given the number of stakeholders and duty bearers in the sector, the WASH Forum and Sanitation Working Group promotes synergies between programmes and interventions. Three government ministries (viz. education, health and public works) are responsible for different aspects of water, sanitation and hygiene in communities, schools and health institutions. The Ministry of State Administration (MSA) also implements small-scale water projects in rural communities under the Decentralised Development Programme (PDD). Key development partners in the WASH sector are: UNICEF, AusAID, National Red Cross (CVTL), ADRA, Plan International, Triangle GH, World Vision, SHARE, WaterAid, and Oxfam. In addition, several national NGOs provide critical linkages with communities.

4.1.2 Key achievements

Timor-Leste is on track to achieve the MDG target to “Halve, by 2015, the proportion of people without sustainable access to safe drinking water”. According to the 2010 Census, 66 per cent of households had access to clean drinking water in 2010. The global Joint Monitoring Programme (JMP) for water and sanitation estimated that by 2011, 69 per cent of the population in Timor-Leste had access to safe drinking water, a 15 percentage points increase since 2000 (54 per cent).¹⁴⁷

This achievement in the water sector is due to an increased focus on water supply with additional investment and a gradual improvement in the institutional capacity to implement the national plan, standards and guidelines (especially for rural water supply). Over the last four years almost 25 per cent of rural people gained access to improved water sources through new or rehabilitated water systems. However a key challenge is the ongoing maintenance of these water systems.

4.2 Key issues – status, progress and disparities

4.2.1 Access to safe and improved drinking water

Timor-Leste is on track for achieving the MDG target on improved drinking water, but significant disparities exist between urban and rural areas, and among districts and sucos. According to the 2010 Census, 66 per cent of households had access to an improved drinking water source. An encouraging 91 per cent of urban households had access to drinking water.

However, this figure was considerably lower in rural areas with only 57 per cent of households having access to an improved water source.

Improved sources of water include piped water supply within homes, public taps or standpipes, tube-wells or boreholes, protected dug wells, protected springs and rainwater.

Figure 4.2 (see next page) shows that among 13 districts, only half of them achieved the national average (66 per cent) or above. Dili, the capital city, had the highest level of access to improved drinking water (95 per cent), far higher than Baucau, which had the lowest coverage (39.8 per cent).

One-fifth of sucos have less than 30 per cent of households with access to safe drinking water (Figure 4.3, see next page).

The WHO/UNICEF JMP Update 2013, based on a range of surveys, estimated that at the end of 2011, 69 per cent of the population were using an improved water source (piped onto premises and other improved source), 93 per cent in urban areas

Figure 4.2: Proportion of access to improved drinking water by district

Source: Timor-Leste Population and Housing Census 2009-2010, NSD and UNFPA.

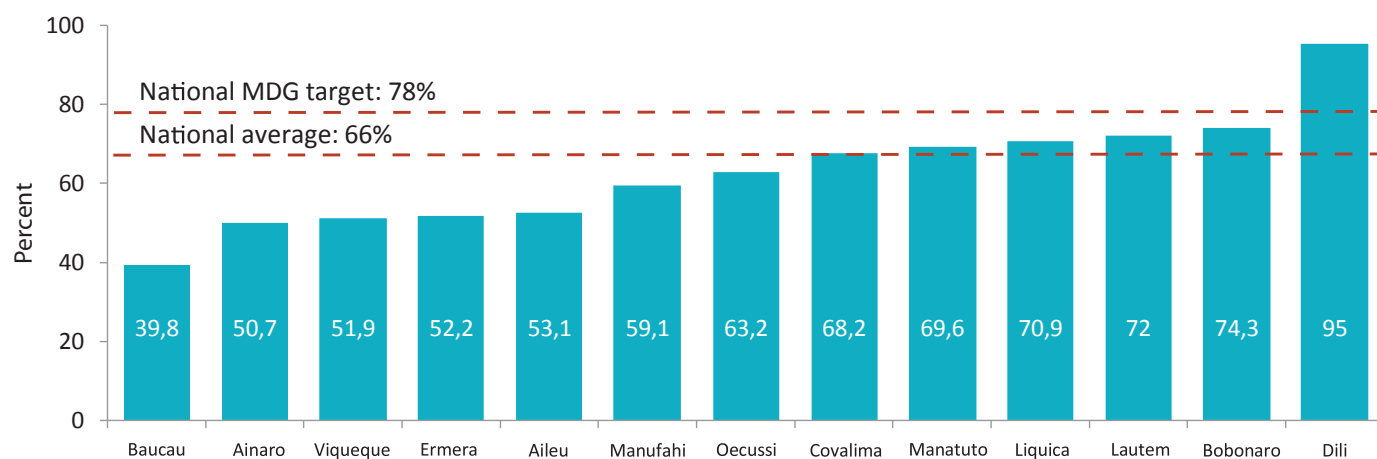
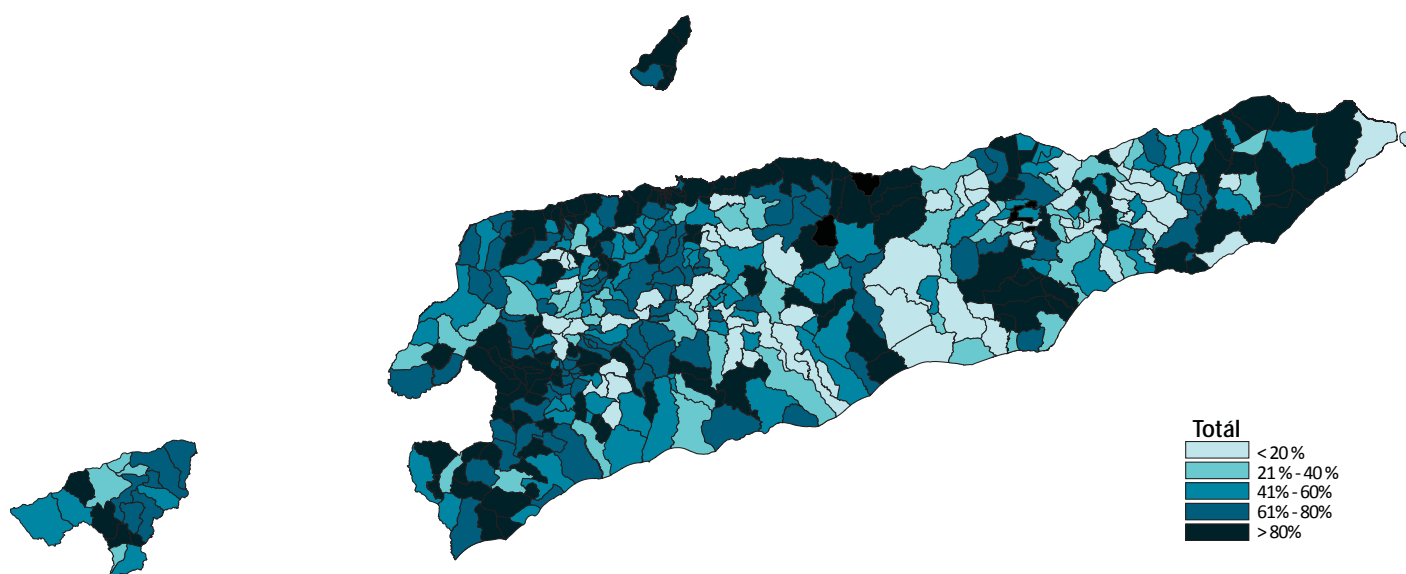


Figure 4.3: Proportion of households with access to improved water sources by suco

Source: Timor-Leste Population and Housing Census 2009-2010, NSD and UNFPA.



and 60 per cent in rural areas (Figure 4.4). The JMP data shows an overall increase in the coverage of improved drinking water by 15 percentage points from 2000 to 2011, 24 per cent increase in urban areas and 10 per cent in rural areas.

Figure 4.5 shows the types of drinking water sources of households in both urban and rural areas from the 2010 Census.

4.2.2 Access to improved sanitation facilities

Timor-Leste is off-track to meet the target on sanitation. The 2010 Census shows only 39 per cent of households had accessed to improved sanitation facilities, an increase of merely 2 percentage points since 2000. This clearly illustrates the lack of progress in sanitation.

Improved sanitation facilities include latrine with slab, Ventilated Improved Latrine (VIP) and pour/flush to septic tank/pit. According to the JMP definition, if these latrines are shared by more than one family, they cannot be counted as improved latrines.

There are clear disparities between rural and urban areas and among the districts in terms of access to improved sanitation facilities.

According to the JMP 2013, only 27 per cent of rural households had access to an improved sanitation facility in 2011, meaning that Timor Leste will miss the MDG target by double digit percentage points (the MDG target for rural sanitation is 60 per cent). Given that 70 per cent of the population reside in rural areas, access to water and sanitation becomes a particularly critical development issue for Timor-Leste. For the large number of rural children in particular, it suggests greater vulnerability to diarrhoea, intestinal worm infections and a number of other water-borne diseases as well as drudgery in fetching water.

Figure 4.4: Drinking water ladders by urban and rural

Source: JMP 2013, WHO & UNICEF.

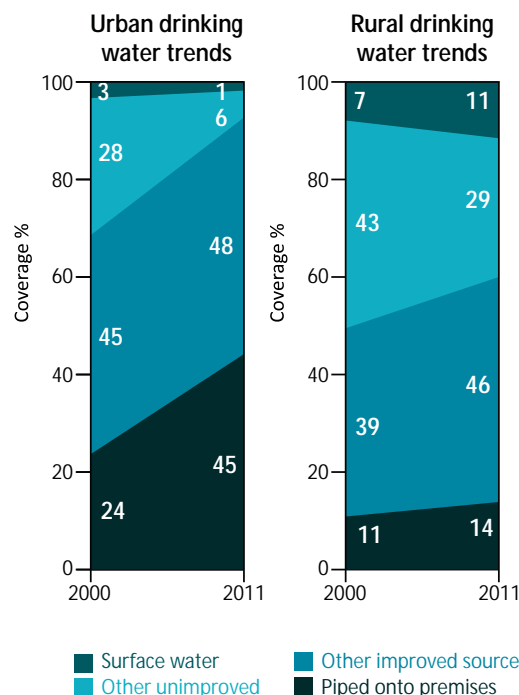


Figure 4.5: Type of drinking water in urban and rural areas (%)

Source: Timor-Leste Population and Housing Census 2009-2010, NSD and UNFPA.

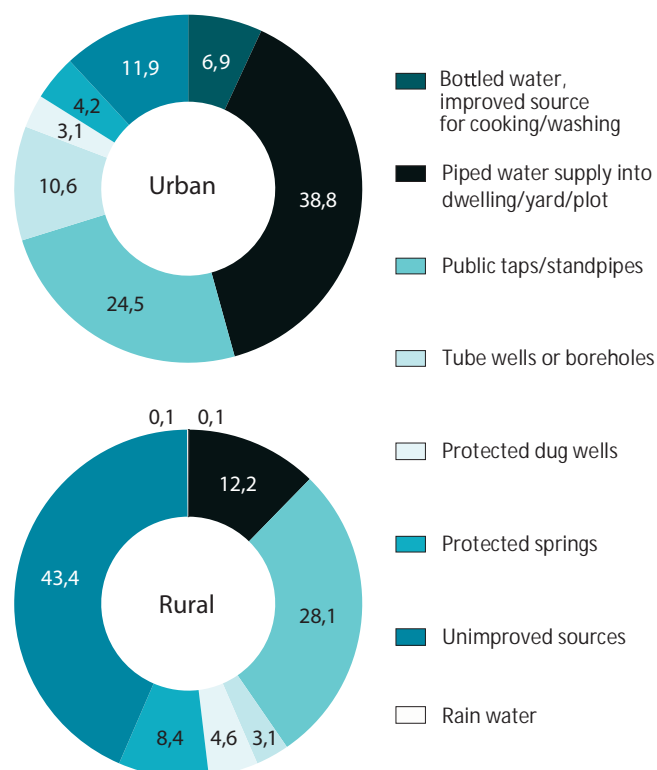


Figure 4.6: Proportion of household access to improved sanitation facilities by district

Source: Timor-Leste Population and Housing Census 2009-2010, NSD and UNFPA.

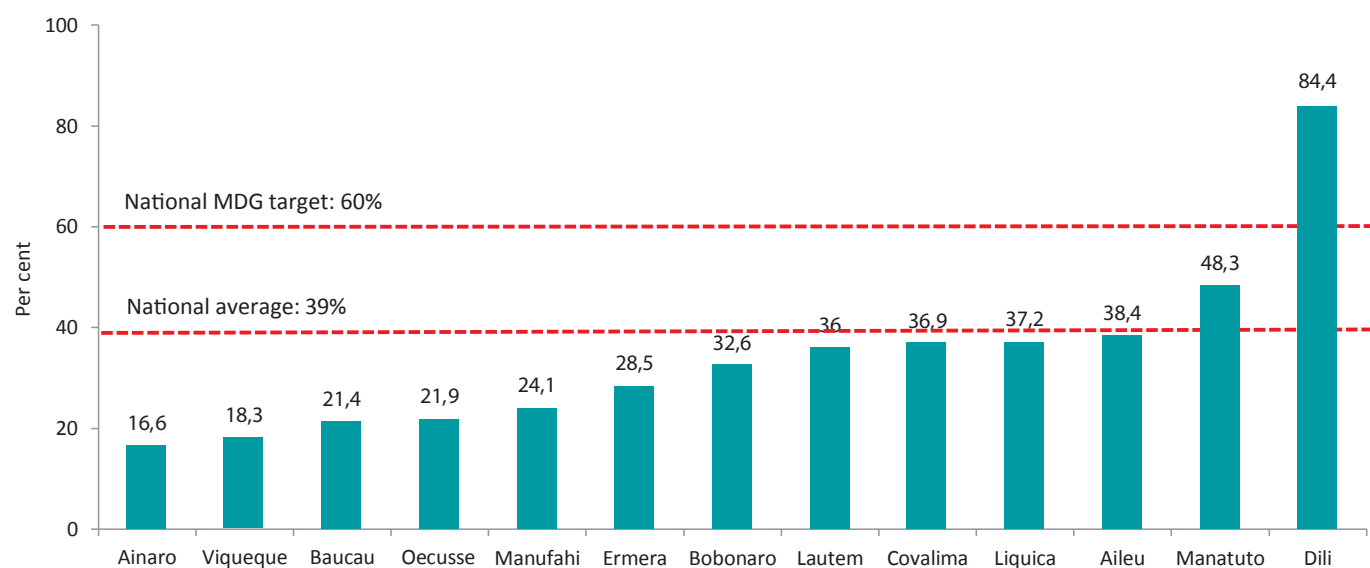
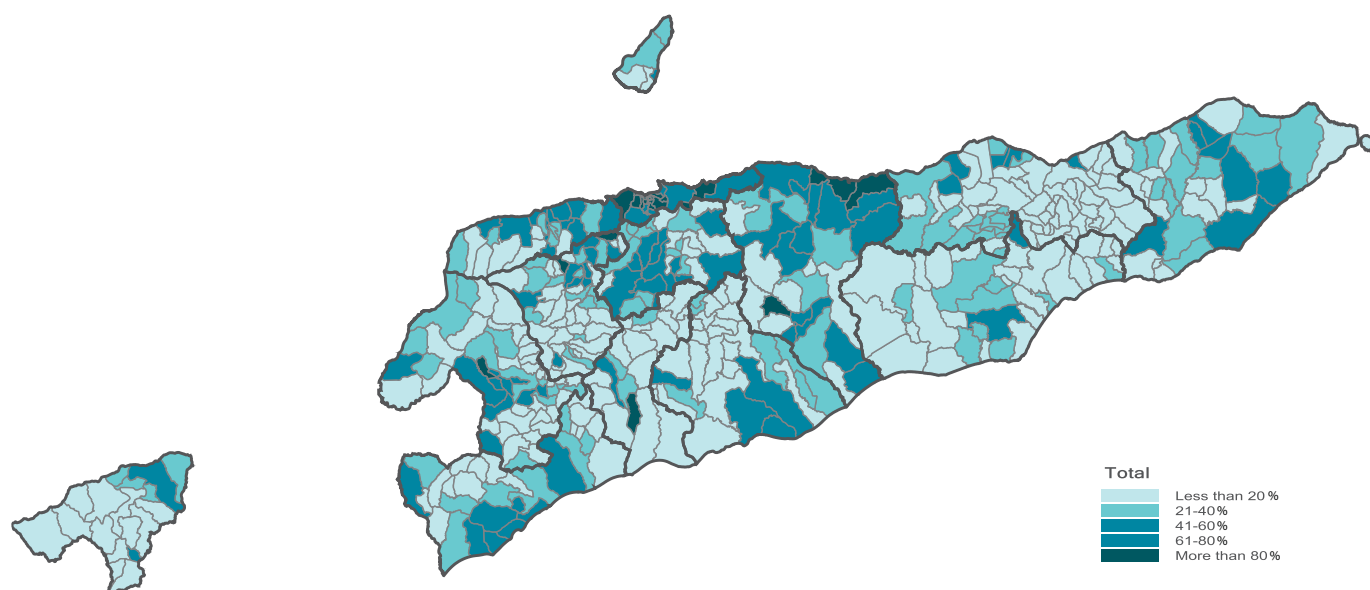


Figure 4.7: Proportion of household access to improved sanitation facilities by suco

Source: Timor-Leste Population and Housing Census 2009-2010, NSD and UNFPA.



The urban-rural and inter-district disparity is striking for access to sanitation. In 2010, only Dili and Manatuto had access to improved sanitation facilities above the national average (39 per cent) and only Dili achieved the national MDG target (Figure 4.6). All urban locations have access to improved sanitation above 50 per cent (except for Ainaro, Ermera and Manufahi district towns), whilst none of the rural areas, with the exception of peri-urban areas of Dili, have access above 40 per cent. In the most remote districts in the country, such as Ainaro, Baucau, Manufahi, Oecusse and Viqueque improved sanitation coverage is below 15 per cent. In over 90 per cent of sucos access to sanitation facilities remains below 20 per cent (Figure 4.7).

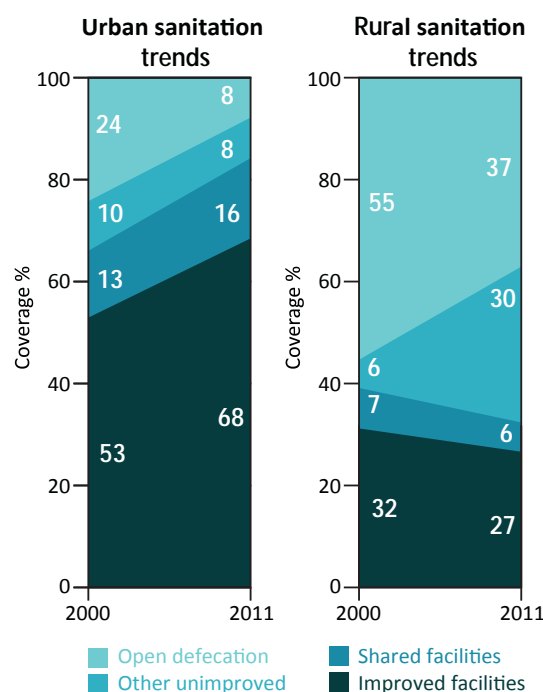
The 2013 JMP update demonstrated a decrease in the rural population's access to improved sanitation in comparison to 2000 (Figure 4.8). This is due to the practice of hanging toilets used by an estimated 27.5 per cent of households. Hanging toilets are not considered improved sanitation facilities as they do not prevent faecal materials from entering into the environment and can also be a major source of contamination of surface and ground water. It is also worth noting that **8 per cent of urban households and 37 per cent of rural households still practice open defecation**. This pollutes the environment and is a major cause of infectious diseases affecting children's health, such as diarrhoea.

4.2.3 WASH in schools

Schools with quality WASH programmes can effectively reduce the transmission of diseases. More than 40 per cent of diarrhoea cases in school children result from transmission in schools rather than homes. Worm infestations among school children are another major barrier for children to reach their full potential in education and beyond.

Figure 4.8: Sanitation ladders, urban and rural

Source: JMP 2013, WHO & UNICEF.



Chronic hookworm infestations are associated with reduced physical growth and impaired intellectual development. Children enduring intense infestations with whipworm miss twice as many school days as their infestation-free peers.

WASH in schools increases school attendance and learning achievement. It also promotes gender equality and equity. Issues relating to managing menstrual hygiene cause many girls to be absent from school, frequently a first step towards dropping out altogether.

Schools in Timor-Leste lack adequate WASH facilities. Nearly half (46 per cent) of the 1,259 primary schools in Timor-Leste do not have access to improved water sources and 35 per cent lack basic sanitation facilities (Figures 4.9 and 4.10, see next page).

Figure 4.9: Number of schools having access to water on a weekly basis

Source: Democratic Republic of Timor-Leste (2012) National Stocktake of School Facilities and Equipment in Basic Education Schools in Timor-Leste, Dili: Ministry of Education.

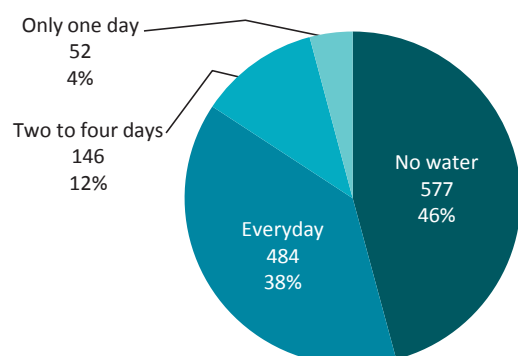
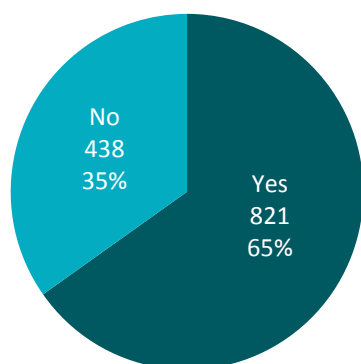


Figure 4.10: Schools with toilets

Source: Democratic Republic of Timor-Leste (2012) National Stocktake of School Facilities and Equipment in Basic Education Schools in Timor-Leste, Dili: Ministry of Education.



Only about 38 per cent of schools regularly have water in the toilets, which indicates that facilities to support cleaning of toilets and personal hygiene are limited.

Even though information on sanitation and personal hygiene is covered in classes, practicing safe hygiene behaviours like hand washing with soap is compromised by lack of enabling factors such as wash basins with running water and availability of soap. Less than 22 per cent of toilets built in the past are appropriate for children with physical disability, i.e. access by wheelchair.¹⁴⁸

4.2.4 WASH in health facilities

Health posts, a critical access point for primary health care for Timorese populations, are also suffering from a predicament similar to the rest of the community. According to the MoH, over 50 per cent of health posts lack access to clean running water supply. Those health posts with a water connection report the service is often unreliable and inadequate. The majority of the health posts have latrines but in the absence of running water latrines are either unused or filled with sludge and not in a usable condition.

None of the rural health posts have en suite facilities in the delivery unit to facilitate use of toilet and hygiene facilities by delivering mothers. In the absence of running water, sanitary latrines and hand washing facilities, the efficacy of health facilities is heavily compromised. The minimum standard for health posts requires 24-hour access to clean running water, sanitary toilets and hand washing facilities for staff and patients. The lack of these services increases the risk of hospital-induced infections. This is one of the contributing factors for high infant and maternal mortality rates in Timor-Leste.

4.2.5 Water quality

Microbiological contamination of water is a major source of health problems for people in Timor-Leste, and a recent study suggests some degree of chemical contamination as well. A WHO supported study of water quality in four districts of Timor-Leste (viz. Lautem, Covalima, Aileu and Dili) in 2009-2010 found that 70 per cent of the sources of water were microbiologically contaminated and some had nitrate content above the permissible limit. Fluoride concentration was within limits and arsenic was not detected.¹⁴⁹

More than 50 per cent of the water sources surveyed had slightly higher concentrations of fluorides but the levels were within the WHO limit. The prevalence was higher in Aileu and Dili districts. High concentration of fluoride contributes to pitting of teeth and severe skeletal problems including crippling fluorosis, severe anaemia, stiff joints and restricted movement.¹⁵⁰ The water quality study highlighted the need for regular monitoring of water quality, especially routine bacteriological testing of water for quality monitoring and promotion of household water treatment and safe storage along with hygienic practices for preventing water-borne diseases. In addition there is a need for strict implementation of Water Safety Plans (WSP) in order to prevent contamination of water at the source, during conveyance and at the point of use.

4.2.6 Indoor pollution and environmental issues

The risk from indoor pollution to children's health is increasingly being recognised as an important issue in Timor-Leste. About 95 per cent of households in the country and nearly all rural households use wood as cooking fuel. The smoke from fuel wood used with stoves without chimneys or hoods within closed spaces is particularly detrimental to the health of women and children, and increases the risk of respiratory illnesses (Figure 4.11).

This method of cooking is not energy efficient or environmentally friendly. It contributes to degradation of forest cover, poor recharge of water sources and places an additional burden on children and women who often perform the task of gathering fuel wood. According to the 2010 Census, 165,423 out of 184,652 households in the country (90 per cent) use wood for cooking (Figure 4.12).

Figure 4.11: Indoor pollution

Source: TLDHS 2009-2010, NSD and ICF Macro.

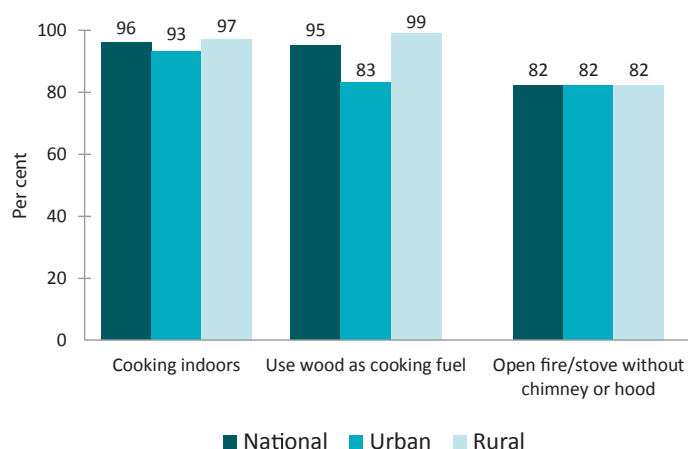
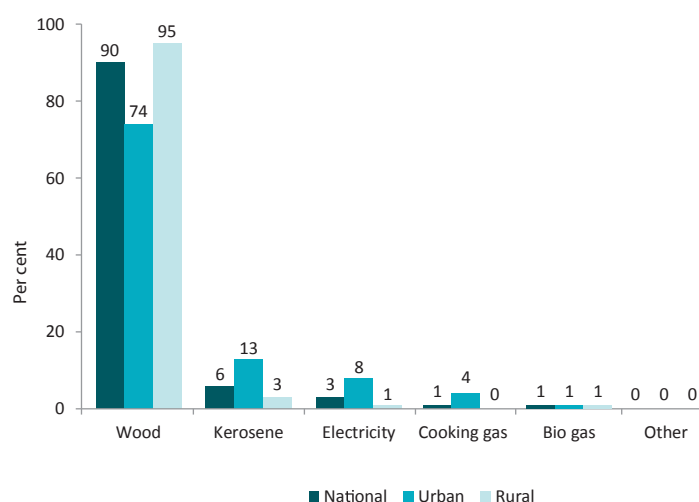


Figure 4.12: Energy sources used for cooking by households

Source: Timor-Leste Population and Housing Census 2009-2010, NSD and UNFPA.



4.2.7 Utilisation of water and sanitation facilities and hygiene behaviours

Unhygienic practices combined with inadequate access to safe drinking water and unsanitary conditions in homes, schools and other public facilities have adverse impacts on children.

They are susceptible to water-borne diseases and worm infestation, which in turn produce nutritional deficiencies, anaemia and undermine their growth. While they are sick or too busy fetching water, they are likely to miss school, rest and recreation. Girls, especially older girls, who have reached the age of menarche, are often reluctant to stay in school when toilet and washing facilities lack privacy, are unsafe or non-existent. Even when children are in school they are often not meeting their learning potential due to chronic bacterial infections (environmental enteropathy), which also have a major impact on the body's ability to absorb nutrients, causing stunting and retarding mental development.

Protection of water sources, construction of latrines away from water sources, use of toilet facilities (stopping open defecation), practicing safe hygiene behaviours such as hand washing with soap and safe storage and treatment of water prior to drinking are effective preventatives of microbiological contamination.

Water treatment

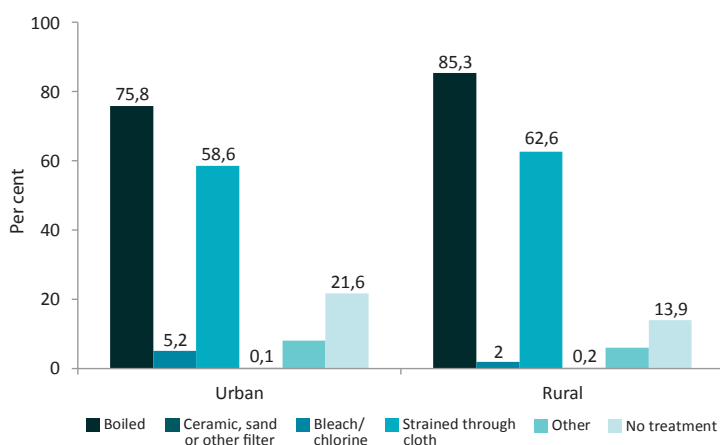
According to the 2010 Census about 43 per cent of rural population obtain water from non-improved sources, and most of them rely on unprotected springs. Although water treatment prior to drinking is reportedly fairly common with 77 per cent of households treating water (boiling, bleaching, straining, filtering or solar deflection) before drinking, about 14 per cent of the rural population still do not treat water before drinking (and contamination often happens after treatment). The appropriateness of the use of these treatments and the handling of treated water before consumption is not known.

The majority of rural water supply systems in Timor-Leste extract water from stream or spring sources which are prone to faecal contamination by human activities such as farming, grazing and open defecation. The WSP focuses on the proper operation and maintenance of water systems and protection of water sources, storage facilities, distribution networks and water taps, which are important measures for avoiding faecal contamination.

Chemical contamination is more difficult to address than microbiological contamination. Regular monitoring and testing of water samples from different sources of water is required to identify the nature and cause of contamination and to design the appropriate responses. If contamination is above the permissible limits, alternative water supplies may need to be made available.

Figure 4.13: Water treatment prior to drinking, urban and rural

Source: TLDHS 2009-2010, NSD and ICF Macro.



Hand washing with soap (HWWS)

According to a behaviour study conducted by the MoH on HWWS in Ainaro, Bobonaro and Viqueque districts in 2011, 99 per cent of the households surveyed (897 households out of 902) had some kind of soap at home. Access to improved sources of water in these communities was reported to be 49.2 per cent. The rates of HWWS reported and observed at critical times are presented below.

Table 4.1: Women reporting hand washing with soap at different junctures (respondent number 902 households)

| | |
|-------------------------------|-------|
| Ever HWWS | 28,9% |
| Before preparing food | 20,4% |
| Before eating | 16,2% |
| After eating | 8,8% |
| After returning from farm | 5,8% |
| Before feeding a child | 3,3% |
| After defecation/toilet use | 1,6% |
| After cleaning child's bottom | 1,2% |
| After cleaning | 1,2% |

According to this survey, the most common critical juncture reported for hand washing with soap was 'before preparing food' (20.4%), which was corroborated with 17.5 % of HWWS observations occurring before cooking or preparing food. Extremely low prevalence of HWWS after touching faeces (after defecation 1.6% and after cleaning child's bottom 1.2%) was reported. This shows that despite relatively positive enabling environments such as availability of soap (99%) and water (50% improved sources) hand washing with soap is not practiced by many.

4.3 Manifestations and causes of deprivation

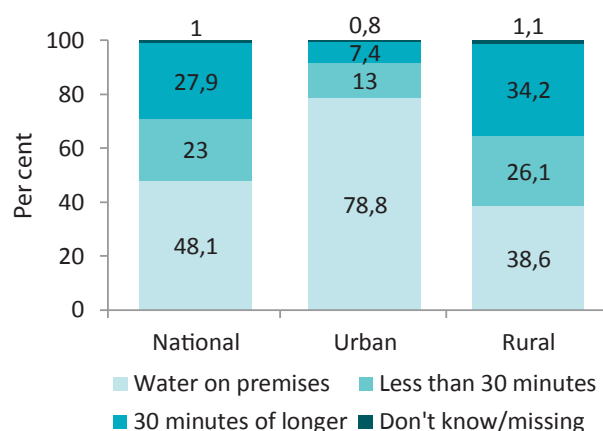
4.3.1 Immediate and underlying causes

Physical access to water sources

Safe water sources near homes are known to reduce the wastage of time and drudgery in fetching water, particularly for women and girls. Communities in rural areas depend mainly on public taps, standpipes and springs and it has been estimated that **nearly 34 per cent of rural households require round trips of 30 minutes duration or more to obtain drinking water**. In urban areas, 7 per cent of households have to undertake such trips. When water is available in homes, the workload of women and girls, who are often entrusted with the task of fetching water, is considerably reduced and poor families are also able to engage in small-scale productive activities to supplement their income such as market gardening (Figure 4.14).

Figure 4.14: Population with improved sources of water on premises

Source: TLDHS 2009-2010, NSD and ICF Macro.



Knowledge and access to information and behaviour change

Although there is consistent demand from communities for reliable and accessible water sources for household use, the importance of sanitation is less recognised. There is a lack of access to information on the importance of sanitary latrines and access to latrine options. As a result, the approach has been supply driven in the past, which tends to foster dependency.

However, both national and international partners involved in the sector are gradually recognising the importance of sanitation promotion to generate demand. The importance of hand washing with soap at critical times is not well understood or practiced by most of the rural population.

Similarly, the need for disposing of baby faeces properly is also not well understood as nearly 80 per cent of mothers dispose of babies' faeces unsafely (66 per cent throw them into the bushes, field or pig pen and over 7 per cent do not dispose of them and just leave them on the ground).¹⁵¹

As noted above, 29 per cent of Timorese still practice open defecation, 37 per cent in rural areas and 8 per cent in urban areas.

At the community level, the WASH sector agencies are now promoting the CLTS approach, which focuses on behavioural change and enhanced ownership of sanitation facilities and their maintenance. No subsidy is provided for building latrines; instead communities are encouraged to use locally available materials to build their latrines and hand washing stations. This is a participatory approach of raising public awareness and mobilising community efforts to increase the use of latrines and practice of safe hygiene behaviours such as hand washing with soap at critical times.

WASH supply chain, financial barriers and maintenance

Some partners are engaged in improving the supply chain by supporting vendors to keep essential spare parts at local kiosks for water systems repair and fostering the marketing of sanitation products at local levels, though with limited success. In view of the high poverty rate and poor sanitation coverage in Timor-Leste, efforts need to be made to ensure that latrine products are widely available at a reasonable cost. Promotion of low-cost technology options are important in terms of affordability, control and thereby the ownership of households and communities.

Given a choice, people tend to prefer pour-flush toilets that are undoubtedly sanitary but are more expensive and relatively difficult to maintain. Undeniably there is a need to develop financing mechanisms that enable communities to access latrine products locally and at a reasonable cost in order for communities to move up the sanitation ladder.

Government support through targeted and result-based incentives and rebate schemes might be required for making these options widely available. At the same time the non-subsidy approach (CLTS) needs to be scaled up to change sanitation behaviours and create demand for sanitary latrines.

Institutional capacity

The WASH sector is constrained by low institutional capacity for water supply and sanitation. Gradual progress has been made over time in increasing the number of staff and enhancing their technical and managerial skills. However, there are gaps to be filled and the key water sector agencies such as DNSA (Directorate of Water Supply Service) and DNSSB (Directorate

for Basic Sanitation Services) of the MoPW and the Environmental Health Department (EHD) of the MoH are still constrained by limited capacity at both national and sub national levels for planning, supervision and monitoring WASH interventions.

The coordination among line ministries at the national and district levels is also not working efficiently. The MoPW has an official mandate to bring water up to the boundary of the school compounds and the MoE to do the internal connections. However, there is no coordination between the MoE and MoPW at the time of planning and site selection of school buildings resulting in insufficient assessment of the potential source for water supply. This hampers the provision of reliable water supplies in many schools. Limited coordination among line ministries also applies to WASH in health facilities with community water supply systems not always designed and constructed to satisfy the water supply needs of the local health facility.

Though significantly improved over time, there are still hiccups in coordination between the EHD of the MoH and the DNSSB of the MoPW. The EHD has the mandate of implementing sanitation and hygiene promotion activities in communities and hence takes ownership of CLTS.

The DNSSB on the other hand is responsible for promoting sanitary latrines by setting standards and guidelines and monitoring their implementation. Since CLTS is a behaviour change approach and the DNSSB under the MoPW is not involved in promotional activities, the two agencies do not naturally concur well on sanitation scale up strategies.

Although segregation of responsibilities is important, DNSSB's involvement in promoting sanitation would help scale up the CLTS approach. The Basic Sanitation Policy provides an opportunity for the DNSSB to engage in CLTS activities but

the agency needs to commit itself by allocating human and financial resources. Overall, there is an urgent need for improved coordination between the MSA, MoH, MoPW and MoE as all these ministries are responsible for water, sanitation and hygiene interventions in communities and institutions.

The District Water and Sanitation Office (SAS) lacks required human resources, materials and tools to respond to water and sanitation needs in rural areas.

The regular fund allocated for district water supply offices is only sufficient to cover the operational cost of the office including staff salaries. The Ministry of Public Work's internal resources are not sufficient at the district level for building new water supply systems in rural areas to increase the coverage let alone to meet the operation and maintenance requirements of the existing community water supply systems. There is in general a shortage of personnel with the technical qualifications required for water and sanitation in the country, although this is gradually being addressed.

The DNSA has placed a rural water supply technical officer with the title of sub-district facilitator (SDF) in every sub-district to provide technical support to rural communities.

They are supported by community water supply development officers (CWSDOs). With training in plumbing and construction of water supply systems and basic sanitation, the SDFs are supposed to provide technical assistance to the water supply management groups (GMF – Grupu Maneja Fasilidade) at the community level in management, operation and maintenance, and monitoring of the status of water supply facilities. However, their performance is compromised by lack of motivation and limited supervision and follow-up from the district SAS.

Limited institutional capacity to monitor and support the regular operation and maintenance (O&M) of rural water supply is a major barrier for sustainability.

According to the water supply coverage study conducted by NGOs in 2008-2009, about 50 per cent of rural water systems are not functioning efficiently. Lack of dedicated operation and maintenance (O&M) funds; unclear asset ownership; and shortages of human resources and capacity for effective supervision, monitoring and follow up are the underlying causes of poor sustainability.

Hygiene education has been included in the school curriculum and standard hygiene education manuals and materials have been made available to schools. Although the hygiene component has not been evaluated formally, the quality of teaching and learning is likely to be determined by the **varied levels of interest and competencies of teachers in delivering hygiene education.** The concept of menstrual hygiene has not been introduced in schools. Global evidence suggests that more than 20 per cent of school absenteeism among adolescent age girls is due to discomfort and insecurity felt by girls in going to school during their menstrual period.¹⁵²

4.3.2 Basic causes

WASH-related policies

Inadequate programme and policy efforts for addressing WASH: Implementation of the National Basic Sanitation Policy approved and launched in 2012 remains a challenge despite the significant win in having the policy. The Rural Water Supply design and construction guidelines have also been approved by the Secretary of State but there are other actors (e.g. the MSA - National Suco Development Programme [PNDS]) that also support water projects

but do not necessarily follow the SAS Guidelines. A water supply policy has been drafted but is waiting for approval. There is a draft national basic sanitation strategic plan that sets the target for improving sanitation and hygiene. The Government needs to first approve this plan, and then the plan has to be costed and the required resources allocated. The National Standards for water and sanitation in schools (WASH in schools) have been drafted and are waiting to be finalised. There is also a need for National Standards for WASH in Health Posts. Finally, the WHO supported the MoH in drafting a National Water Safety Plan (equivalent to water quality monitoring and surveillance guidelines). This document needs to be field tested and shared with stakeholders for their inputs before its finalization.

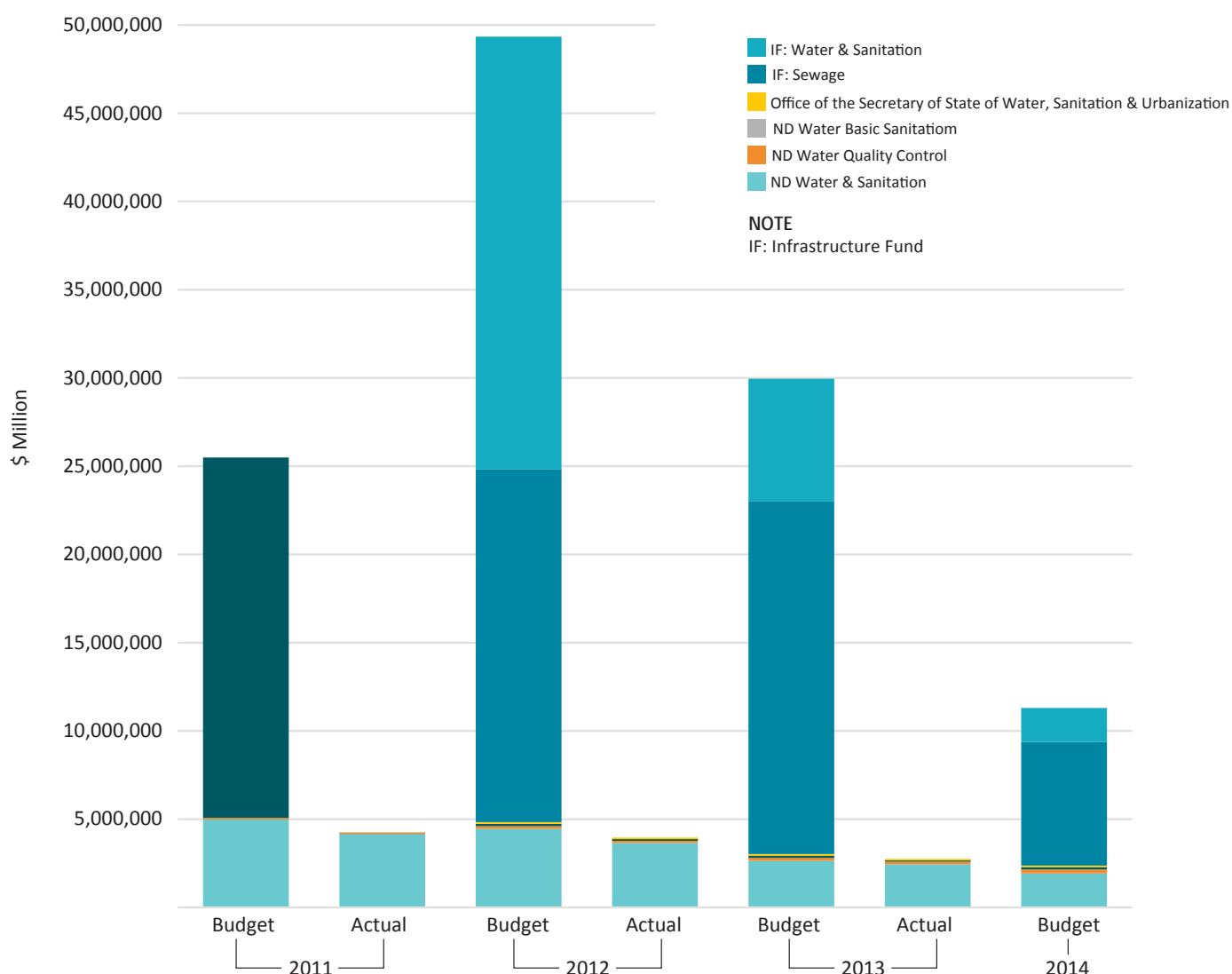
Budget and expenditure

In the past, spending in water and sanitation was predominantly funded by donors; however recently, public budget increases resulted in the government becoming the largest investor in the sector. This trend indicates the government's growing prioritisation of water and sanitation issues. As indicated in Timor-Leste's Statement of Commitment delivered during the 2012 Sanitation and Water for All High Level Meeting, the government "regards increased access to sanitation and water as a development priority".

About US\$25 million and US\$49 million were budgeted by the state for the sector in 2011 and 2012 respectively, mostly to expand urban water supply (Figure 4.15). However, execution was hindered by a limited absorptive capacity (Figure 4.15 and 4.16, see next page). Insufficient recurrent budget for basic administrative operations and inadequate human resources further hamper WASH investments and undermine their sustainability. In this context, the government reduced the sector's budget to US\$30 million in 2013 and further down to US\$11 million in 2014.

Figure 4.15: Composition of budgeted and actual public expenditure on water and sanitation (CFTL and Infrastructure Fund) in 2011-2013

Source: Timor-Leste Budget Transparency Portal, MoF.



Only 1.6 per cent of the central MoPW budget in 2013 was directed to water and sanitation (Figure 4.17, see next page). Moreover, only 35 per cent of the budget of the National Directorate of Basic Sanitation was directed to the districts, with the bulk of the funds remaining in the capital.

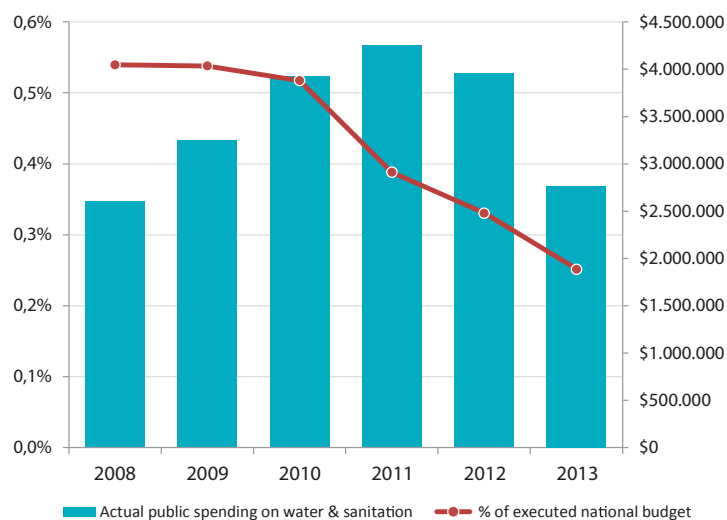
Further, limited funds are available for promotional activities, such as CLTS in communities. According to the MoPW, US\$100,000 was allocated for the

DNSSB to strengthen Sanitation Marketing in rural areas in 2013 but due to the lack of a clear strategy the fund has not been utilised.

About US\$12 million per year for 2012-2017 from AusAID constitutes the bulk of funding from development partners for the development of rural water supply. Other contributions total about US\$3.5 million per year.

Figure 4.16: Actual public expenditure on water and sanitation, (CTFL and Infrastructure Fund) in 2008-2013

Source: Timor-Leste Budget Transparency Portal, MoF.



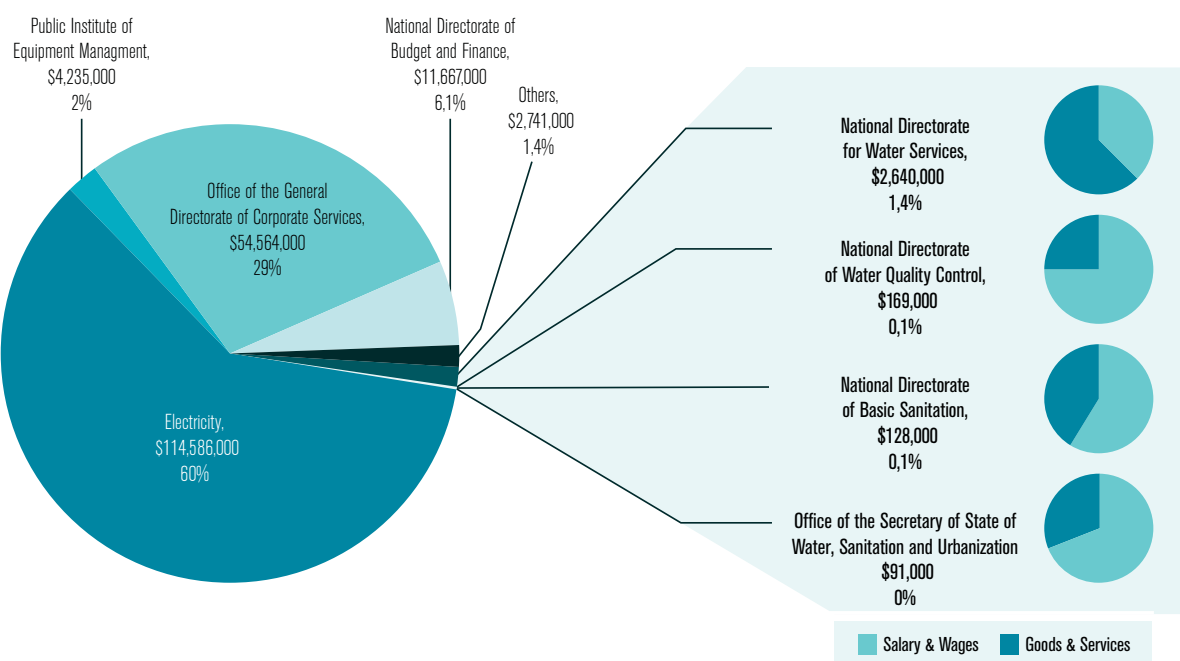
Very limited funds are allocated by the Government to meet the recurrent costs of district water supply (about US\$3000 per month per district).

A recent funding opportunity for WASH infrastructure is represented by the PNDS, which plans to allocate a grant of US\$50,000 to each suco to develop small-scale infrastructure (the fund can be used for building new infrastructure and/or rehabilitating and maintaining existing facilities).

Another funding opportunity arises from the PDD, which is managed by the MSA at the national level and by the district administration at the local level. This fund has a dedicated budget allocation for rural water supply (about \$6 million for 2014). There is a need for strong advocacy at the sub-district and suco levels to better manage these funds to improve the water supply and sanitation infrastructure (especially for operation and maintenance).

Figure 4.17: Composition of the 2013 budget of the Ministry of Public Works, US\$

Source: Timor-Leste Budget Transparency Portal, MoF



Social norms

Women's status and gender issues: Women are the primary caregivers in households and the ways in which they carry out sanitation and hygiene related activities and control resources are determinants of the health status of themselves and those under their care. Women's participation in the management of WASH facilities and membership in community GMFs has been minimal and not very effective, however the agencies involved in the sector are continuously encouraging local authorities and communities to increase their participation and give greater decision making roles to women. There has been some progress in this area in recent years.

Social practices that are negatively affecting the use of improved water and sanitation: There is a lack of consensus among community members regarding the need to protect water sources as well as the continuation of slash and burn farming practices. In addition, open defecation remains an accepted practice. Safe hygiene behaviours like hand washing with soap at critical times have not been inculcated as part of social practices.

4.4 Opportunities for action

The following opportunities for action are proposed:

- **To expand WASH to those areas that are relatively poorly served.**

Building on Timor-Leste's steady progress in terms of access to improved sources of water, more attention should be focused on improving access to water and sanitation facilities in rural areas where the majority of the population lives.

While the thrust is on improving access to water supply facilities for reaching the majority of the population through household and community tap stands, water in schools, health facilities and other public spaces also need to be improved.

- **To increase resources for water and sanitation to meet the tremendous challenges faced by the sector, and improve budget execution.**

Sanitation has been largely neglected when it comes to resource allocations and there is an urgent need to increase related investments in rural areas.

A dedicated budget allocation for WASH in schools should be created.

At the same time, efforts should be made to improve the capacity for the execution of the funds allocated by identifying and addressing related bottlenecks.

- **To continue supporting national and sub-national capacity building for effective operation and maintenance of existing water and sanitation facilities.**

Due to the destruction and damage of water systems during past conflicts, the focus of the WASH sector has been on the construction of new systems, but the sustainability of existing ones is often compromised due to inadequate maintenance and repair, and poor management of water supply facilities. There is a need to develop the national and sub-national systems and capacities for effective operation and maintenance of rural water supply systems and to ensure that sufficient budget allocation is available.

As part of reinforcing institutional and technical capacity development in the WASH sector, there should be a focus on strengthening management, operation, maintenance and monitoring of WASH services. Improved governance relating to guideline adherence is required to improve the effectiveness of the sector.

- **To promote community management and maintenance of water and sanitation facilities.**

As community ownership is an essential attribute for the operation and maintenance of water supply systems and facilities, an enhanced role for community-based groups is envisaged. The democratic and effective functioning of these bodies, including women's participation, should be strengthened.

In addition, efforts should continue in equipping these bodies with appropriate skills and knowledge in the areas of management, community mobilisation and basic technical capacity for water systems repair and maintenance with a specific focus on relevance, effectiveness and sustainability.

Catchment protection education and tree planting programmes should be incorporated into existing functions to improve water resource management and water security.

- **To scale up sanitation promotion and hygiene education.**

Hygiene practices, which play an important role in optimising the benefits of water and sanitation for children and their families, have not received adequate attention. Behavioural change for WASH within communities, especially for children

and women, needs to be promoted through evidence-based communication for development strategies and interventions.

The basic sanitation policy clearly outlines the need for creating demand for sanitation by the entire population through awareness programmes and provision of incentives and credit. The policy also indicates the need for options for the supply of sanitation and hygiene goods and services to poor households in rural and urban areas. A system and mechanism to scale up and strengthen strategies and translate policy into practice need to be devised. Continual support and monitoring of community groups to strengthen and encourage good practice is also required.

More inclusive and creative methods of 'triggering' behaviour change should be applied at the national and community levels.

- **To expand inclusive school-based WASH programmes and improve access to WASH facilities in Health Posts.**

Specifically in schools this includes easy availability of clean drinking water and child-friendly, inclusive (considering people with disability), functional toilets and hygiene facilities that are essential elements of a child-friendly learning environment.

National guidelines and strategies that contribute to the universalization of child-friendly WASH services and WASH supplies at primary schools are required. Menstrual health needs to be incorporated into the school curriculum and considered as part of the provision of sanitation facilities.

There is a need for developing a strategic action plan to increase WASH coverage on an incremental basis (basic minimum, minimum standard and national standard or a 3 STAR approach).

Sufficient quantity of clean running water is a pre-requisite for performing clinical processes and part of the basis for maintenance of hygiene standards of the Health Posts. Given the very low coverage of WASH in rural Health Posts and the low level of reliability and adequacy of the existing WASH facilities, there is a need for developing and implementing national standards for WASH in Health Posts in Timor-Leste, including WASH supplies integrated in the basic health package.

- **To strengthen the quality of the database for WASH.**

Although a management information system for WASH is being developed, relevant indicators need to be incorporated in the database of the Health Management Information System and the Education Management Information System to enable routine monitoring in health facilities and schools.

A national water quality monitoring and surveillance system that effectively monitors the implementation of National Water Safety Plan needs to be developed for routine bacteriological testing of water from various sources to prevent the contamination of sources.

Prevention of contamination, quality control of drinking water and consumer education through a well-established water quality surveillance system will be of importance.

- **To enhance multi-sectoral collaboration for WASH.**

Given the multi-sectoral orientation of water, sanitation and hygiene, coordination and collaboration among related sectors, government institutions and agencies, and development partners must remain a priority.

Footnotes in Chapter 4

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147. WHO and UNICEF (2013) Progress on Sanitation and Drinking Water 2013 Update, Geneva: WHO.
148. Source: Democratic Republic of Timor-Leste (2012) National Stocktake of School Facilities and Equipment in Basic Education Schools in Timor-Leste, Dili: Ministry of Education.
149. Democratic Republic of Timor-Leste and World Health Organization (WHO) (2010) Water Quality Study, Dili: Ministry of Health. This study was undertaken to gather information necessary for developing water quality standards and monitoring guidelines.
150. National Academy of Sciences (2008) Safe Drinking is Essential.
151. Mattson, K. (2011) Baseline Household and School Knowledge, Attitudes and Practices (KAP) of Water, Sanitation and Hygiene (WASH) Study Preliminary Draft Results. Dili: UNICEF Timor-Leste and Belun.
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5

Education

Education is a fundamental human right: every girl and boy in every country is entitled to it. Quality education is critical to the development of societies and of individuals, and it helps pave the way to a successful and productive future. When all children have access to a quality education rooted in human rights and gender equality, it creates a ripple effect of opportunity that influences generations to come.

Quality education remains a distant dream for many of the world's children, even though it is a fundamental human right enshrined in international commitments. From the MDGs to the Dakar Declaration, countries have repeatedly committed themselves to achieving universal primary education and eliminating gender disparities at all levels of education by 2015.

This chapter looks at the extent to which the right of children in Timor-Leste to education has been realized (disaggregated into pre-school, basic education and secondary education and focusing on the issues of access, completion and quality), the causes of violations of this right and finally the opportunities for action by the duty bearers who are responsible for ensuring children's education.



5.1 Overview

Education provides support to break the cycle of generational poverty and disease, and provides a foundation for sustainable development. A

quality basic education equips girls and boys with the knowledge and skills they need to adopt healthy life-styles, and take an active role in social, economic and political decision-making as they transition to adolescence and adulthood. Educated adults are more likely to have healthier families, to be informed about appropriate child-rearing practices and to ensure that their children start school on time and ready to learn.

Education provides the knowledge, values and skills that form the foundation for lifelong learning and professional success. Quality education is child-centered, gender-sensitive and tailored to different age groups. It is based on a curriculum that is relevant to the needs and reality of all learners, and it is transmitted through professionally trained teachers equipped with appropriate learning materials. Child-friendly environments are safe, clean and conducive to learning and play.

Traditionally, concern for access to education has focused on the primary school years, the fundamental period for learning literacy, numeracy and other basic skills. But while primary education is absolutely essential, it is simply not enough.

Children start learning at birth, and the first few years of their lives are critical to developing their cognitive, language, emotional and social skills. Early Childhood Development (ECD) programs are therefore an essential step on the educational journey giving children the tools they will need to succeed when they enter primary school and laying the foundation for their future success. In fact, global evidence shows that the return on investment in pre-school education is higher than for any other level of education.

The future success of children is also enormously impacted by a quality post-primary education, critical to improving societies and achieving gender equality. Girls reap enormous benefits from post-primary education, including skills that translate into employment and empowerment. In addition, there is a correlation between education beyond primary school and having healthier families and lower fertility rates.

The past decade has seen mixed progress towards Education for All (EFA) in East Asia and the Pacific region. More children are participating in pre-school education, many countries have achieved universal primary education (UPE) and more children are moving from primary school to secondary education. Gender parity has been achieved at the primary level in a majority of countries and adult literacy rates are improving. However, challenges remain. The Pacific sub region has seen a 7 per cent decline in primary enrolment rates, and 7.9 million children are not enrolled in school in the region as a whole. About 77 per cent of children in the region participated in secondary education in 2008, pointing to a relatively high level of unmet needs. Participation levels remain low in some countries, with GERs below 50 per cent in Cambodia, the Lao People's Democratic Republic and the Solomon Islands. By contrast, Japan and the Republic of Korea had secondary net enrolment rates above 95 per cent in 2008.¹⁵³ Some 105 million adults are still illiterate and levels of learning achievement are low in many countries in the region. **The region as a whole spends a lower share of its national income on education than the world average.** On the other hand, external aid to basic education has increased in recent years, despite stagnation in overall levels of development support.¹⁵⁴

The CRC commits States Parties to making primary education compulsory and free, making secondary education and vocational guidance available and accessible to all children and taking measures to encourage regular school attendance and reduce the drop-out rates. With its full endorsement of the Millennium Declaration, Timor-Leste has committed to achieving universal primary education (MDG 2) and gender equality at all levels (MDG 3) by 2015. In addition, Timor-Leste is also committed to the EFA goals, which highlights that pre-school education is an integral part of Basic Education that is effective to achieve Universal Primary Education goals.

5.1.1 Education programming context

“In 2030 the people of Timor Leste will be educated, knowledgeable and qualified to live long and productive lives, respectful of peace, family and positive traditional values. All individuals will have the same opportunities for access to quality education that will allow them to participate in the economic, social and political development process, ensuring social equity and national unity”

- National Education Strategic Plan (NESP) (2011-2030)

Education is a key Government priority, as stipulated in the SDP and the Program of the 5th Constitutional Government. The SDP reiterates the government's accountability to education and highlights the importance of quality education for Timorese people, so as for all individuals to "actively participate in economic, social and political development, promoting social equality". In the ongoing reforma of education, particular emphasis is placed on pre-school (non-compulsory) and basic education (grade 1-9) that is universal, compulsory and free.

The government's commitment in education was demonstrated in the Education Mini-Summit held in December 2012. The Mini-Summit was a solid action taken by the new Government, as a follow up to the UN Secretary General's visit to Timor-Leste in August 2012 for the pre-launch of the UN Global Education First Initiative. The Mini-Summit proved the capacity of Timor-Leste in actively promoting inter-governmental collaboration within the region and beyond.

The Ministry of Education has been active in regional and south-south cooperation in education through forums such as the South East Asian Ministers of Education Organization (SEAMEO) and the Asia-Pacific Regional Network for Early Childhood (ARNEC). The country is also a recipient of the Global Partnership for Education (GPE) funds.

Education System

A complete education system covers from pre-school to higher education, with nine-years of free, compulsory, basic education (Grade 1-9) in Timor-Leste. Recurrent education also complements the system through second-chance education programs targeting youth and adults (age 15 and over) that have not completed their basic education and/or secondary education.

The Timor-Leste education system has experienced several reforms since independence. Since 2008, the education sector in Timor-Leste has covered pre-school education up to university. Currently, the education system for children under 18 includes (Chart 5.1): pre-school education (age 3-5); nine-years of basic education which is composed of Cycle 1 (Grade 1-4: age 6-9); Cycle 2 (Grade 5-6: age 10-11) and Cycle 3 (Grade 7-9: age 12-14) and three-years of secondary education (Grade 10-12: age 15-17). The official age to start Grade 1 is six years old. Secondary education is organized

Chart 5.1: Education structure

Source: NESP 2011-2030, MoE.

| AGE | LEVEL | CYCLE | BASIC EDUCATION |
|-----|---------------|---------|-----------------|
| 3 | Pre-school | | |
| 4 | Pre-school | | |
| 5 | Pre-school | | |
| 6 | Primary | CYCLE 1 | |
| 7 | Primary | CYCLE 1 | |
| 8 | Primary | CYCLE 1 | |
| 9 | Primary | CYCLE 1 | |
| 10 | Primary | CYCLE 2 | |
| 11 | Primary | CYCLE 2 | |
| 12 | Pre-Secondary | CYCLE 3 | |
| 13 | Pre-Secondary | CYCLE 3 | |
| 14 | Pre-Secondary | CYCLE 3 | |
| 15 | Secondary | | |
| 16 | Secondary | | |
| 17 | Secondary | | |

through two modalities: general secondary education that prepares students for university education; and technical vocational secondary education that prepares students to enter the labour market.

Catholic churches play an important role in the education sector. Out of just over 1,000 primary schools, approximately 14 per cent are privately owned,¹⁵⁵ mostly church-related. Church-based organizations are also active in pre-school education and teacher training.

Education laws, policies and strategies

A number of laws and regulations ensure the people's rights to education in Timor-Leste. These include:

- Timor-Leste Constitution - "The State shall recognize and guarantee that every citizen has the right to education and culture" and "Everyone has the right to equal opportunities for education and vocational training" (Section 59), and it is

incumbent upon the State that it "should ensure the access of every citizen, in accordance to their abilities, to the highest level of education" (Section 59).

- Basic Law for Education (2008) – "All citizens are entitled to education and culture." This right is meant to "promote equal opportunities and the overcoming of economic, social, and cultural inequalities ... ensuring the right to free and effective equalities of opportunities regarding school access and success" (Article 2). "Basic education is universal, mandatory, free and has a nine-year duration." (Article 11).

There are a number of government policies and strategies that support the principles of education for all:

- The SDP 2011-2030 presents the vision that "all Timorese children should attend school and receive a quality education that gives them the knowledge and skills to lead healthy, productive lives and to actively contribute to our nation's development." (Part 2 Social Capital – Education and Training). It has a specific highlight of "Social inclusion in the education system", which underlines the importance of ensuring the right to education for all, especially the most vulnerable, and eliminating exclusion for any reasons, such as economic status, gender, disability and language etc.
- The Program of the 5th Constitutional Government 2012-2017 echoes the SDP's focus on universal quality education for all people, and reaffirms the Government's commitment in achieving this goal.

Chart 5.2: NESP 2011-2030 sub-sector targets

| Overall Objective | Purpose | Pre-school Education | Basic Education | Secondary Education | Higher Education | Recurrent Education | Social Inclusion | Teaching Quality |
|---|---|--|---|---|---|---|--|--|
| Short term goal (2015) All individuals will have the same opportunities to access to a quality education that will allow them to participate in the economical, social and political Development process, ensuring social equity and national unity | By 2015, the main reforms in all the education levels are introduced and functional | By 2015 at least one half of all children between 3 and 5 years old will be enrolled and receive quality pre-school education | By 2015 quality basic education is available for 88% of the children, and drop outs are drastically reduced | By 2015 introduce a paradigm shift of quality in Secondary Education (General and Technical) | To consolidate a comprehensive system regulated by rigorous quality standards; provides relevant technical and university education and develops solid partnerships with the market | By 2015 completely eradicate illiteracy in all age groups and complete the introduction of the National Equivalence Program that will allow accelerated completion of Basic Education | A Social Inclusion Policy to promote the educational rights of socially marginalized people is developed, fully implemented and adequately financed by 2015 | Improved the quality of education by substantially increasing the quality of teaching in Pre-school, Basic, Secondary and Recurrent Education |
| Long term goal (2030) | | By 2030, parents and other caregivers from all the 442 sucos of the country should have access to send their children to a good quality kindergarten school or classroom located at a reasonable distance from their house | By 2030 all children, boys and girls alike, will be able to complete a full course of quality Basic Education | By no later than 2030, all children, boys and girls alike will be able to select and enroll in a course of quality and relevant Secondary Education | Graduates of the higher education system will have the advanced skills and knowledge to analyse, design, build and maintain the social and economic infrastructure of Timor-Leste | As all Timorese are literate, the system recurrent education is mainly concentrated on providing the National Equivalence Program for adults | To promote the educational rights of socially marginalized groups (those groups which are systematically denied access to entitlements and services because of their socio-economic condition, ethnicity, language, race, religion, age, gender, disability, HIV status, migrant status, or where they live) ensuring that they gain full access to the same opportunities, rights and services that are accessed by the mainstream of society | All students in Pre-School, Basic, Secondary and Recurrent Education are taught by well trained and qualified teachers so that they receive a quality education. |

- The NESP 2011-2030 states that “All individuals will have the same opportunity for access to quality education that will allow them to participate in the economic, social and political development process, ensuring social equity and national unity” (The Vision). “Social Inclusion” is a specific priority area, which sets the goal “To promote the educational rights of socially marginalised groups ... ensuring they gain full access to the same opportunities, rights and services that are accessed by the mainstream of society”. The education sub-sector targets set by the NESP are indicated in Chart 5.2.

Support to the education sector

Currently, the major players in providing support to the education sector are key international partners including but not limited to: Australian Aid Program, the Portuguese Cooperation, the Brazilian Cooperation, KOICA, the New Zealand Aid Program (NZAID), UNESCO, UNICEF, USAID and the World Bank. International NGOs, including Plan International, CARE International, ChildFund and World Vision, are active in the areas of pre-school and basic education.

In the provision of pre-school education, the major players are church/faith-based organizations, NGOs, and international development partners.

Since 2011, an Early Childhood Education (ECE) Working Group was established under the leadership of the MoE and involving the key ministries, NGOs, church-based organizations and development partners. The direct result of this coordination is the successful promotion of pre-school education in the government development agenda, and the formulation and approval of the National Policy Framework for Pre-school Education. However, laws and regulations that can sustain pre-school development are still lacking. An integrated ECD framework is yet to be put in place to ensure a holistic child development approach.

5.1.2 Key achievements

Timor-Leste has made remarkable progress in the education sector over the past twelve years since independence in 2002 and education reform is ongoing.

Significant progress has been made in access to basic education with the achievement of a 94 per cent Net Enrolment Rate (NER) for Grade 1-6 (Cycle 1 & 2). The 2010 Education Statistical Yearbook indicated that nationwide, 94 per cent of children of the official school age enrolled in Grade 1-6 (Cycle 1 & 2, equal to primary level), and 30 per cent in Grade 7-9 (Cycle 3, equal to pre-secondary). Achieving 94 per cent of net enrolment is a dramatic increase compared to merely 64 per cent in 2005. The Gross Enrolment Rate (GER) reached 128 per cent and 79 per cent for Grade 1-6 and Grade 7-9 respectively. This national rate compares well with other fragile nations and with the average level in the East Asia and Pacific Region. In order to support the substantial increase of enrolled children, the number of primary schools increased from 674 in 2000 to over 1,070 in 2010, accompanied by an increased number of teachers from 3,860 to over 7,500 during the same period.¹⁵⁶

The education system has been re-established from its foundation – As noted, during the past twelve years a number of legal and policy frameworks and the structural system foundations for education have been established. Being a new nation, this task has been an utmost priority for Timor-Leste. Some of these key foundations are: the Basic Law of Education (2008); the Basic Education Law (2010); the Teacher Career Regime (2010); the Teacher Qualification System (2011); the NESP 2011-2030; the MoE Organic Law (2013) and the National Policy Framework for Pre-school Education (2013). Effective implementation of these is an on-going effort.

The National Institute for Training of Teachers and Educational Professionals (INFORDEPE) (2011) cluster-based approach to school management (2011) and General Inspections of the MoE (2012) have been also established.

The Education Management Information System (EMIS) has also been introduced facilitating a more effective, efficient, evidence-based approach to management in the sector.

Basic education and secondary education curricula have been developed and approved, and Child Friendly School (“Eskola Foun”) principles were adopted in the Basic Education Decree Law.

5.2 Key issues – status, progress and disparities

Despite the significant progress to date, universal quality basic education is yet to be achieved and there are persistent geographical and socio-economic disparities.

5.2.1 Pre-school education

School readiness is a proven strategy to improve education quality and efficiency, and socio-economic development. Various studies show its benefits and the returns on investment, in terms of reduced education costs and disparities, increased human productivity and income, and benefits to society and national development. Effective ECD programs, including pre-school education, reduce education costs by improving the internal efficiency of primary education.

School readiness rests on three pillars: children's readiness for school; schools' readiness for children; and the readiness of families and communities to help children make the transition to school.

Together, these pillars bolster the likelihood of a child being able to succeed in school.

Lack of school readiness of children contributes to the existing challenges of students repeating grades or dropping out of school at primary levels. Rapid expansion of affordable, quality pre-schools, especially in remote areas, remains as a big challenge that needs to be urgently addressed.

Pre-school education is still new in Timor-Leste. According to the preliminary data collected by the National Directorate of Pre-school Education, as of February 2013, **the GER of pre-school education is about 14 per cent.** It is almost equal for girls (14.8 per cent) and boys (14.1 per cent). Since there is no age-specific data available, the NER (proportion of children aged 3-5 who enrol in pre-school education) cannot be calculated. However, it can be estimated to be lower than the GER, therefore making it very difficult to achieve the 2030 target (50 per cent).

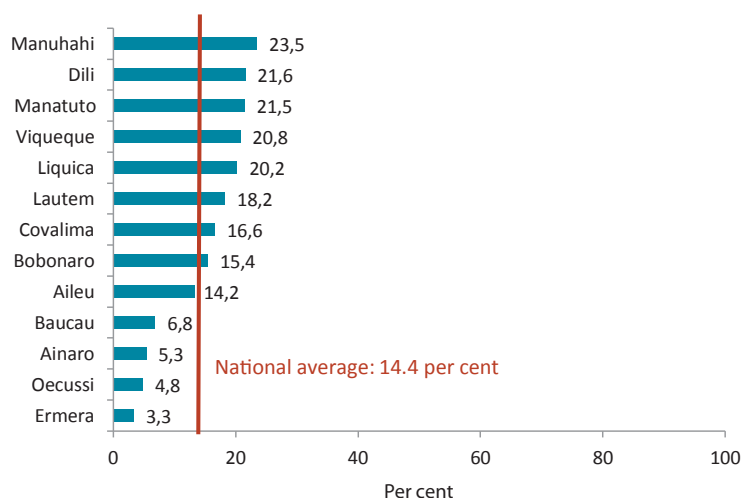
Significant disparities exist among children living in different districts. The GERs of pre-school education in Ermera, Oecusse, Ainaro, and Baucau districts are much lower than the national average (Figure 5.1).

Pre-school education is receiving increased attention from both the government and civil society. The approval of the National Policy Framework for Pre-school Education demonstrates the strong commitment of the government to promoting pre-school education in Timor-Leste.

Timor-Leste's vision for preschool education is to provide all children between 3-5 years of age access to a quality preschool program close to their home. **The NESP 2011-2030 aims to reach 50 per cent of coverage by 2015 and 100 per cent by 2030.** A quality preschool education will help children to develop the basic skills, knowledge, confidence and self-esteem needed to arrive at primary school ready

Figure 5.1: Gross enrolment rate of pre-school education, 2013

Source: National Directorate of Pre-school Education, MoE, 2013, calculated by UNICEF.



to learn,¹⁵⁷ and hence the Policy Framework takes a holistic approach incorporating other aspects besides education, including health and hygiene, nutrition and child protection.

5.2.2 Basic education

Basic education supports children at a critical time in their physical, emotional, social and intellectual growth. More broadly, education is a key tool for development and an invaluable means of addressing structural inequality and disadvantage. Basic education provides children with life skills that enable them to prosper later in life. It equips children with the skills to maintain a healthy and productive existence, to grow into resourceful and socially active adults, and to make cultural and political contributions to their communities.

Basic education in Timor-Leste covers Cycle 1 (grade 1-4), Cycle 2 (grade 5-6) and Cycle 3 (grade 7-9) as free compulsory education. Cycle 1 and Cycle 2 combine as primary education. The NESP 2011-2030 aims to achieve 95 per cent of school-age children enrolled and completing Grade 9 by 2015, and 100 per cent by 2030.

Access to basic education

Timor-Leste has made steady progress in basic education and achieved 94 per cent primary NER in 2010. More Timorese children are now entering schools compared to previous years. The number of children who entered primary school (Cycle 1 and 2) increased from 157,516 in the 2004/05 school year to 238,936 in the 2011 school year.¹⁵⁸ In 2010, over 60,000 children entered pre-secondary school (Cycle 3, Figure 5.2).

The GER of primary education has increased from 99.6 per cent in the 2004-2005 school year to 127.8 per cent in 2010 (Figure 5.3). The significant difference between the GER and NER indicates that a large number of children enrolled in basic education are either under or over age (Figure 5.4, see next page). Specifically, 68 per cent of primary (Cycle 1 and 2) and 80 per cent of pre-secondary (Cycle 3) students are enrolled in grades below their age; and two-thirds of primary students (Cycle 1 and 2) and four-fifths of pre-secondary school students (Cycle 3) are over age. In 2010, only 32 per cent of students were at the official school age when entering the first grade. About 27 per cent of

Figure 5.2: Number of students in primary, pre-secondary and secondary schools

Source: EMIS, MoE.

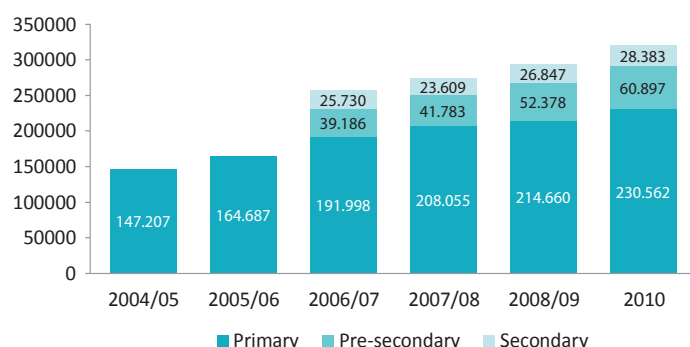


Figure 5.3: Trends in GER and NER in primary school

Source: EMIS, MoE

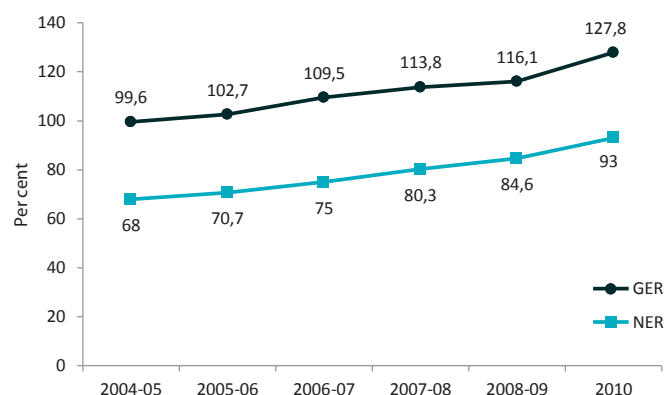
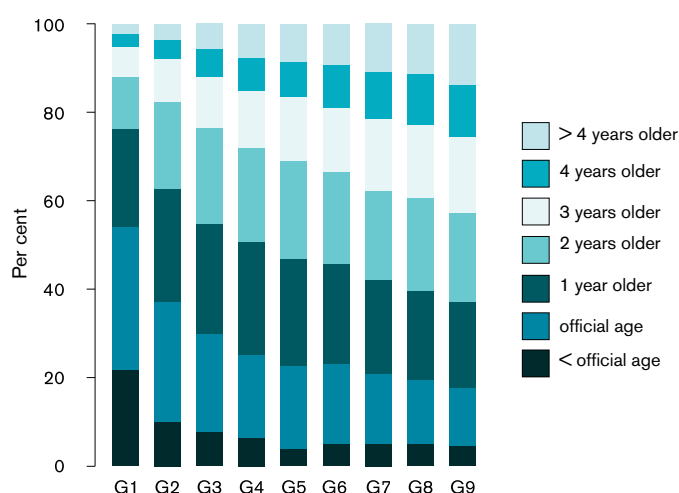


Figure 5.4: Age distributions of primary and pre-secondary students by grade, 2010

Source: EMIS 2010, MoE.



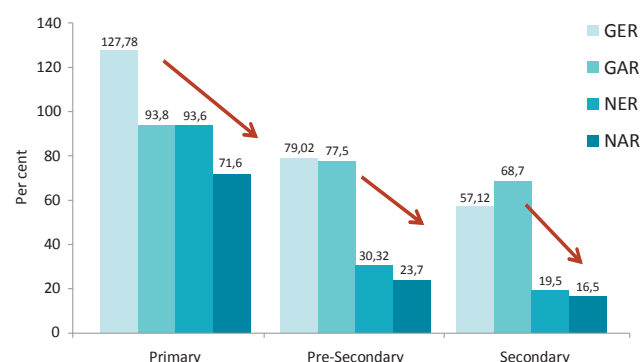
students in grade two were at the official school age. For grades 3-9, the majority of students were two years older than the official school age. This leads to a further strain on the already limited resources for basic education, contributing to over-crowding and reduced teacher contact with pupils. There is also a significant number of under-age children particularly in Grade 1. EMIS also shows that the Net Intake Rate¹⁵⁹ was 54 per cent in 2010.

Keeping children in school is still a challenge.

There are some discrepancies between the enrolment data from EMIS and the attendance data from the household surveys. While the primary NER is estimated at 94 per cent in EMIS, both the TLDHS 2009-2010 and the 2010 Census show a much lower Net Attendance Rate (NAR) at around 70 per cent (TLDHS: 72 per cent and Census: 71.6 per cent, Figure 5.5). Inaccurate reporting of age by children and parents could be an issue.

Figure 5.5: Comparison of enrolment rate and attendance rate 2010

Source: EMIS 2010, MoE, and Census 2010, NSD & UNFPA.

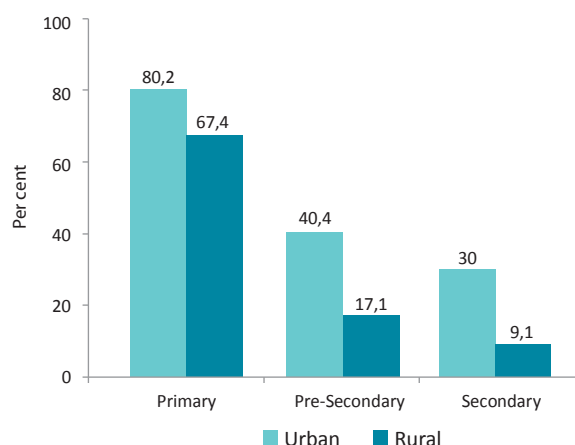


Frequent absence from school can be another possibility, as suggested by a recent school survey, which found that more than one third of Grade 1 students were absent for various reasons on the day of survey.

Geographic disparities exist between urban and rural areas, and among districts. Children living in urban areas receive better quality and access to education than those in rural areas.

Figure 5.6: Net attendance rate by education level and urban/rural, 2010

Source: Census 2010, NSD & UNFPA.



All education indicators demonstrate significant differences between urban and rural areas.¹⁶⁰ For instance, in rural areas, girls drop out earlier than those in urban areas.¹⁶¹ Non-attendance is more of an issue in rural than urban areas, with only 67.4 per cent of rural based children aged 6-11 attending primary school (Cycle 1 and 2). More than 32 per cent of rural based children aged 6-11 have never attended school, as compared to 20 per cent of urban-based children (Figure 5.6).

Significant disparities exist among districts. According to the 2010 Census, Dili has about 80 per cent of children aged 6-11 attending primary schools (Cycle 1 and 2), while Ermera and Oecusse have less than 60 per cent net primary (Cycle 1 and 2) attendance. Districts in the western area of the country perform better than those in the eastern side. Ainaro, Bobonaro, Liquica, Ermera and Oecusse have lower attendance than the national average at the basic education level (Figure 5.7).

Attendance also very much depends on the wealth of the family. According to the TLDHS 2009-2010, children from the wealthier homes are more likely to attend primary school than those from poorer households, proving that financial means is a barrier to accessing education.

Gender equality in primary education has been achieved. Both the GAR and NAR in the 2010 Census show a slightly higher level of primary enrolment for girls than boys. The EMIS data proved the same trend and found that girls normally perform better than boys in all grades with lower repetition rates. However, school attendance by girls from age 13 declines faster than for boys (Figure 5.8). Girls generally leave school earlier than boys after the age of 14-15 years old. Gender-based violence within and outside schools, and early pregnancy of adolescent girl students remain as key hindrances for the completion of the basic education cycle for girls.

Education for vulnerable groups

Children with Disabilities (CWD): It is difficult to capture a full picture of the education status of CWD. The 2010 Census indicates that 59 per cent of children aged 6-14 with disabilities were attending school (Figure 5.9). While little information is available on out-of-school CWD, a survey by the East Timor Blind Union documented at least 300

Figure 5.7: Primary net attendance rate by district, 2010

Source: 2010 Census, NSD & UNFPA.

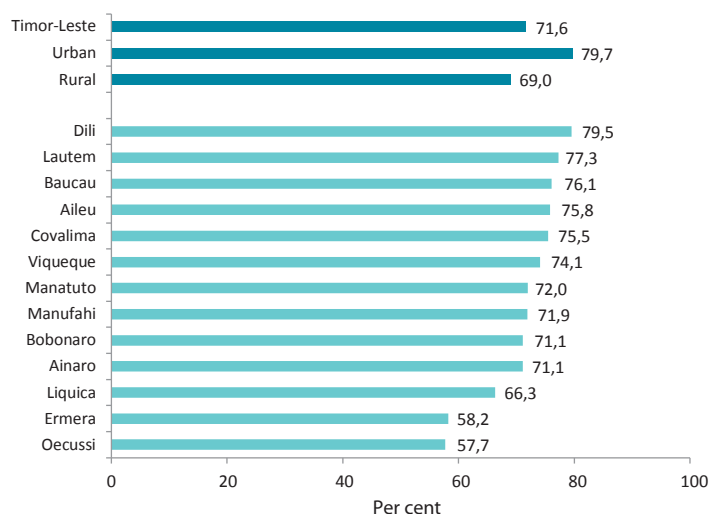


Figure 5.8: Age-specific school attendance rates, 2010

Source: EMIS 2010, MoE.

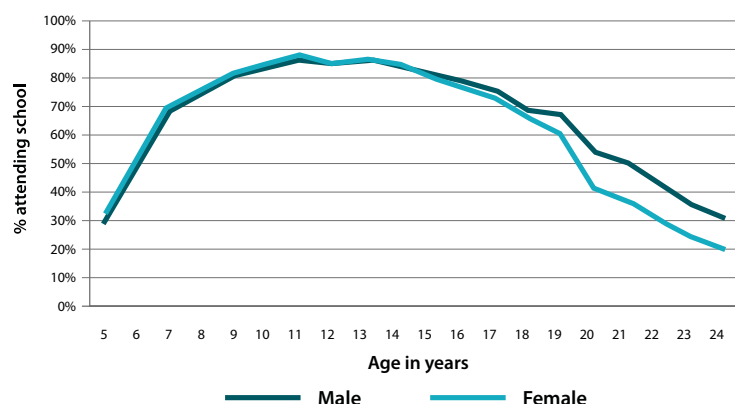
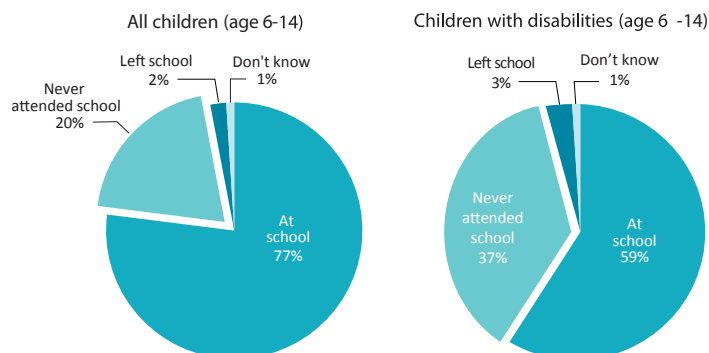


Figure 5.9: Education status of all children (age 6-14) and of children with disabilities

Source: Census 2010, NSD & UNFPA.



school-age children with visual impairments outside Dili district that were not in school. Persons with disabilities interviewed for an UNMIT/OHCHR report ranked access to education as the area where most improvement is needed in Timor-Leste.

Adolescent mothers: Young mothers (aged 15-19) are targeted as a vulnerable group in Timor-Leste's education policy. Indeed, according to the 2010 population census, almost half (47.9 per cent) of the 3,569 teenage mothers in Timor-Leste had left school, compared to only 12.8 per cent of all young women (Figure 5.10). In addition, most adolescent mothers had never attended school compared to the overall female population of the same age emphasizing the role that education can play in reducing teenage pregnancies.

Working children: The questions on work in the recent census were asked about every child aged 10 years and above. Working children are considered to be aged 10-14, given that children of this age should be attending compulsory basic education. At the time of the 2010 Census, there were more than 8,000 working children in Timor-Leste. Of these, most were boys (58 per cent) and almost all (93 per cent) were residing in rural areas.

About one third (35 per cent) of working children were still in school, compared to 92 percent of all children aged 10-15. In rural areas, where the vast majority of working children reside, there is no significant difference in school attendance between working boys and girls. The number and relative proportion of working children varies across districts. The proportion of children aged 10-14 who are working ranges from 16 percent in Ermera to 1 percent in Dili. In some districts, such as Oecusse, Manatuto, Liquica and Bobonaro, there is a higher proportion of boys compared to girls in the workforce.

Migrant children: There were more than 23,000 internal migrant children at the time of the 2010 population census, that is, children counted in a district other than the districts in which they were born. Comparing the current education status of migrant children aged 6-14 to all children aged 6-14 indicates that migrant children are more likely to be attending school than non-migrants. This is not surprising because, migrants often move to urban centers to seek for opportunities; thus school attendance is higher for migrants in urban than rural areas.

Quality of basic education

Timor-Leste has a national examination system to determine pass or fail for students at grades 4, 6 and 9. It does not yet have a national learning assessment system established that allows tracking of students' learning against the national learning standards for each year. As such, challenges exist for analysis of overall performance improvement of students and also for improving teaching.

The Early Grades Reading Assessment (EGRA) in 2010 found that more than 70 per cent of students at the end of grade one could not read a single word of the simple text passage they were asked to read (Figure 5.11).

Figure 5.10: Education status of adolescent women (age 15-19)

Source: Census 2010, NSD & UNFPA.

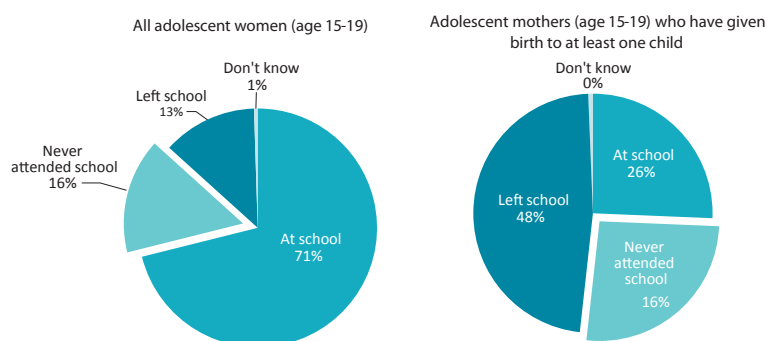
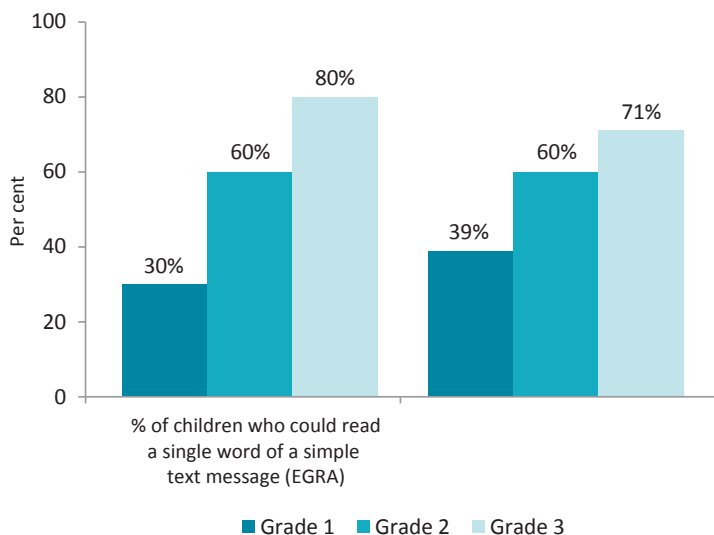


Figure 5.11: Percentage of students at grade 1-3 meeting the basic learning outcomes

Source: Census 2010, NSD & UNFPA.



About 40 per cent of children were not able to read a single word at the end of grade two. The share of children scoring zero dropped to about 20 per cent at the end of grade three. The Early Grades Mathematics Assessment (EGMA) in 2011 noted that the average score of students in mathematics in Grade 1 is 39 per cent, 60 per cent in Grade 2, and 71 per cent in Grade 3.¹⁶²

5.2.3 Secondary education

In Timor-Leste, secondary school runs from grade 1 (age 15) to grade 3 (age 17) and is not compulsory. The NESP 2011-2030 has committed to introduce by 2015 an improved quality and relevant secondary education that allows students to learn the core of scientific-humanistic knowledge needed to proceed to higher education or to enter employment, and by 2030 ensures that all children be able to select and receive a quality, relevant secondary education.

Access to secondary education

In 2010, there were more than 41,100 students attending secondary school. Over half (52 per cent) of them were male (21,240) and 48 per cent were female (19,866). The coverage has been constantly and moderately increasing over time. There were 91 secondary schools in total in 2010, of which 74 were Secondary General schools (43 public/31 private) and 17 were Technical-Vocational schools (12 public/5 private).¹⁶³

More young people attend secondary school than before. According to the EMIS 2010, 57.1 per cent (GER) of young people are enrolled in secondary education, a significant improvement from the 36 per cent enrolled in 2001. However, the secondary school NER is only 19.5 per cent, indicating that most students are outside the official age range of 15-17 years. This late entry to the secondary level could largely be attributed to the frequent repetition that occurs in basic education.

There is a significant urban-rural disparity in access. Around 30 per cent of young people from urban areas aged 15-17 are in secondary school versus 9 per cent in rural areas.¹⁶⁴ This can be attributed to the limited and unevenly distributed secondary schools, with more than a quarter of them being located in Dili. In Dili, 75 per cent of the students go to private institutions.

As education levels advance, the gender gap in favour of boys increases. Boys are more likely to attend secondary school than girls in almost all areas of Timor-Leste. This is particularly the case in the districts of Liquica, Manufahi and Oecusse. In Covalima, the situation is different, with girls more likely than boys to attend secondary school. Participation is close to equal in Manatuto, Dili and Viqueque.¹⁶⁵

However, 20 per cent of young people (15-24 years) are illiterate, down from 27 per cent in 2004. They are more literate than the general population (with an illiteracy rate of 40 per cent). The youth illiteracy phenomenon is very concentrated with 14 per cent of sucos having more than half of their youth illiterate, mostly in remote parts of Oecusse, Ermera and Manatuto.

Access to secondary education remains very unequal. School is only mandatory up to basic education (grade 9) and continuing on to secondary school is therefore a decision of parents. Many more urban youth than rural youth are enrolled in secondary schools. Attendance also very much depends on the wealth of the family, with the lowest quintile recording less than half the attendance rate of the wealthiest quintile.¹⁶⁶

Quality of secondary education

As the NESP 2011-2030 indicates, low enrolment rates in secondary education may well be related to the outdated curriculum that is taught, which lacks quality and relevancy. The NESP therefore places particular emphasis on fundamental quality reforms to make secondary education more meaningful for students, including relevant curriculum that may bring in enhanced life-based skills education, as well as expanded choices for secondary technical-vocational education that meet the needs of the labour market and the country's development priorities.

Timor-Leste's level of upper secondary education attainment compares with a selection of other countries. The data are drawn from the international comparisons for the year 2010 published by the Organisation for Economic Co-operation and Development (OECD) in Paris. These comparisons show that Timor-Leste has more of its 25-34 age group with an upper secondary education than China did in the year 2000. However all other countries

listed have higher levels of upper secondary education attainment in 2010. These include Portugal (52 per cent) and Brazil (53 per cent).

5.2.4 Youth Literacy

Literacy levels have improved considerably between 2004 and 2010. In 2010, as indicated in Figure 5.12, the adult literacy rate was 57.8 per cent with a clear gender gap (Male: 63.1 per cent, Female: 52.5 per cent). The literacy rate was much lower for the rural population (45.9 per cent), in comparison to that of the urban population (83.2 per cent). The Youth Literacy Rate (age 15-24) was 79.1 per cent with a difference of 20 percentage points between urban and rural rates (92.3 per cent versus 70.5 per cent) with only a small difference by sex.

The higher rate for the youth population indicates considerable progress in the last decade in primary education enrolment. The challenge however remains with rural populations, particularly women.

Since 2007, the Government has given priority to promote recurrent (non-formal) education to address the issue of illiteracy and meet the education needs of youth and adults. It started with a national literacy campaign in 2007, followed by the establishment of literacy and post-literacy classes.

The current National Equivalency program provides accelerated learning courses, and its graduates are offered equivalency to the formal Basic Education system qualifications. In order to enter the equivalency program, those youth who are illiterate need to access the basic literacy program to get basic reading, writing and counting skills. Dropped-out children who are over-age for going back to school also have the opportunity to complete basic education through the education equivalency program. The effectiveness and impact of the equivalency program is yet to be assessed.

5.3 Manifestations and causes of deprivation

5.3.1 Immediate causes

Despite the significant progress made to date, universal quality basic education is yet to be achieved and there are persistent geographical and socio-economic disparities. Universal basic education completion is prevented directly by three key causes:

- 1) children who are never enrolled;
- 2) children enrolled but dropped out of school; and
- 3) children repeating the same grade at school.

Out-of-school children

Out-of-school children include dropouts and those who never attended schools. They are likely to be those children with disabilities, those living in remote areas, those living in poverty, and members of minority cultural, and linguistic groups. Language is a particular form of exclusion when the home language differs from the language of instruction. Children involved in child labour, living on the streets and those affected by emergencies are also often out of school. Girls and young women tend to be more at risk.

The 2010 Census found that about one-fourth (25 per cent) of primary school age children (6-11 years) either left school (2 per cent) or never attend school (23 per cent). Some 15 per cent of children at pre-secondary school age (12-15 years) were not attending school, while the remaining 85 per cent were in attendance but most of them (72 per cent) were in primary schools.¹⁶⁷ A total number of over 55,000 children aged 6-15 years were out of school (Figure 5.13).¹⁶⁸

Figure 5.12: Literacy rate, 2010

Source: 2010 Census, NSD & UNFPA.

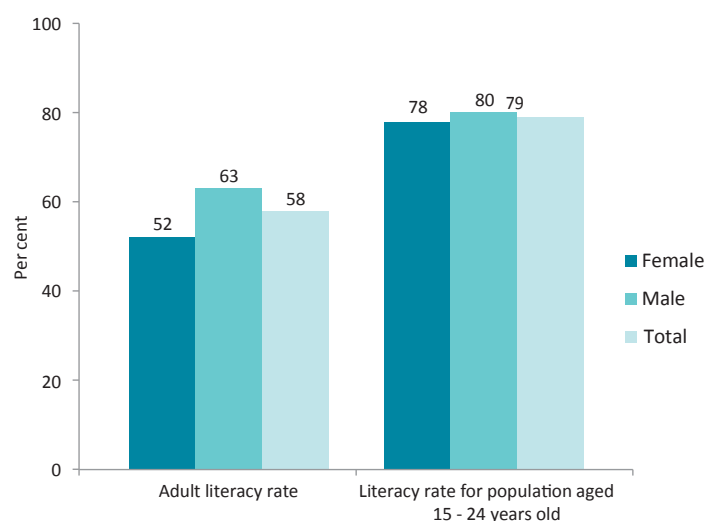
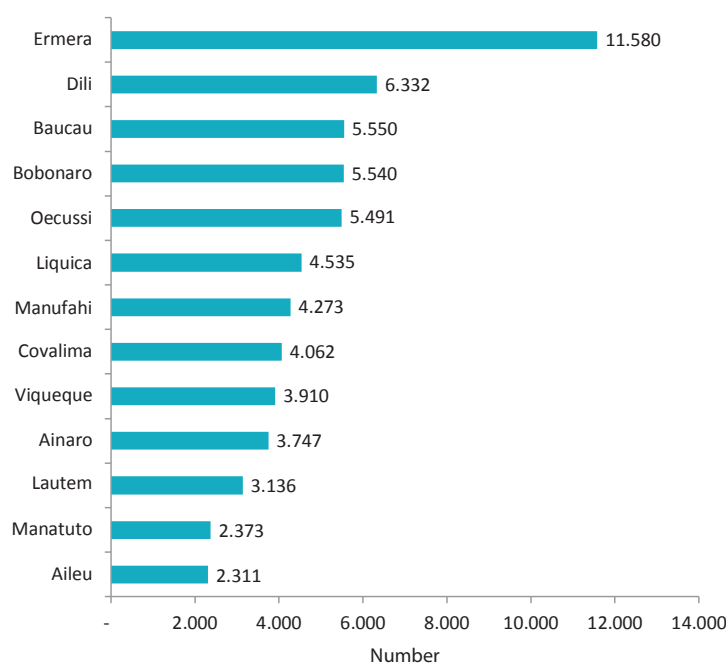


Figure 5.13: Number of out-of-school children (age 6-14), 2010

Source: Census 2010, NSD & UNFPA.



Over 11,000 of out-of-school children were from Ermera district. Dili, Baucau, Bobonaro and Oecusse have over 5,000 children who were not attending schools.

School dropout

Over 10,000 students dropped out from primary (Cycle 1 and 2) and pre-secondary school (Cycle 3) in 2010. The dropout rate was 4.4 per cent for primary education (Cycle 1 and 2) and 2.8 per cent for pre-secondary education (Cycle 3).

This rate had significantly reduced compared to the previous year with a rate above 10 per cent nationwide. In total there were 9,613 primary students and 1,383 pre-secondary students dropping out of school in 2010.

The dropout rate is higher in early grades. Boys had a slightly higher level of dropout than girls. It is interesting to note that the dropout rate for grade

6 and for grade 9 seems much lower than other grades. It could be interpreted that this shows children intended to complete primary or pre-secondary school education when they reached the last year (Figure 5.14). Inaccurate reporting by schools due to children's change of school (caused by proceeding to the next Cycle) could be an issue as well.

Late enrolment and high repetition rate

Late enrolment and high repetition rates contribute to difficulties in retaining students.

Total first grade primary education new entrants (from all ages) or Apparent Intake Rate¹⁶⁹ in 2010 was approximately 144 per cent. The Net Intake Rate was only 54 per cent in the same year. This indicates a **high degree of access to primary education but more than half of children are over-aged or under-aged.**

EMIS data clearly indicates the high repetition rate at primary and pre-secondary level, in particular in the first four grades (20.8 per cent) that reflect the challenges for the quality of basic education. **About 30 per cent of students in grade one had to repeat the first year of school indicating the need of increased school readiness through quality pre-school education.** The repetition rates remain high at 17.2 per cent, 16.4 per cent and 12.8 per cent for grades 2-4 respectively (Figure 5.15).

Figure 5.14: Drop-out rate by grade, 2010

Source: EMIS 2010, MoE.

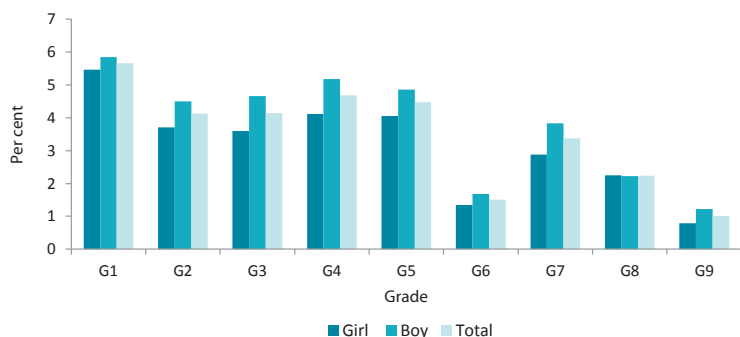
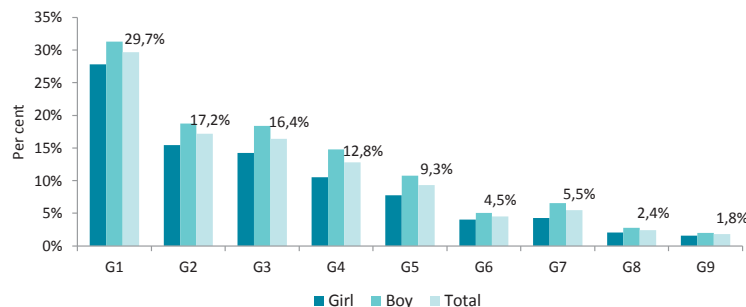


Figure 5.15: Repetition rate by grade, 2010

Source: EMIS 2010, MoE.



5.3.2 Underlying causes

Access to schools

School distribution and distance to school: Since independence, the Government of Timor-Leste has invested in building more schools to reach children, including those living in remote and hard to reach

areas. According to the EMIS statistics, by 2010, there were 1,008 primary schools, 57 pre-secondary schools, 200 Escola Basica Clusters covering primary and pre-secondary education, 74 general secondary schools and 17 technical secondary schools. Included within the total are 220 private schools that represent 16.2 per cent of the total number of schools.

Schools are distributed throughout the country but with concentration in certain areas and along the main roads (Map 5.1).

The number of pre-schools is far from meeting the existing needs. According to the National Directorate of Pre-school Education of the MoE, the total number of pre-schools was 200 by 2012 and increased to 236 by the end of February 2013, which meets only one-third of the current need. Only 13.8 per cent of primary schools had a pre-school attached or in close proximity in 2012. Because the majority of the existing pre-school institutions are private or NGO/community-supported, there are cost implications, which also affect the access of children, especially those from poor households.

About 90 per cent of children aged 3-5 still have no access to pre-school education, which, if any, is concentrated in urban areas with varied quality and costs. In Dili, there is one pre-school for every 500 children between the ages of 3 and 5. This ratio is even higher in Oecusse where every 1,700 children between the ages of 3 and 5 have access to a pre-school facility.¹⁷⁰

Human resources

The 2010 EMIS reported a total of 12,038 teachers for basic and secondary education in Timor-Leste, 7,576 primary school teachers, 2,391 pre-secondary teachers, and 2,071 working in secondary schools.

Map 5.1: Locations of all schools in Timor-Leste, 2012

Source: Census 2010, NSD & UNFPA.

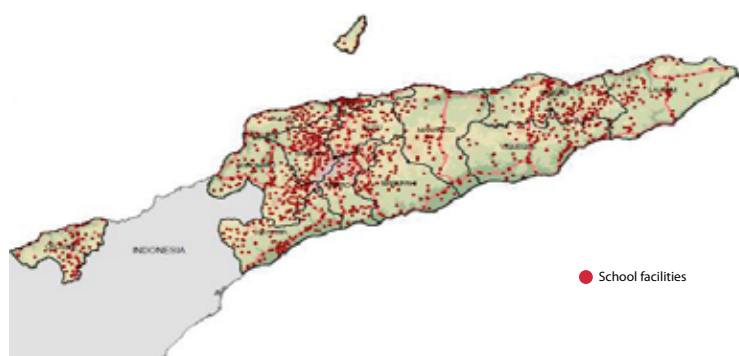
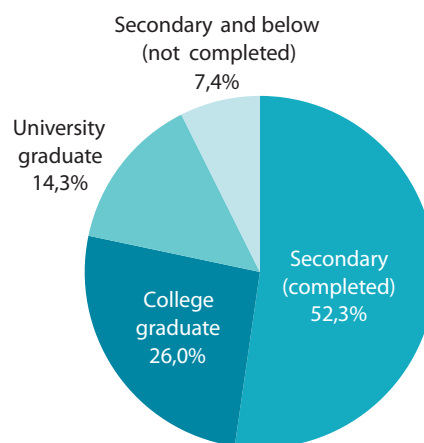


Figure 5.16: School teachers' educational background

Source: EMIS 2010, MoE.



Insufficient qualified teachers with limited teaching capacity (Figure 5.16). Nationally, only 40 per cent of teachers meet the national qualification standards, with 60 per cent of teachers in Dili being qualified, and only about 25 per cent of teachers in Ermera and Aileu being qualified.¹⁷¹

The salary level of school teachers is relatively low and some of them have a second job. Since the country's independence, in order to fill the shortage of teacher supply, there had been a significant number of volunteer teachers in the education system. These volunteer teachers often lack minimum qualifications and effective teaching skills.

Acknowledging the urgent need to address this issue, from 2014 MoE has converted all the existing volunteer teachers to temporary contracted teachers who are paid by the government, as a gradual pathway to permanent contract teachers.

A lack of teachers' capacity in the official languages of instruction (Tetun and Portuguese) hampers an effective teaching-learning process.

In pre-school education, only 6 per cent of pre-school teachers are available (irrespective of qualification) against the total number required. Many of these teachers do not meet the national qualification standards and are often "volunteers" who do not hold the requisite training.

There are less than ten teachers with specialized training in teaching persons with disabilities in the country.

Learning conditions

Poor learning conditions: The above situation is further compounded by non-child friendly learning conditions, including a shortage of proper school infrastructure and limited availability of WASH facilities (only 61 per cent of primary schools have toilet facilities and water).¹⁷²

Insufficient number of classrooms and in adequate condition (there is a 77 per cent classroom availability; 47 per cent of existing classrooms are in poor condition – 1,904 need repair, 1,939 need to be rebuilt).¹⁷³ A shortage of classrooms is one of the problems most frequently voiced by school directors and teachers. Many schools with a classroom shortage run shifts. The high frequency of overage students remaining in school grades lower than their specific age leads to a further strain of limited resources for basic education. This not only contributes to over-crowding

of classrooms but also a reduced teacher contact with pupils.

Lack of essential commodities, including learning materials available in the classrooms.

There is insufficient school furniture such as desks and chairs. Age-appropriate, relevant, bi-lingual textbooks for grade 1-6 for some subjects are nonexistent. Availability of textbooks, in particular in Tetum, is still insufficient. No systematic study on the availability or quality of essential commodities in pre-school facilities has been done. The supply of secondary schools in most districts is very low and contributes to the GER of every district (except Dili) falling below the national average of 57.1 per cent gross enrolment.¹⁷⁴

Lack of school safety and security: The prevalence of school related violence, including gender-based violence and corporal punishment hinders the regular attendance of students, particularly girls. Though the available data is limited, a project-based baseline survey¹⁷⁵ indicates that 81 per cent of students reported student-to-student violence and 49 per cent reported being beaten by their teachers on a regular basis (once a week or more). Less than half of the students (48 per cent) said they knew where they could get help.

Education demand

There is a clear demand from communities and from parents for pre-school education. The 2010 EMIS data shows that 21 per cent of students in grade one are under the official age (6 years) in 2010. This may not necessarily be because parents recognize the importance of a pre-school education, but rather than they want to send their children to some type of child care facility, or that children follow their elder siblings when parents have to work. Rather, it indicates the critical potential need for pre-school education at community level. At the same

time, there are many parents who still do not support sending their children to pre-school education, especially in rural areas. Further efforts are required to educate parents on the benefits of children attending pre-school education.

There are perceived low returns on family investment in education in general and weak links with employment. The current low level of education attainment of the population (39 per cent of adult population have never been to school)¹⁷⁶ contributes to this. Weak relevance and poor quality of education is another contributing factor.

The current curriculum is not fully relevant and age-appropriate, and does not sufficiently provide practical life- and livelihood-skills to meet the fast-changing demands of modern world. To address the issue, the curriculum reform is currently ongoing (primary grades 1-6) by MOE. Limited contact hours (four hours per day) and time on task, compounded by limited parents' support at home also hamper effective learning.

Financial access

The informal costs of schooling (uniforms, learning materials, etc.) are an impediment to a child receiving basic education. Financial barriers increase when accessing secondary education. Children usually have to travel and live away from home to complete their education. Children from the wealthiest homes are more than twice as likely to attend secondary school as those from the poorest households.¹⁷⁷ There is also the lost opportunity cost of the child attending school rather than working and contributing to household income.

5.3.3 Basic causes

Legislation and policy

The Basic Education Law (2008) adopted in Timor-Leste stipulates universal free compulsory basic education (Grade 1-9). Despite this legislation there are no specific mechanisms for the full enforcement for marginalized groups of children. The NESP 2011-2030 includes a strategic framework to reduce gender and other disparities (girls, children with disabilities, poorest, language), but as yet there are no costed operational plans and secured budget allocations for implementation. The National Inclusive Education Policy is also yet to be approved and costed Action Plans have still to be developed.

Effective implementation of the Policy Framework for Pre-school Education is key for achieving the national targets. The Policy Framework approved by the Council of the Ministers in July 2013 will provide strategic guidance to put the NESP into practice. Development of a costed Action Plan is underway.

However, the Government's commendable commitments are yet to be fully reflected in practice. Budget allocations to the pre-school education sub-sector stood at only 0.9 per cent of the total education budget in 2013. EMIS data on pre-school information is not yet fully operationalized. The existing capacity of the local authorities is not meeting the increasing needs for decentralization.

Child Friendly School principles have been successfully adopted in the Basic Education Decree Law, but the National Quality School Standards for implementation are still to be finalized and approved.

The diversity of mother tongue languages (Map 5.2) and literacy in official languages has made instruction of children in basic education complicated. To date, there is also no official approved policy that allows mother-tongue-based education to bridge the gap between home and pre-school, and for gradual transition to the acquisition of official languages (Tetun/Portuguese).

The National Policy for Inclusion and Promotion of the Rights of People with Disabilities was approved in 2012. Further efforts are needed to support children with disabilities in a more inclusive manner, supported by improved data and financing, and mobilizing relevant line Ministries in a coordinated manner.

Education budget and expenditure

Timor-Leste has one of the lowest education spending levels in the region (Figure 5.17) and needs to expand its total investment in the sector from US\$ 91 million in 2010 to US\$192 million in 2015 and up to US\$ 313 million in 2030 to meet the targets set by the National Education Strategic Plan.¹⁷⁸

Absolute government spending on education has increased consistently since 2003, however, as a proportion of the total national budget and GDP, public spending on education has been declining (Figure 5.18).

Excluding the 2006 crisis, **execution rate averaged 88 per cent between 2003 and 2012**, thereby increasing significantly the credibility of the MoE budget (Figure 5.19). After reaching a peak of 97 per cent in 2010, the execution rate started to decline from 2010 and was 86 per cent in 2013.

The capacity of the MoE to spend the allocated resources is critical, as this is one of the major factors that the MoF considers when receiving requests for increased budget.

The total budget devoted to the Ministry of Education in 2014 was US\$124 million (CFTL and Infrastructure Fund), accounting for 8.2 per cent of the total 2014 Government budget of US\$1.5billion. This represents a remarkable 23 per cent increase as compared to the previous year's funding, largely due to an increased allocation to the

Map 5.2: Mother tongue languages used by suco 2010

Source: Fischer, J. P. (2011) Major language groups in East Timor. http://tet.m.wikipedia.org/wiki/Imajen:Sprachen_Osttimors.png

AUSTRONESIAN LANGUAGES

ATAÚRO (WETAR)
Dadu'a
Rahesuk
Raklungu
Resuk

Baikeno
Bekais
Galoli
Habun
Kemak
Mambai
Tokodede

IDALAKA
Idaté
Isni
Lakalei
Lolein

KAWAIMINA

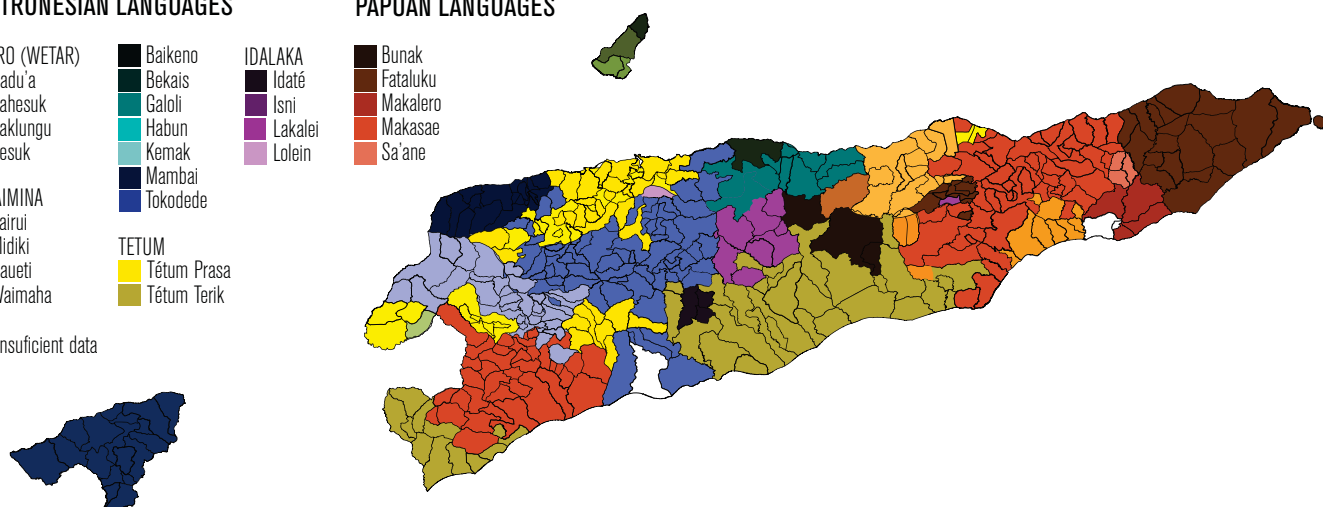
Kairui
Midiki
Naueti
Waimaha

TETUM
Tétum Prasa
Tétum Terik

□ Insufficient data

PAPUAN LANGUAGES

Bunak
Fataluku
Makalero
Makasae
Sa'ane



National Directorate of School Social Action that runs the school feeding programme (from US\$10 to US\$ 22million).

Further, while the National Directorate of Basic Education suffered a reduction of almost 5 per cent in funding, the National Directorate of Pre-School Education benefited from a 84 per cent increase of its budget, which however remains low as compared to the existing needs, merely US\$1.5 million.

In 2014, the Government has also allocated US\$14 million to the National University of Timor-Leste, representing a 37 per cent increase as compared to 2013. Further, every year since 2011 the Government has invested in the Human Capital Fund, to which it has directed \$40 million in 2014 (6 per cent reduction as compared to 2013), mostly consisting of scholarships.

Overall, albeit increasing over time, public resources allocated to the education sector appear insufficient to address the broad range of issues faced by the sector. However, it must also be acknowledged that increased funds need to be matched with adequate spending capacity and efficiency in order for the government to be able to translate financial resources into better outcomes for children. Therefore, enhancing execution of funds is paramount.

Further analysis in this regard is desirable to identify specific bottlenecks. Finally, planning and policy linked to budgeting and accounting is still rather weak, constituting a further obstacle towards ensuring maximum impact of public resources.

Education management and coordination

There is a need for enhanced technical and operational capacity of the Ministry of Education at all levels to meet the Government targets.

Figure 5.17: Percentage of public budget directed to education, 2011

Source: World Bank.

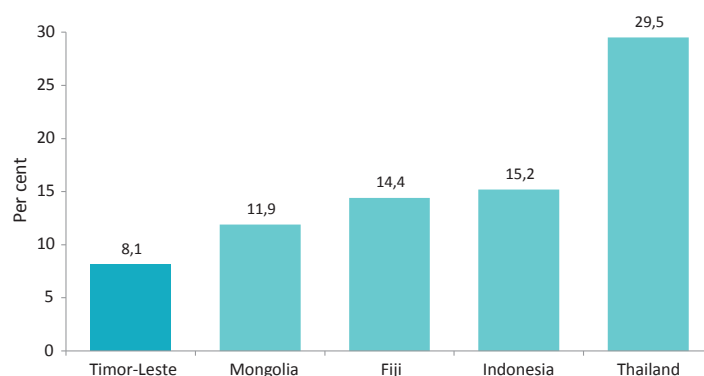


Figure 5.18: Actual public education spending¹⁷⁹ (2003-2012)

Source: Timor-Leste Budget Transparency Portal, MoF (data on public spending), and IMF, Report for Selected Countries and Subjects (data on GDP).

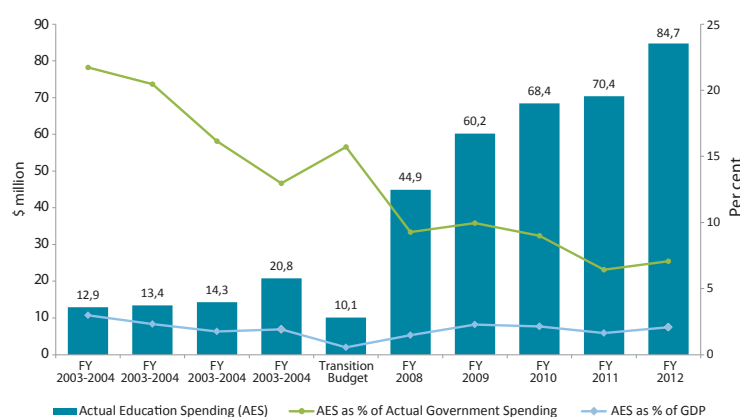


Figure 5.19: Education Public Spending Execution Rate (2003-2013)

Source: Timor-Leste Budget Transparency Portal, MoF.

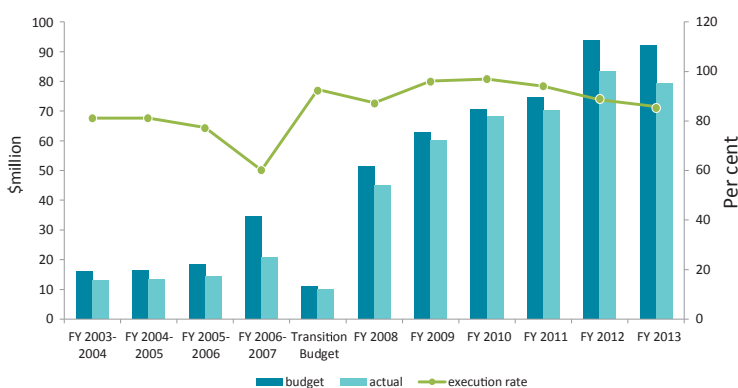
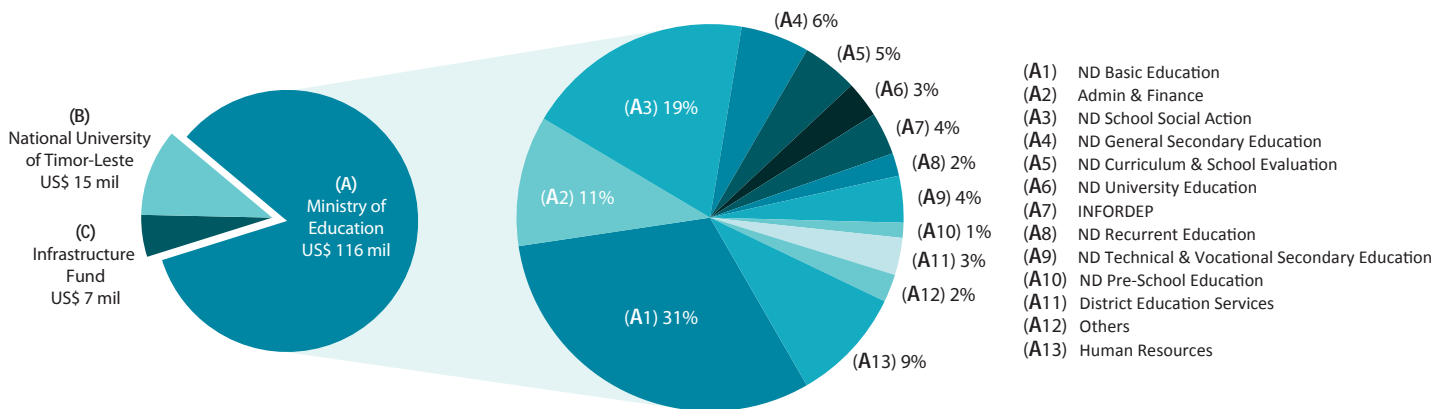


Figure 5.20: Education budget in 2014

Source: Timor-Leste Budget Transparency Portal, MoF.



Lack of clear job descriptions and systematic reporting lines hinder this effort. Capacity gap analysis and a functional review of the MoE have not yet been conducted in a holistic manner.

Ensuring timely availability of reliable, updated, disaggregated data through EMIS for evidence-based policy-making, and sector planning and management is a priority.

Whilst some improvement has been made, intra- and inter-Ministerial coordination needs to be further strengthened, as well as coordination among central-district-school levels and with development partners.

More efforts are required to ensure increased investment for education, along with support for improved efficiency of education finances. The decentralization process needs to be better supported (both technically and financially), as it is an opportunity to enhance the bottom-up approach to management in the sector.

Gender

Though more girls than boys enroll and proceed to the higher grades in basic education in total, fewer girls enroll in some districts. Further, participation of girls becomes less than boys at the post-compulsory level. Gender-based violence within and outside schools, and early marriage and pregnancy of adolescent girl students remain as key hindrances for the completion of the basic education cycles for girls.

A more systematic approach to address gender issues is needed. This includes: enhanced gender mainstreaming in sector planning and management, including curriculum and textbooks; teacher training components; teacher recruitment; and teacher deployment.

Areas for further studies shall be identified for gender-specific challenges (such as school-related gender-based violence) and targeted interventions should be generated to directly tackle bottlenecks.

Social norms, practices and beliefs

There are some perceptions of low returns on family investment in education especially among wealthier families. Strong stigma against education for teenage mothers and children with disabilities leaves these vulnerable groups “invisible” and prevents their full participation and completion of basic education.

5.4 Opportunities for action

Education remains as a **top priority of the government agenda at the policy level**. This is being supported by strong leadership within the Ministry of Education.

As discussed, challenges remain in terms of access, quality and equity, as well as for the system and capacity development. How the government goes about getting all children into school, keeping them there, and helping them to learn, whatever their background and experience, will depend on a series of policy decisions, many of which are discussed in the National Education Strategic Plan.

Major developments have already taken place in the past decade in education in Timor-Leste and the success of these must be maintained and further advanced.

The Timor-Leste Strategic Development Plan 2011-2030 covers a number of the policies and strategies that Timor-Leste needs to implement in the coming decade.

The following opportunities for action are proposed:

- **To ensure the expansion of quality pre-schools.**

Pre-school education has gained a full recognition within the government and with other stakeholders as a key driver for achieving the goal of universal quality basic education, and as such requires increased attention to and support from Ministry of Education and other ministries. Sufficient budget has to be allocated and the institutional and human resource capacity needs to be strengthened to achieve this goal. Further data on community pre-school initiatives; and play groups is also required to further facilitate planning and budgeting.

- **To improve the quality and relevance of education.**

The Ministry of Education should prioritise implementation of key strategies for quality improvement, including: **mainstreaming the Child Friendly Schools (CFS) approach and undertaking a complete curriculum reform.**

Inter-sectoral and inter-Ministerial coordination needs to be strengthened to holistically support this effort. It is very important to develop a national learning assessment system in accordance with the new curriculum that enables continuous measuring and monitoring of the progress of children's learning.

Efforts should be increased to further inform public thinking and to advocate to both government and the broader community beyond parents on education status and disparities in the country.

In order to increase public debate on basic education, a national campaign is suggested highlighting the importance of a child having a pre-school education, their full participation at school and completion of basic education.

This will in turn overcome some of the perceived low returns on family investment in education and the stigma against the education of vulnerable children such as those with disabilities and teenage mothers. Furthermore, the plan will be used for coordination among development partners to pool available resources and to prioritise strategies for vulnerable children and according to geographic needs.

- **To promote life skills-based education.**

Life skills-based education through the formal education structure and through the network of NGOs working with adolescents and youth should be strengthened and support for greater access to services is needed for both young children and adolescents to deal with challenges and risks, maximise opportunities, manage expectations and solve problems in cooperative, and non-violent ways. Life skills are defined as a group of cognitive, personal and inter-personal skills.

- **To increase funding and improve execution and quality of spending for education.**

The political commitment to basic education has not been satisfactorily reflected in the current sector budget, which amounts to only 7 per cent (including the Infrastructure Fund) of the total state budget for 2013. It is essential to increase the allocation of the state budget to education, as well as improve the effectiveness and efficiency of the available education funds to meet the needs of children, especially the most vulnerable and excluded.

The current process of resource allocation to districts does not consider the level of deprivation of children so that spending does not prioritise areas in greatest need. Budget allocation for education should be based on key indicators such

as the numbers of children who are not enrolled; children who have enrolled but dropped out of school; and children who repeat the same grades at school.

In addition, there is a need to strengthen capacity for evidence based planning, to enable districts to identify and address bottlenecks resulting in deprivations of children.

- **To strengthen evidence-based sector planning, budgeting and management.**

The Education Management Information System (EMIS) is a useful tool for this purpose. EMIS needs to be strengthened both in terms of quantity and quality so as to produce updated, disaggregated, credible data in a timely manner.

At the same time, capacity building for data analysis is necessary to make best use of the available data for sector planning and management.

- **To enhance a bottom-up approach in education sector management by continuing to support decentralization.**

This includes the strengthening of the autonomy of the district education offices and local level data management. Capacity of School Inspectors should be reinforced to ensure provision of quality education at the school level.

There is also the need to strengthen school level management capacity, including financial management and quality assurance capacity. The bonds between school and community should be reinforced, which will also contribute to ensuring community ownership.

Active participation of parents through Parent Teacher Associations and of students through Student Councils should be further encouraged. The capacity of school inspectors needs to be enhanced to better support the needs of schools.

- **To enhance coordination to optimise resources and quality of education.**

Improved coordination among different Directorates in the Ministry of Education, as well as among the line Ministries for crosscutting areas of work for quality education is essential.

Communication and coordination among the central, district and school levels need to be strengthened. Sub-national level capacity should be further enhanced, especially as the ongoing decentralization process advances. Further, coordination with development partners is also an effective tool for the Ministry. This should be undertaken throughout the stages of sector planning and management, including data analysis, planning and budgeting, implementation and monitoring.

- **To provide more education opportunities for excluded children:**

The emphasis placed on marginalized groups of children in the National Education Strategic Plan 2011-2030 is a positive development.

This emphasis should be duly translated in actions by targeting specific interventions to marginalized groups of children (such as child marriage and teen pregnancy, those from poor households, with disabilities, etc.) and providing programs with adequate funding allocations.

A comprehensive study to identify the reasons for dropout would be a useful tool to help design and prioritise such interventions.

Remediation not repetition should also be encouraged. There is a gap in developing remediation programs for students at risk in Timor-Leste.

Students that fail either repeat or drop out. Teaching must be responsive to children's levels of learning, not independent of it. For those who have dropped out of school, such programs must be linked to formal systems of education to provide pathways back to further learning in formal education, and employment where possible.

The government is in the process of post-MDG agenda discussion. It is critical to consider beyond universal primary education, looking further at universal "completion" at the right age with learning outcomes attained and transition to post-compulsory education.

Equally important is a focused attention to the last 10 per cent who are marginalised and are left out of the formal education system for different reasons.

- **To focus social protection systems directly on education for those in greatest need.**

There has been good support to education through social protection programmes, although there is little coordination between them and they use different data sources for administration. The Ministry of Education will need to find innovative ways of addressing the financial barriers that keep children out of school. Scholarships and conditional cash transfers can assist in addressing the lost opportunity costs for poor families and working children, but they may not be the only key to getting excluded children into school and completing their education.

Footnotes in Chapter 5

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154. Ibid.
155. EMIS 2010, MoE.
156. NESP 2011-2030, MoE.
157. Democratic Republic of Timor-Leste (2010) A Policy Framework for Pre-school Education, 2010. Dili: MoE.
158. Democratic Republic of Timor-Leste and World Bank (2012) 2011 Early Grades Mathematics Assessment, Result Analysis and Recommendation Report, Dili: MoE.
159. Net Intake Rate (NIR): New entrants in the first grade of primary education who are of the official primary school-entrance age, expressed as a percentage of the population of the same age UNESCO.
160. The EMIS does not provide disaggregated data by urban and rural. The comparisons between urban and rural are based on household survey data.
161. Democratic Republic of Timor-Leste and UNFPA (2012) 2010 Timor-Leste Population and Housing Census: Education monograph, Dili, Timor-Leste: National Statistics Directorate (NSD) [Ministry of Finance] and UNFPA.
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165. Census 2010, NSD & UNFPA.
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167. Democratic Republic of Timor-Leste and UNFPA (2012) 2010 Timor-Leste Population and Housing Census: Education monograph, Dili, Timor-Leste: National Statistics Directorate (NSD) [Ministry of Finance] and UNFPA.
168. The Out of School Children study (OOSC) carried out in 2011 using five dimensions of OOSC estimated that the proportion of OOSC was 28 per cent at primary school age and 14 per cent at pre-secondary school level.
169. Apparent intake rate: The number of new entrants in the first grade of primary education, regardless of age, expressed as a percentage of the population at the official primary school-entrance age. UNESCO.
170. Calculated by UNICEF based on the number of pre-school facilities (EMIS) and the number of population aged 3-5 (Census).
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173. Democratic Republic of Timor-Leste (2012) National Stocktake of School Facilities and Equipment in Basic Education Schools in Timor-Leste, Dili: MoE.
174. EMIS 2010, MoE.
175. From the baseline survey in a Ba Futuru's project school (164 secondary school students - 89 girls and 75 boys) in 2013.
176. Census 2010, NSD & UNFPA.
177. UNICEF (2012) Out of School Children Timor-Leste Country Study (draft), Dili: UNICEF Timor-Leste.
178. NESP 2010-2030, MoE.
179. Public education spending includes: Consolidated Fund of Timor-Leste (CFTL) and Infrastructure Fund.

6

Children's right to protection

All children have the right to be protected from violence, abuse, neglect and exploitation. Yet, millions of children worldwide from all socio-economic backgrounds, across all ages, religions and cultures suffer violence, abuse, neglect and exploitation every day. Millions more are at risk.

The Convention on the Rights of the Child (CRC) commits States Parties to protecting children from “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse”.

This chapter looks at the extent to which the right of children in Timor-Leste to protection has been realised, the manifestation and causes of violations of their right to protection and the opportunities for action. Validated information on child protection issues in the country is difficult to generate and analyse given the high level of under-reporting. However, the data from recent surveys such as: the TLDHS 2009-2010; the 2010 Census; and a mapping and assessment of the child protection system in 2010 do provide some useful insights on critical issues.



6.1 Overview

Child protection refers to the protection of all children from abuse, exploitation, neglect and violence. It also includes services for children who are at-risk of harmful circumstances. Some girls and boys are particularly vulnerable because of gender, race, ethnic origin or socio-economic status. Higher levels of vulnerability are often associated with children with disabilities, who are orphaned, indigenous, from ethnic minorities and other marginalised groups. Other risks for children are associated with living and working on the streets, living in institutions and detention, and living in communities where inequality, unemployment and poverty are highly concentrated. Natural disasters, armed conflict, and displacement may expose children to additional risks. Child refugees, internally displaced children and unaccompanied migrant children are also populations of concern. Vulnerability is also associated with age; younger children are at greater risk of certain types of violence and the risks differ as they get older.

Over the last 20 years, the situation for children in the Asia Pacific region has improved in many ways. However tangible gains in child protection have not kept pace and rates of violence against children remain disturbingly high. For example, the 2012 UNICEF systematic review of research on child maltreatment found that between 14 per cent and 30 per cent of the region's boys and girls report having experienced forced sex, and for many young people their first experiences of sexual intercourse was forced.¹⁸⁰

There is a critical lack of clear data on not only the nature and extent of violence, abuse, neglect and exploitation against children, but also the effectiveness of interventions for preventing and mitigating the negative consequences of such violence.

The lack of available data has led to poorly planned and implemented policies and programmes, and a scattered approach to combatting violence against children. However, governments are increasingly recognising the need for a detailed breakdown on where children are being abused in their countries, the perpetrators of such abuse, the types of violence children are suffering, and whether or not the services being provided are indeed working in order to better provide information and social welfare support to reach children and families in need.¹⁸¹

Children subjected to violence, exploitation and abuse are at increased risk of death, poor physical and mental health, HIV, lack of education and more. Sadly, these violations are widespread, under-recognised and under-reported.

6.1.1 Child protection programming context

The Ministry of Social Solidarity (MSS) has been mandated to create a protective environment for children in Timor-Leste. A broad range of strategic partnerships have been established with the Ministries of Health, Education and Justice – the National Police of Timor-Leste (PNTL) (including Community Police and the Vulnerable Persons Unit [VPU]); UNICEF, UNDP, UNFPA, UN Women, IOM and Plan International to tackle gender inequality and violence against women and girls in Timor-Leste. There is also close collaboration with local NGOs and Civil Society Organisations (CSOs), such as PRADET, Casa Vida and the Forum Komunikasaun Joventude (FCJ).

There has been considerable progress in Timor-Leste since 2006 **to establish a Child and Family Welfare System** through policy development and establishment of formal structures and procedures for protecting children and women.

In line with global and regional strategies on child protection, the Government has adopted a “systems building” approach to child protection. This approach aims to develop appropriate laws, services, behaviours and practices to minimise children's vulnerability by addressing known risk factors and strengthening children's own resilience.

The **establishment of the National Commission on the Rights of the Child (NCRC)**, with a clear mandate to promote and protect children's rights, has also been a positive step forward in monitoring progress of child welfare and justice in Timor-Leste. However, there are concerns as regards its legal status and capacity to effectively monitor the implementation of children's rights.

Formal justice structures for supporting child victims of abuse, exploitation, neglect and violence remain limited. The traditional authorities remain the major force for maintaining the wellbeing of their communities.

Access to support and services is not equitable around the country. Child Protection Officers (CPOs) are based at district level and most care services are based in district or regional capitals making it unlikely that victims will have access to them.

The system is highly reliant on NGOs to provide immediate and long term care and support to victims. However, the roles of the NGOs still need to be formalised to provide consistency based upon recognised standards. While inter-sectoral Child Protection Networks are in place in all 13 districts and are currently being established at sub-district level, the functioning and quality of the networks is inconsistent.¹⁸²

There is also a lack of multi sectoral planning between different sectors. In addition, the protection and care services are not developed

enough to appropriately provide for children in need of crisis intervention. Given the currently limited resources available and considering the prevalence of violence against children, **the service delivery needs to shift its focus from investing in supporting response to increasing preventative services.**

The achievement of a protective environment for children requires a more comprehensive consideration of the causes of vulnerability in order to improve data and provide support and social welfare services to reach children and their families.

6.1.2 Key achievements

Birth registration - considerable increase in the rate of children below five having their birth registered.

Development of a Child and Family Welfare System Policy to provide a strategic vision for the development of a comprehensive, integrated child and family welfare system.

The **establishment of a NCRC** with a clear mandate to promote and protect children's rights is a positive step forward in monitoring the progress of child welfare and justice in Timor-Leste.

Capacity building of CPOs, police officers and judiciary actors and the further strengthening of Child Protection Networks have further enhanced children's and families' **access to improved child protection services.**

Enhanced children's rights reporting. Timor-Leste has finalised the combined 2nd and 3rd State Party Report on the Implementation of the CRC and its two optional protocols: the Optional Protocol on the Involvement of Children in Armed Conflict and the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography.

6.2 Key issues – status, progress and disparities

6.2.1 Birth registration

Birth registration, the official recording of a child's birth by the government, establishes the existence of the child under law and provides the foundation for safeguarding many of the child's civil, political, economic, social and cultural rights. Article 7 of the CRC specifies that every child has the right to be registered at birth without any discrimination. Apart from being the first legal acknowledgement of a child's existence, birth registration is central to ensuring that children are counted and have access to basic services such as health, social security and education.

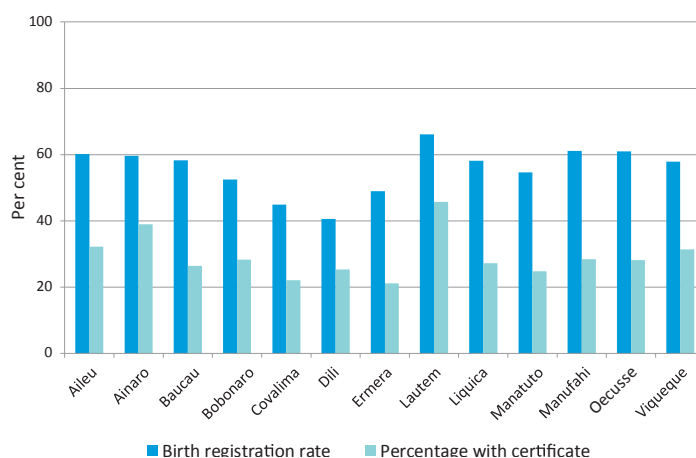
Knowing the age of a child is central to protecting them from child labour, being arrested and treated as adults in the justice system, forcible conscription in armed forces, child marriage, trafficking and sexual exploitation. A birth certificate as proof of birth can support the traceability of unaccompanied and separated children and promote safe migration. In effect, birth registration is their 'passport to protection.'

Universal birth registration is one of the most powerful instruments to ensuring equity over a broad scope of services and interventions for children.

As a result of substantive collaboration between the Government, development partners and other stakeholders, progress has been made in the birth registration of children under the age of five years in recent years. Both the TLDHS 2009-2010 and 2010 Census found that 53-55 per cent of children under five were registered. District disparities exist due to various local capacities. Dili and Covalima

Figure 6.1: Birth registration rate and registration with certificate by district

Source: 2010 Census, NSD & UNFPA.



had lower level birth registration rates at around 40 per cent while other districts reached to 58-61 per cent. Only half of registered children received birth certificates (Figure 6.1).

Since then significant progress has been made. The National Birth Registration Campaign from February 2011 helped with the registration of over 63,300 children. Based on population estimates and the number of birth registrations, it was estimated that after the campaign 85 per cent of children currently under-five have had their births registered. Continuous efforts have been made in the past two years to improve the birth registration system through mobilising midwives and suco chiefs.

The national birth registration campaign was preceded by strengthened inter-ministerial collaboration, training of all village leaders (chefe de suco) and midwives on notifying births. The chefe de suco and midwives were enlisted in the process to make birth registration of children easier for the parents. It had been observed that most children without birth registration were from poor families living in remote areas and whose parents could not afford the time and money required to travel to the capital for birth registration. All 442 chefe de

suco were trained to complete the birth notification form so that parents could approach them locally. A Memorandum of Agreement with the ministries of Justice, State Administration, Health, Education and the religious sector to assist parents during the birth registration process and engagement of various faith-based organisations, development partners and parents played a crucial role in the process.

Ensuring birth certificates and sustaining the process for new cohorts of children through equitable provision of services are now the challenges. Efforts are now underway to further institutionalise this process and to concomitantly increase the proportion of children with birth certificates so that they would have a proof of Timorese identity and improved entitlements.

6.2.2 Violence against children

Emotional, physical and sexual violence, exploitation and abuse are often practiced by someone known to the child. Studies show that it often takes place in the home, school, care and justice institutions and communities involving parents, other family members, carers, teachers, employers, law enforcement authorities, state and non-state actors and other children.

Violence destroys lives – in every country and at all levels of society. Witnessing or experiencing emotional, sexual and physical violence affects a child's health, wellbeing and future and can drain their potential. Very often, however, it is invisible simply because it is ignored and fails to be reported and it is too often tolerated. Worldwide, the numbers normally do not reflect the true magnitude of the problem.

In Timor-Leste, there is **very limited information and reliable data available on violence against children to inform policy and decision-making processes.**

Only a small proportion of acts of violence, exploitation and abuse are reported and investigated, and few perpetrators are held accountable.

To date, the only statistics available to the MSS, policy-makers and service providers are those numbers of cases that come to the attention of the CPOs, the VPU or service providers, such as shelters. In 2012 the MSS recorded 169 (F:123/M:46) cases of child abuse, neglect, violence and exploitation.

Given the widely accepted anecdotal evidence of abuse and violence patterns, even a cursory glance at this data suggests that the national statistics do not reflect the prevalence of violations against children. Absence of reliable data regarding children at risk adversely affects budget allocation and delivery of protection services.

Domestic violence

Domestic violence is commonly acknowledged as a serious issue in Timor-Leste, which affects women as well as children who are both witnesses and victims.

The TLDHS 2009-2010 found that approximately 38 per cent of women aged 15-49 years and 30.8 per cent of women 15-19 years reported that they had experienced physical violence since the age of 15.

Among the reported perpetrators to women aged 15-49 were parents (76 per cent), partners (60.4 per cent) and siblings (15.2 per cent), indicating the vulnerability of girls and women to violence at all stages of their lives. Reported physical violence by women against their spouse (about 5.5 per cent) reflects the acute dysfunction within a large number of households.

Sexual abuse is grossly under-reported as it occurs within the private domain and school setting amidst a culture of secrecy. Cases of incest, sexual assault, rape, sexual abuse, sexual exploitation through forced prostitution or consent of families and internal trafficking were identified in a baseline study of Sexual and Gender Based Violence (SGBV) conducted in Covalima and Bobonaro. Research by the Judicial System Monitoring Programme's Women Justice Unit (WJU) and former Victim Support Services (VSS)¹⁸³ indicated 49 cases of incest committed against underage females in the period between January 2010 and June 2012.¹⁸⁴

In the TLDHS 2009-2010, **about 3.4 per cent of women aged 15-49 years and 2 per cent of women 15-19 years reported that they had experienced sexual violence since the age of 15.** Some 7 per cent women in Baucau and 6.8 per cent in Lautem reported sexual abuse while only 0.4 per cent reported in Viqueque. However, even with the high possibility of under-reporting it is evident that women and girls in poor families are more vulnerable to suffer sexual abuse.

Almost one-third of girls aged 15-19 years have experienced physical and sexual violence since the age of 15. Figure 6.3 shows that about 28.2 per cent of girls aged 15-17 and 29.1 per cent of young women aged (18-19) suffer physical violence.

Women with higher education level, living in urban areas and rich families, and women who are employed are more likely to report physical violence (Figure 6.2). More than half of the women in predominantly urban Dili (52.7 per cent) reported

Figure 6.3: Violence against girls aged 15-19 years

Source: TLDHS 2009-2010, NSD and ICF Macro.

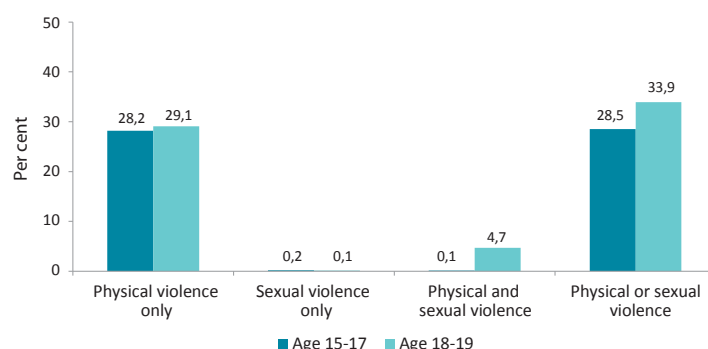
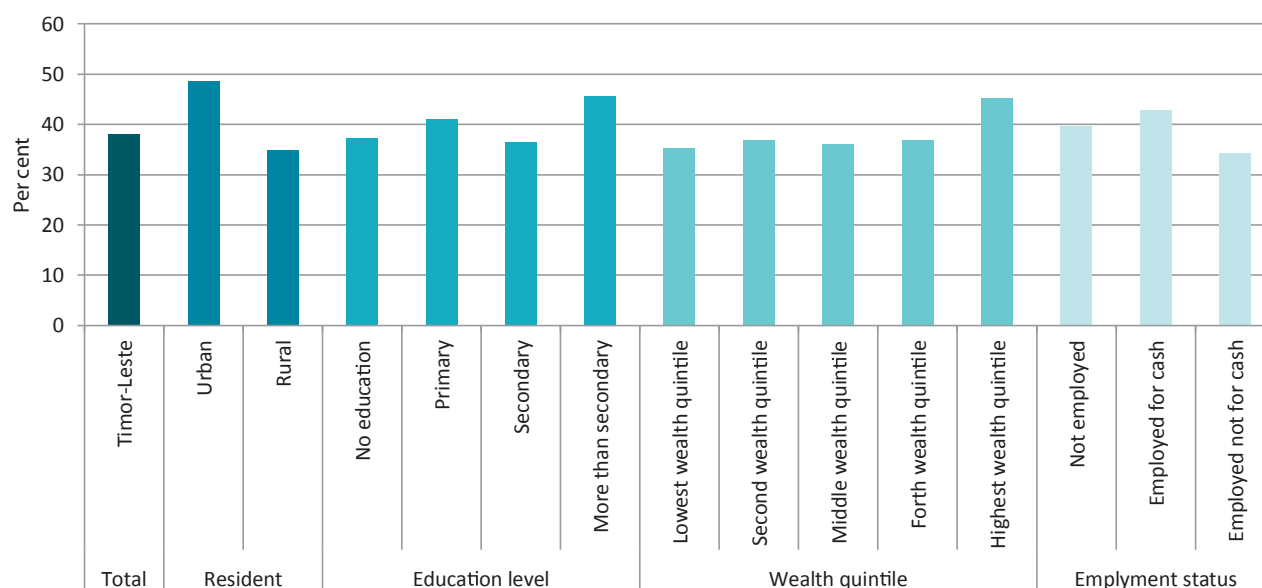


Figure 6.2: Percentage of women (15-24) reported experiences of physical violence since age 15

Source: 2010 Census, NSD & UNFPA.



experiencing physical violence since the age of 15 years. Women in Manufahi were most likely to report physical violence (75.6 per cent) while those living in Ainaro were least likely to report (10.5 per cent). While in-depth studies are required to explore these differentials, the higher reported prevalence in urban areas, rich families and women with higher education level and employed could indicate higher reporting due to better knowledge and understanding of domestic violence and higher coverage of redress services. Around 16 per cent of women who experienced sexual violence reported their first experience when they were in the 15-19 years age group while 6 per cent were in the 10-14 year age group, and one per cent before the age of 10.

Human trafficking mostly for sexual exploitation from the neighbouring countries in the region has been recognised as a problem by the VPU, MSS and NCRC. However, due to its clandestine nature, very little data and information is available on providing targeted preventative services to children and families identified at risk.

Corporal punishment

Several studies have highlighted widespread practice of corporal punishment (or physical violence) as a device for disciplining children in Timor-Leste. However, accurate data is still required. Disciplining children even if it entails violence is socially accepted. "Speak Nicely to Me", a 2006 study that used both qualitative and quantitative methods,¹⁸⁵ concluded that most **children are physically punished in their homes and/or at school.** Over two-thirds of children (67 per cent) reported being beaten with a stick and 39 per cent reported being slapped on the face by teachers. Three out of five (60 per cent) reported being beaten with a stick by their parents. Almost two thirds of the parents (63 per cent) felt it was acceptable to yell violently at a child; almost two in

five (39 per cent) said it was acceptable to beat a child with a stick, and just over a third considered other physical punishments such as ear twisting and face slapping acceptable.¹⁸⁶ As recognised by the Government, corporal punishment and verbal abuse is an issue of concern in schools.¹⁸⁷ The MoE has issued a dispatch on 'zero tolerance' for teachers using such methods of discipline, and Government and civil society have collaborated to increase awareness of different methods of discipline. While the Penal Code has provisions on assault of children, civil society has raised the issue that there is no explicit prohibition in law against corporal punishment.¹⁸⁸ An article prohibiting all forms of corporal punishment in all settings, including in the home, has been incorporated into the draft Child's Rights Code.

6.2.3 Children without parental care

Children sometimes lose their first line of protection – their parents. Reasons for separation are said to include abduction, trafficking, migration, living on the street, being displaced, or recruited by armed forces; living in alternative care due to health issues, educational reasons, household violence, poverty, death of parents, or stigma.

The issue of child neglect is now beginning to be discussed in Timor-Leste. As an act of omission, neglect usually has a higher incidence than child abuse, which is more easily recognised. In the focus group discussions undertaken for the Mapping and Assessment of the Child Protection System (2011), commissioned by the MSS and UNICEF, certain behaviours approximating neglect (e.g. leaving children under 10 years alone overnight and discrimination in the share of food and love) were identified as unacceptable by both children and adults.

Poverty, livelihood insecurity and other immediate concerns limit the protective abilities of parents and other caregivers in Timor-Leste and heighten the risk of child neglect. The failure of parents and caregivers to meet the minimum needs of the child for adequate food, supervision, guidance, education, clothing or health care constitute neglect and could result in accidents and physical, sexual and emotional abuse besides stunting their physical and cognitive development. Children below the age of six are at high risk, as they need more continual care and lack developmental abilities to reason and understand behavioural and developmental expectations along with the physical ability for self-protection. Older children who often assist with the rearing of younger siblings as part of their household work are also at risk in the typically large households in conditions of poverty and deprivation. In the Mapping report several male adults argued that the financial imperative might create circumstances where preferential treatment of children is acceptable. Although the extended family has traditionally assumed the responsibility for the care and upbringing of children without parental care, they are less likely to receive financial and emotional support.

Children without adequate parental care are a phenomenon in both rural and urban areas; however, the issue manifests itself in different ways. In remote rural areas parents are more likely to neglect children due to the necessity of securing sufficient income for the family. In urban areas, evidence suggests parents tend to neglect children due to alcoholism and gambling pursuits resulting in children often living and working on the streets. Data is limited and further research is required. Almost 1 in 4 households in Timor-Leste contain a foster or orphan child under the age of 18.

Orphans and foster children

In 2009, nearly one in four (23 per cent) of households had orphans or foster children under the age of 18 (Figure 6.4).

Kinship care is a widespread traditional care practice in Timor-Leste. It enables children to be cared for by extended family maintaining relationships with their families and culture. This traditional practice is usually more successful if immediate family members, rather than distant relatives care for children. However, children may still be treated differently than the carer's own children, and exploited, abused or denied access to education and health services.

Children in kinship care have a right to protection and family support services and therefore the use of this system of care should be closely monitored by protection services. At the same time the positive effect it has on many children's lives should be recognised and any unnecessary disruption of this traditional caretaking practice should be avoided.¹⁸⁹

Figure 6.4: Percentage of households with orphans and foster children under 18

Source: TLDSHS 2009-2010, NSD and ICF Macro.

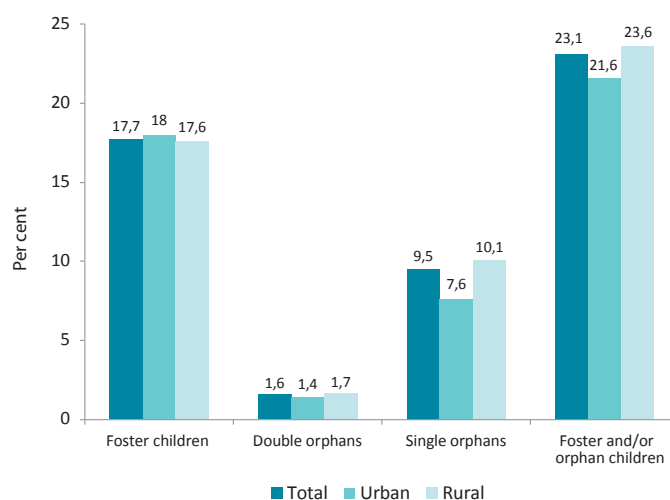
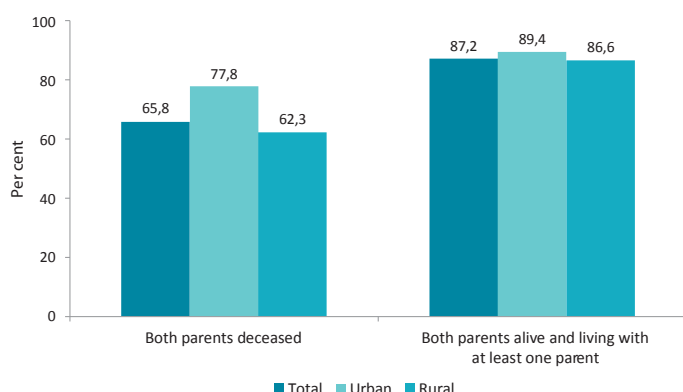


Figure 6.5: School attendance of children aged 10-14 years by survivorship of parents

Source: TLDHS 2009-2010, NSD and ICF Macro.



Only 66 per cent of 10-14 year old orphans attended school in comparison with 87 per cent of children with parents (Figure 6.5). Orphaned children are at greater risk of dropping out of or not attending school because of a lack of financial and psychological support.

Single parent households

In this context, the ability of single parent households to provide children with adequate care and protection also needs to be researched. About 16 per cent of the households in Timor-Leste are “female-headed”, a much stereotyped category that is listed among “the poorest of the poor” in developing countries. Although male-headed households do not guarantee children’s wellbeing, the protective capacities of women in Timor-Leste are undermined by the patriarchal social norms, livelihood insecurity and lack of safety nets.

The 2010 Census shows that there were 9,146 (5 per cent) households with: a single parent; headed by a parent who is widowed, divorced, separated and not remarried, or by a parent who has never married. Most single parent households were headed by women (63 per cent), 76.7 per cent of these women were widows. The majority of them (78.4 per cent) were employed in the vulnerable informal sector.¹⁹⁰ The ability of single parent households to provide children with adequate care and protection needs further research.

Figure 6.6: Type of residential care facilities

Source: Democratic Republic of Timor-Leste (2012) Mapping of Residential Care Facilities for Children, Dili: MSS and UNICEF Timor-Leste.

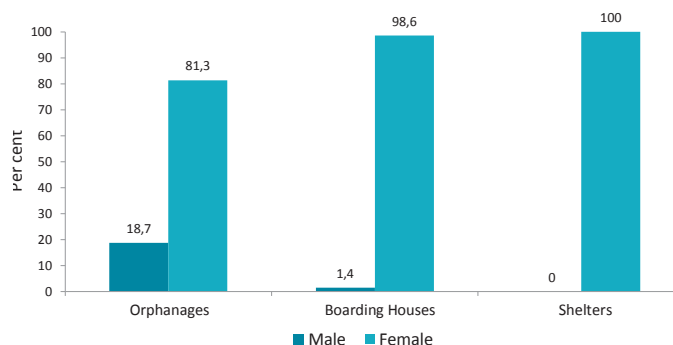


Table 6.1: Residential care facilities by district and type of facility

Source: Democratic Republic of Timor-Leste (2012) Mapping of Residential Care Facilities for Children, Dili: MSS and UNICEF Timor-Leste.

| Districts | Orphanages | Boarding Houses | Shelters | All facilities |
|--------------|------------|-----------------|----------|----------------|
| Dili | 5 | 6 | 4 | 15 |
| Oecussi | 2 | 1 | 1 | 4 |
| Viqueque | 2 | 2 | 0 | 4 |
| Baucau | 5 | 5 | 1 | 11 |
| Manufahi | 2 | 6 | 0 | 8 |
| Covalima | 0 | 1 | 1 | 2 |
| Liquica | 1 | 1 | 0 | 2 |
| Bobonaro | 1 | 3 | 0 | 4 |
| Manatuto | 0 | 1 | 0 | 1 |
| Lautem | 1 | 3 | 1 | 5 |
| Ermera | 2 | 1 | 0 | 3 |
| Aileu | 0 | 0 | 0 | 0 |
| Ainaro | 0 | 0 | 0 | 0 |
| Total | 21 | 30 | 8 | 59 |

Institutional care

Institutionalisation of children is an exception rather than the rule in Timor-Leste. However, there are 59 residential care facilities in Timor-Leste, of which 21 are orphanages and the remaining ones are 30 boarding houses and 8 shelters for victims of abuse. None of these 59 facilities are formally licensed to

provide care or protection to children. The Catholic Church runs the majority of care facilities.¹⁹¹

The estimated number of children in residential care is 3,500.¹⁹² The majority of children in residential care are girls (88.4 per cent sampling of 439 children, Figure 6.6).

Children are most likely to enter residential care facilities between 6 and 17 years of age, including 29.2 per cent between 6 and 10 years of age, 30.1 per cent between 11 and 13 years of age, and 29.4 per cent between 14 and 17 years of age. The percentage of children below 5 years of age when being admitted to residential care is relatively low (8.9 per cent), which is positive, as residential care for children below the age of 3 is considered the most harmful period and most detrimental to child development. The vast majority of children spend more than one year in residential care (86.3 per cent).

6.2.4 Children in contact with the law

Children encounter the justice system as victims or witnesses, because they are in conflict with the law or as parties to a justice process, such as in custody arrangements.

While detention should be used as a last resort and for the shortest period of time, children suspected or accused of having committed an offence are often detained throughout the world. Children are also detained for various reasons: because they were accompanying a parent to detention or seeking asylum in another country; for vagrancy, begging, or missing school; for reasons such as after being removed from an abusive home situation; or for reasons such as race, religion, nationality, ethnicity or political views. UNICEF estimates that more than one million children globally are deprived of their liberty by law enforcement officials.¹⁹³

Many justice systems around the world do not have child-sensitive procedures due to lack of resources or political will and those services for a child's development may not be available to promote the child's rehabilitation and reintegration into society.

In detention, children may suffer violations of their rights – they may be detained with adult prisoners – and are exposed to torture, physical and emotional abuse. Legal and social norms, as well as practical constraints may complicate issues of justice for children.

The involvement of many young people, as members of martial arts groups (MAGs), in the violence during and after the 2006 riots highlighted the particularly serious issue of children in conflict with law in Timor-Leste. The MAGs were mostly founded as legitimate sporting organisations during the Indonesian occupation in the 1980s but were later mobilised by different political factions.

Thereafter, they graduated to large-scale violence and are reported to have a strong presence in the security forces. The MAGs are spread out across the country but also have pockets of influence in certain areas. Their members reportedly belong to all age groups and all classes of society. The 2006 riots as well as in the growth in organised crime, extortion and other criminal acts, led to public concern and policy debates on the need for a youth policy and national legal provisions for juvenile justice and good practices. Since 2012, the Government has tried to rein in MAGs. A law regulating their functioning was passed. In 2013, three groups were closed down. However, the impact of this on the levels of youth violence in society remains unknown.

Violence is all-pervasive in Timorese society and it manifests itself also in youth relationships. It doesn't necessarily lead to crime nor does it necessarily send young people into contact with the law. But it still is detrimental to young people's development. Most

youth violence involves a youth as the perpetrator and a youth as the victim.

The number of children in conflict with the law (CICL) in Timor-Leste is normally under-reported.

There is no centralised or consistent data collection system for CICL across different organisations, and there is no single number or trend that can comprehensively capture the number of CICL in the country. The best estimates available are the total number of cases reported by CPOs in all 13 Districts and the number of detained children, as shown in Figure 6.7.¹⁹⁴

MSS data indicates a steady number of CICL over the past 7 years. There is only a difference of 15 cases between the highest (72 in 2006) and the lowest (57 in 2012) number of cases during this six-year period. This comes out to an average of 64 cases each year of CICL documented by CPOs.

The Ministry of Justice (MoJ) data between 2006 and 2012 revealed a total of 58 children (ages 14-18) who entered Becora Prison. An additional 13 children (ages 10-16) were sent to FCJ during the same time period. Between Becora and FCJ a total of 71 CICL were held in custody over the past 7 years. This reveals an average of 10 children being sent to detention each year.

The greater number of CICL reported by the MSS versus the number of children detained suggests that the majority of cases were resolved at the community level and involved lesser crimes that did not require detention. Both the MSS and the MoJ report the lowest number of CICL in 2012, with only 57 cases reported by the MSS and only 2 youths entering Becora.

The overwhelming majority of cases of CICL documented and reported were of boys. Approximately 93 per cent of the cases reported by CPOs, VPU and chefe de suco in the Districts were cases involving boys. All of the CICL who were detained in either Becora prison or FCJ from 2006-2012 were boys.

CPOs, VPUs and chefe de suco reported 6 cases of girls in conflict with the law between 2008 and 2012 that were all minor cases of fighting or stealing and were handled at the community level.

Most of the CICL reported were 16 years old and above (73 per cent). Inconsistency in the reports of children's ages by different entities suggests a gap in accurate age determination of CICL. The districts with the highest prevalence of children detained were Dili, Baucau and Ermera. Based on the districts visited for the 2012 assessment, Baucau and Ermera also had high numbers of reported CICL. However Liquica had the second highest number of CICL suggesting most cases in Liquica being either resolved at the community level or of being lesser offenses.¹⁹⁵

Between 2008 and 2012, the major types of crimes reported for CICL are stealing (23 cases), fights/assaults (18 cases) and rape (12 cases). As regards to detained children, between 2006 and 2012, there were 26 cases of homicide, 11 cases of robbery and 9 cases of fighting.¹⁹⁶

Figure 6.7: Number of children in conflict with the law, by year

Source: UNICEF (2012) Juvenile Justice Strategy Paper.



6.2.5 Child labour

Worldwide, millions of children work to help their families in ways that are neither harmful nor exploitative. However, UNICEF estimates that around 150 million children aged 5-14 in developing countries, about 16 per cent of all children in this age group, are involved in child labour. The ILO estimates that throughout the world, around 215 million children under 18 work, many full-time. Although aggregate numbers suggest that more boys than girls are involved in child labour, many of the types of work girls are involved in are invisible. It is estimated that roughly 90 per cent of children involved in domestic labour are girls. Even though the prevalence of child labour has been falling in recent years everywhere apart from Sub Saharan Africa where it is actually increasing with regard to children aged 5-14, it continues to harm the physical and mental development of children and adolescents and interfere with their education.¹⁹⁷

Child labour reinforces intergenerational cycles of poverty, undermines national economies and impedes progress towards the Millennium Development Goals. It is not only a cause, but also a consequence of social inequities reinforced by discrimination. Children from indigenous groups or lower castes are more likely to drop out of school to work. Migrant children are also vulnerable to hidden and illicit labour.

Often justified with reference to the compulsions and economic hardships faced by the families and the moral economy of the household, child labour is also seen as a learning opportunity, particularly when the education infrastructure and services are limited and the quality of learning is inadequate. Such perceptions seek to give primacy to the collective interests to the detriment of the rights of the child. As members of the household, children are expected to assume certain responsibilities. However, the distinction between acceptable child

work and unacceptable child labour is not sufficiently recognised.

The prevalence of child labour remains high in Timor-Leste with about 9.3 per cent of 10-14 year olds considered to be economically active and 24 per cent of children in the 6-14 years age group out-of-school.¹⁹⁸ Over 8,000 children aged 10-14 (6.4 per cent) were reported as employed during the 2010 Census and more than 4,000 children were seeking work.

In rural areas, 11 per cent (over 11,000) of 10-14 year olds were economically active (i.e. either working or seeking work) compared with 3.8 per cent (over 1,200) in urban areas (Figure 6.8).

Many rural children are engaged in agriculture, particularly in the cultivation and processing of coffee, where they are exposed to hazards while using potentially dangerous machinery and tools, carrying of heavy loads, and applying harmful pesticides. Many of them also work in fishing where they may be at risk of drowning and exposure to the elements. It has also been reported that in a few cases, particularly in rural areas, families are forced to have their children work as indentured servants in order to settle outstanding debts.¹⁹⁹

Figure 6.8 Percentage of economically active children aged 10-14 years by sex and residence

Source: 2010 Census, NSD & UNFPA.

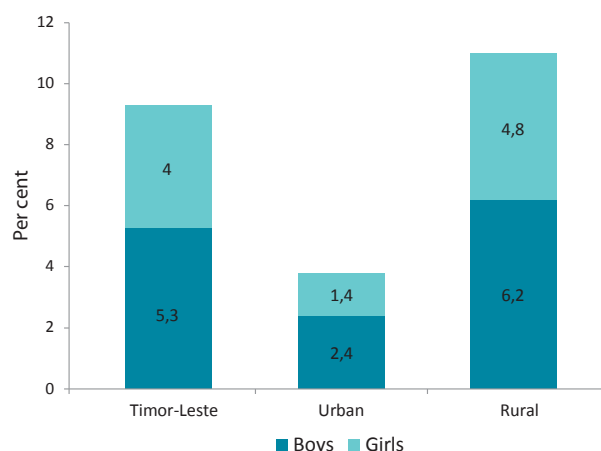
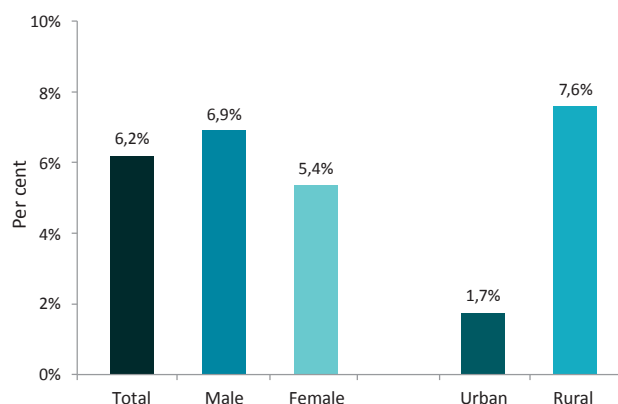


Figure 6.9: Percentage of children aged 10-14 years engaged in work

Source: 2010 Census, NSD & UNFPA.



Six per cent of children aged 10-14 are engaged in work with rural children four times more likely to be at work than urban children (Figure 6.9).

Street children and working children are a common feature in urban areas in Timor-Leste

where they are usually found selling fruits, vegetables, fuel, newspapers, mobile phone cards, and DVDs. Their work often exposes them to the vagaries of weather, traffic and accidents, and criminal elements. Many children, in particular girls, are also engaged in domestic work, mainly for their immediate and extended families and adoptive families. Some of them work for third parties where they may be exposed to long hours of work and to physical and sexual exploitation. Children are also known to work at construction sites.²⁰⁰

Boys more than girls appear to be engaged in work (5.3 per cent as against 4 per cent) largely as a result of the gender-based division of labour. Surveys have consistently confirmed that children often relieve older members of the family by undertaking household chores. However, conventional survey methodologies are often unable to capture the work of girls resulting in such under-estimation.

Based on the available data, it is difficult to ascertain if child labour is increasing or declining. Comparison

with data from earlier surveys and studies is not feasible because of the differences in definition, indicators and methodologies and a lack of consensus on what actually constitutes child labour. Indeed, there are several grey areas in the legislation on child labour in Timor-Leste. Although the Labour Code sets the minimum age for employment at 15, it exempts children working in family-owned businesses or vocational schools. It allows a child in the 12-14 years age group to perform “light work” without clarifying it and renders illegal any work that jeopardises the health, safety and morals of children in the 15-18 years age group without defining activities that are considered hazardous.

The child labour issue is likely to manifest itself in different ways as Timor-Leste proceeds on the path of peace, economic development and social change. For a robust understanding and response to the issue, children’s access to quality education and engagement in work in different spheres and arenas that is neither excessive nor hazardous requires monitoring on a regular basis.

6.2.6 Children with disabilities

Protecting and promoting the rights of persons with disabilities is a global human rights issue. The World Bank estimates more than 1 billion persons, including adults and children, are living with disabilities in the world, or approximately fifteen percent of the world’s population.²⁰¹ **Approximately 400 million persons with disabilities live in the Asia-Pacific region.**²⁰² More than two thirds (426 million) of persons with disabilities are living below the poverty line in developing countries and the **proportion of persons with disabilities is higher in conflict and post-conflict settings.** Depending on how disability is defined, global figures estimate that **200 million children experience some form of disability.**²⁰³

However, statistics on incidence and prevalence of childhood disabilities are slim and assumptions often lie within large ranges of uncertainty and are outdated.²⁰⁴ Children with single or multiple forms of physical, mental, intellectual, or sensory impairments can become disabled if attitudinal and environmental barriers deny their human rights, hinder access to basic services and foreclose equal participation. The realities of disability are alarming in all parts of the world. Legislation, policies and attitudes that fail to recognise the legal capacity of children with disabilities are factors that aggravate their discrimination and exclusion from society and increase their vulnerability to violence, abuse and exploitation.

A key objective in the National Strategic Development Plan 2011-2030 prioritises the development of the public health system, enlarging and improving the facilities and increasing the development of human resources.

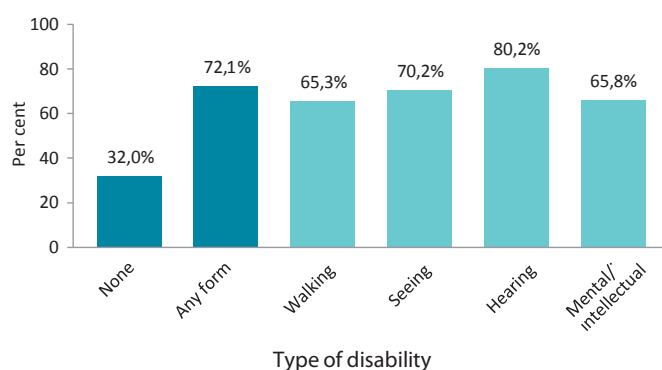
These measures will contribute significantly to improved standards of living and access to services for people living with a disability.

In Timor-Leste, it is estimated that there are at least **48,243 people living with a disability**.²⁰⁵ The MoH reports 2,064 people are presently receiving treatment for intellectual disabilities. However, the most recent Census results indicate there are approximately 13,308 people living with an intellectual disability in the country.²⁰⁶ There are an estimated 29,488 people with visual impairments and 17,672 people with hearing impairments. A National Disability Survey conducted by MSS in 2002 estimated there are at least 2,241 persons who are mute in Timor-Leste.

According to the 2010 Census, there are **2,723 school students (from pre-primary to university level), living with a disability in Timor-Leste.** However, children living with a disability are twice as likely to never attend school as able-bodied children;

Figure 6.10: Percentage of population who have never attended to school

Source: TLDHS 2009-2010, NSD and ICF Macro.



and children with hearing difficulties have the highest risk of missing out on an education (Figure 6.10). Children with disabilities are unable to attend school due to issues of accessibility and inclusion.

In response to this issue, the MoE is in the process of finalising the “National Inclusive Education Policy”. This policy has the objective of education for all without discrimination of any kind and aims to remove barriers to participation and learning for all children who are out-of-school or at risk of dropping-out, including those with disabilities. Timor-Leste has taken progressive steps to fulfil the rights of persons with disabilities.

6.2.7 Child marriage and early pregnancy

Child marriage, defined as a formal marriage or informal union before age 18, is a reality for both boys and girls, although girls are disproportionately the most affected.

Evidence shows that girls who marry early often abandon formal education and become pregnant. Maternal deaths related to pregnancy and childbirth is an important component of mortality for girls aged

15–19 worldwide, accounting for 70,000 deaths each year. If a mother is under the age of 18, her infant's risk of dying in its first year of life is 60 per cent greater than that of an infant born to a mother older than 19. Even if the child survives, he or she is more likely to suffer from low birth weight and malnutrition. Child brides are at risk of violence, abuse and exploitation. Finally, child marriage often results in separation from family and friends and lack of freedom to participate in community activities, which can all have major consequences on girls' mental and physical wellbeing.²⁰⁷

People marry young in Timor-Leste. Women get married around 21 and men at 25. Most women have their first child at 22, so shortly after their marriage. There are however a number of girls who are getting married and having children at a very young age. Almost one in five (19 per cent) marries before the age of 18 and one in four has a child in her teens (before turning 20).²⁰⁸ Marrying at a young age is more common for girls in Oecusse, Covalima, Ermera and Liquica but is an issue for very few young men. Teenage pregnancy is more of an issue in Oecusse, Bobonaro and Viqueque.²⁰⁹ It is more common in rural areas, amongst girls with little or no education and amongst the poorest quintiles.

6.3 Manifestation and causes of deprivation

6.3.1 Immediate and underlying causes

Access to child protection facilities and human resources:

Birth registration is under the National Directorate of Civil Registry and Notary of the MoJ. Currently, the 13 Civil Registry Offices are responsible for issuing

birth certificates. The Civil Registry Offices are only based at district level. Midwives and chefe de suco can facilitate birth registration by notifying births. However, the over-burdened chefe de suco do not always actively conduct outreach to communities and do not always facilitate birth notifications as part of their routine trips to communities. UNICEF and Plan International supported mobile birth registrations in 8 districts back in 2002-2007 to ease access in remote areas and successfully advocated for the community leaders and midwives to be given the authority to conduct birth notifications in 2010, easing access of parents to birth registration.

Birth Registration Posts have also been established at the National Hospital in Dili (2010), all referral hospitals (2011 and 2012) and three more community health centres in Dili (Comoro, Becora, Formosa, 2013) to encourage immediate birth registration.

Families have reported the process and length of time it takes to get a birth certificate as a reason for not registering children. There is a need to streamline and advocate for better coordination between relevant actors to speed up the delivery of birth certificates. In 2012 with UNICEF support the civil registration system was computerised in all 13 districts. However, to date the system is not being used in most districts due to limited computer skills among staff. Further capacity building by the MoJ and UNICEF is therefore required to accelerate the process.

The Child and Family Welfare System remains at an embryonic stage in Timor-Leste. There are significant regional disparities in access to child protection services with over half of the districts in Timor-Leste not having any short-term shelters, which greatly reduces the quality of care the protection system is able to offer to those in need. There are 26 CPOs at district level (of which 13 were recruited by the MSS in August 2013, though

so far only as project staff) and 64 social animators at sub-district level. The VPU under the National Police is only available at district level. Access to justice including courts and lawyers are not available in all districts. Community Police are also available at sub-national level, including suco level in certain districts however; their capacity in child justice needs to be strengthened.

The MSS and local NGOs providing services to child victims have reported the need for professional training on social work and psychology, including case management, psychosocial counseling and trauma therapy. The National Police of Timor-Leste, in particular the VPU needs further capacity-building on child-friendly investigation and interviewing skills and judiciary actors need further capacity-building on child-friendly court procedures.

In terms of **preventing placement in residential care**, family support services to ameliorate the risk of family separation are still scarce, there is no effective gatekeeping at community level, and there is no formal alternative care apart from residential care and limited regulated and monitored domestic and inter-country adoption in Timor-Leste. The MSS' Bolsa da Mae scheme needs to better target families at risk of separation. Most management and staff in residential care facilities, in particular orphanages and boarding houses, do not meet minimum qualifications of childcare and development. Case management and care planning, including regular review of children's placement in residential care, are hardly ever conducted.

The capacity of the police to conduct investigations in cases of child abuse is still very limited and there are limited child sensitive judicial procedures in place. Regarding children in conflict with the law, there are few services for children in custody. Youth offenders in Becora prison are not adequately separated from adults and do not receive adequate education or vocational training. MSS provides some subsidies for families to visit youth in prison and transportation for

youth leaving prison, but otherwise does not provide further support services to promote the child's rehabilitation and reintegration into society.

There are no programmes in place to specifically address the worst forms of child labour, especially for children in rural areas. This is further compounded by a lack of access to quality education and employment opportunities. In 2011, the Government employed 20 labour inspectors to undertake a monitoring role.

The Government and civil society have taken measures to increase access to education for **children with disabilities**, but there is room for improvement. In addition, access to public information is not readily available to people with disabilities. Children and people with disabilities in general, are also not provided with sufficient access to rehabilitation, health care, public buildings, transport and other forms of national infrastructure.

Social practices and beliefs:

In Timor-Leste, the Catholic Church exercises a considerable influence on parents' decisions regarding which name to give to their children. It can considerably delay the process of birth registration. There have been some attempts of collaboration with the Catholic Church (Bishop of Dili) and Pastoral da Crianças in raising awareness on birth registration at the Day of Prayer and Action for Children in 2011 and 2012.

Beliefs and social practices, such as bride price and traditional systems of law and conflict resolution are an impediment in protecting **children against violence, exploitation and abuse**. Family involvement in marriages and family pressure not to take issues of abuse and violence outside the family compound is an issue. Patriarchal organisation in many districts and strongly held beliefs on men as the heads of the families further complicate the issue of child protection.

Resolution of domestic violence is sought either within the household or through traditional or community-based mechanisms, which continue to be quite strong. Only when the experience becomes unbearable do the victims seek assistance from the police or NGOs that provide shelter, legal assistance and counseling. About one in four women (24 per cent) sought help in the event of domestic violence, and mostly when they experienced sexual violence.

There is not an over-representation of children with disabilities or children with HIV/AIDS in residential care in Timor-Leste. Anecdotal evidence suggests that there remains a strong belief that vulnerable children especially from poor families are better off in residential care. Further research is required in this area.

Traditional ways of resolving conflict and crimes perpetrated against children are still very much the norm in Timor-Leste. Respondents in the mapping and assessment of the Child Protection System in Timor-Leste underlined the importance of reaching an agreement between all parties involved, rather than evoking the formal system. Even when a case is referred to the formal authorities, usually the police, it is often referred back to the traditional leaders for final resolution.

There is no officially recognised role or mandate for community leaders to resolve less serious cases, which creates a lack of transparency and consistency in how traditional justice is applied. A majority of people remain confident in local and traditional justice mechanisms and there appears to be little knowledge of formal protection and judicial services, especially within rural communities.

Some families are reportedly forced to have their children work as indentured servants or as bonded labourers in order to settle outstanding debts. It seems rather common that families from the districts send their daughters to live with extended family or friends in Dili. These girls apparently often work

full-time as maids and nannies and are often denied the right to education. More research in this area is urgently needed to inform appropriate strategies for prevention and response.

Children with disabilities are also vulnerable to discrimination in accessing education. They also are sometimes victims of verbal and physical abuse within their communities. Stigmatising language is commonly used to refer to persons with disabilities in Timor-Leste. Women (and girls) with disabilities are particularly vulnerable to sexual violence.

6.3.2 Basic causes

Legislation/Policy: The national legal framework for child protection is marked by sizable gaps in legal regulation and confusion over applicable law. Justice for children is currently administered with few or no special considerations for children under adult justice laws. The Child's Rights Code and the Juvenile Justice Law are still in draft pending approval. So far the Penal Code applies for children who are above the minimum age of criminal responsibility (MACR): 16 years.

To date there is no specific child protection law in place. However, MSS has prioritised the development of such a law, with Draft 0 being publicly consulted in 2014.

Children without Parental Care: Policy, Procedures and Standards for Child Care Centers and Boarding Houses exist but are not enforced as MSS lacks the legal authority to implement its provisions. A Decree Law on the Regulation of Residential Care is planned for 2014.

The Child's Rights Code, which is still pending approval, clearly states that a child has the right to grow up in a family environment and establishes institutional care as a measure of last resort. The Child and Family Welfare System Policy, which also

stipulates the primacy of family support services and family- and community-based alternative care, is also awaiting approval.

The Civil Code Article 1800 places all the authority for family separation and alternative care with the court, at the petition of the Public Ministry, a family member or guardian of the child. In addition to the Civil Code regulations on adoption, in 2009 Timor-Leste ratified the Hague Convention on Protection of Children and Cooperation in Respect of Inter-country Adoptions. To date, no action has been taken to implement the provisions of this Convention.

Child Labour: Timor-Leste has not yet ratified the Minimum Age Convention, 1973 (No. 138). The Labour Code does not clearly stipulate what “light work” constitutes and does not list prohibited hazardous work. The Code does not make any reference to children working in the agricultural sector or domestic chores, the main areas of child work. At present, there is no policy or national action plan in place to combat child labour.

Children with Disabilities: The existing national legal framework requires further development to protect children (persons) with disabilities from discrimination and to guarantee their access to public services. Timor-Leste has approved a National Policy on Persons with Disabilities. However, the policy focuses on health and education but hardly at all on child protection. Timor-Leste has not yet ratified the Convention on the Rights of Persons with Disabilities. Further development of legislative and institutional frameworks needs to occur to ensure compliance with the principles and objectives of the treaty prior to its ratification. The development of these frameworks is resource intensive and takes considerable time. In addition, there is no mental health legislation.

Child marriage: In accordance with the Civil Code, boys and girls can get married at 17, and at 16 with parental permission.

Budget/expenditure: There is a requirement for stronger investment from the MSS in (targeted) preventive child protection services. The MSS primarily provides financial support to shelters for child victims of abuse and orphanages get sporadic support for rice only. There are few programs targeting justice for children and children with disabilities so allocation of adequate resources cannot be evaluated.

Management /Coordination: Capacity at the national level for policy development, strategic planning and monitoring needs to be further strengthened. Roles and responsibilities in the area of child protection need to be further delineated. Inter-sectoral coordination has considerably improved through the establishment of Child Protection Networks (CPNs) in all 13 districts. In 2013, the MSS has commenced to roll out the establishment of CPNs at sub-district level. However, the functioning of these CPNs varies from one district to another. While some CPNs work relatively well, others hardly ever meet. A national coordination mechanism for juvenile justice has been incorporated into the draft Juvenile Justice Legislation but still remains to be established.

A comprehensive mapping of residential care facilities for children has been recently conducted with the support of UNICEF.²¹⁰ Plans for licensing and enforcing minimum standards of care are underway. The MSS CPOs are often not involved in decisions of placing children into residential care. Most of the time, parents or extended family members place children into residential care without informing the MSS. Cooperation between CPOs and management of orphanages, boarding houses and shelters needs to be enhanced. In particular, informal custody transfers and legal guardianship in absence of parental care needs to be regulated to ensure MSS and service providers can adequately represent a child in legal proceedings and ensure adequate care.

6.4 Key opportunities for action

The following key opportunities for action are proposed:

- **To improve data systems and the knowledge base on child protection.**

Obtaining reliable prevalence statistics on child protection is extremely difficult but a baseline of understanding is required in order to formulate appropriate policies, targeted programmes and advocate for necessary financial resources. The efforts to strengthen the knowledge base on child protection must address the challenges of disseminating perspectives, approaches and lessons from other countries in a way that a critical mass of people with relevant knowledge and skills is created, and are also able to devise innovative practices that respond to the local context.

- **To review and finalise the legal and regulatory frameworks on child protection.**

There should be a thorough and collective review of all related draft policies, from the perspective of an integrated and reinforcing package that should create a cohesive national child protection legal framework. This review should also take account of the Labour Code, Civil Code, Juvenile Justice Draft Law and Customary Draft Law, and should ensure full compatibility with all relevant international standards individually and collectively. Draft bills should provide sufficient legal mandates and regulation that also correspond to the reality and institutional capacity of Timor-Leste. There is also a need to ratify or accede to further international child protection instruments, including among others the ILO Minimum Age Convention 138 and the Convention on the Rights of Persons with Disabilities.

- **To sustain gains towards universal coverage of birth registration and certification.**

An effective birth registration system strengthens the protective environment for children by providing them with valid documents on their age and identity. This can in turn assist them in claiming their entitlements and being protected from unlawful arrests and detention, illegal adoption, labour exploitation and trafficking. The birth registration process, which is free and compulsory, helps to ensure outreach to the poor and marginalised. Notable progress in expansion of birth registration of children below the age of five years has been made in the recent years. Sustaining the process to include new cohorts of children as well as substantial improvement in the system of certification are required.

- **To strengthen and support the protective role of families and communities.**

There is a need to implement culturally appropriate and gender sensitive parenting and care-giving programmes to support families in providing a violence-free home. Such programmes should include: (a) increasing the understanding by parents and caregivers of the physical, psychological, sexual and cognitive development of infants, children and adolescents in the context of social and cultural factors; (b) promoting non-violent relationships and non-violent forms of discipline and problem-solving skills; (c) addressing gender stereotypes; and (d) support to parenting education initiatives to encourage alternatives to violence for disciplining children.

In the child and family welfare system, this would entail more proactive and preventative support for children, their families and communities. This is in addition to interventions after violence, neglect, abuse or exploitation has occurred. A much wider range of interventions that are community-based, strengthen parents' capacities to provide appropriate care and protection, and provide

alternative family-based care for children who cannot live with their own family may be needed.

Communities are the primary source of protection and solidarity for children. Working at the community level is an effective way of promoting social change, notably through non-coercive and non-judgmental approaches that emphasise the fulfilment of human rights and empowerment of children and women. There are nearly 450 chefe de suco and over 2,200 chefe de aldeia in Timor-Leste. Given the embryonic status of the formal child protection system, coupled with the strong informal resolution mechanisms, it is essential to harness role of the chefe to the system. Due to cultural factors, chefe de sucos will continue to play a central role in the welfare of children and families, even if the formal system expands its scope, and thus support to them should be strengthened.

- **To continue strengthening the justice and child and family welfare systems.**

The need for a more integrated and systems-based approach, which looks beyond specific issues and responses, has been recognised in Timor-Leste. It is important to ensure that a systems model is congruent with the Timorese context and culture – yet founded upon international standards.

The current challenge is to operationalise and strengthen systems, particularly on justice and social welfare, so that their capacities, processes and outcomes are geared to preventing and protecting children from all forms of violence, abuse, neglect, and exploitation.

There is also the need to develop a full framework for continuum of care: this must recognise the delineation of voluntary measures and formal protective interventions. This continuum should recognise the importance of preventative

interventions (identification of risk, family mediation, and financial assistance). It should seek to ensure the wellbeing of children beyond a single intervention. This approach will necessitate working in closer partnership with other sectors, such as education and health, to increase the protective environment.

This would entail ensuring child-friendliness in the justice system through strong legislation on matters concerning children in contact with law, effective implementation of legal processes and delivery of justice, mechanisms for redress and checks and balances at different stages and levels. These procedures need to be effectively relayed to communities to clarify which cases are appropriate and transparent processes for resolution at a community level and when necessary, dispel reluctance to access formal justice mechanisms.

- **To invest more in child protection in terms of budget allocation and human resources.**

Develop a solid, costed long term human resources strategy. Clearly this will be dependent upon the vision agreed for the legal framework and service delivery infrastructure, at which time the precise function and requirements of the CPOs and other social welfare officers can be delineated. The development of a wider pool of statutorily and voluntary social workers is crucial for the effective and sustainable functioning of the system.

In addition, develop a long-term financial plan in line with the expansion of human resources and the development of a full continuum of care and protection services. A full cost analysis of the envisioned child protection system should then be developed as the key advocacy strategy for ensuring funding for child protection is significantly enhanced.

- **To strengthen and continue life skills-based education.**

The life skills-based education should be expanded to provide greater access to services needed for both young children and adolescents to deal with challenges and risks. Life skills-based education can maximise opportunities, manage expectations and solve problems in cooperative, non-violent ways. Life skills are defined as a group of cognitive, personal and inter-personal skills that enhance such abilities.

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181. Ibid.
182. Child Frontiers Limited (2011) Mapping and Assessment of the Child Protection System in Timor-Leste, Dili: MSS and UNICEF Timor-Leste.
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186. Ibid.
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189. Better Care Network, 2013.
190. Democratic Republic of Timor-Leste and UNFPA (2013) 2010 Timor-Leste Population and Housing Census: Fertility Monograph, Dili, Timor-Leste: NSD and UNFPA.
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192. MSS data from 2010.
193. UNICEF (2009) Progress for Children: A report card on child protection, Number 8, September 2009, New York: UNICEF.
194. UNICEF (2012) Juvenile Justice Strategy Paper.
195. Ibid.
196. Ibid.
197. UNICEF (2011) The State of the World's Children 2011 Adolescence An Age of Opportunity, New York: UNICEF; and ILO (2010) Facts on Child Labour 2010, Geneva: ILO.
198. 2010 Census, NSD & UNFPA.
199. ILO (2007) Rapid Assessment on Child Labour in Timor-Leste, Jakarta: ILO.
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Annex 1: Adolescents and young people at a glance

Adolescents and young people represent a particularly important group in Timor-Leste. They are a group full of opportunities but also vulnerabilities. At the crossroad between childhood and adulthood, they get to experience a progressively greater autonomy and responsibility towards themselves and others.

Adolescence usually starts with the onset of puberty. Individuals then go through an important physical, emotional, cognitive and intellectual transformation. In terms of their ages, adolescents are internationally defined as anyone between 10 and 19 years old and youth as those between 15 and 24 years.²¹¹ In Timor-Leste, the Youth Policy defines young people as anyone between the age of 16 and 30 years. Young people aged 15-24 years numbered 210,962 persons in 2010 according to the Census, and 358,215 people were between 12 and 30 years.

The present situation analysis has already discussed many key issues pertaining to adolescents and young people in each of the thematic chapters. However, there are many cross-cutting issues that deserve an integrated analysis. Their impact on adolescents and young people as a whole demonstrate how they have to be addressed in a holistic manner.

Youth bulge

Timor-Leste is currently experiencing a youth bulge, a challenge that many other developing countries are also facing. With currently 34 per cent²¹² of the adult population between 15 and 24 years, the country expects an additional 100,000 young people by 2020. Most young people live in rural areas; however, they increasingly move to urban areas in search of better opportunities (in education or employment). Half of internal migrants in Timor-Leste are young people. Dili is the district with the highest number of young people.

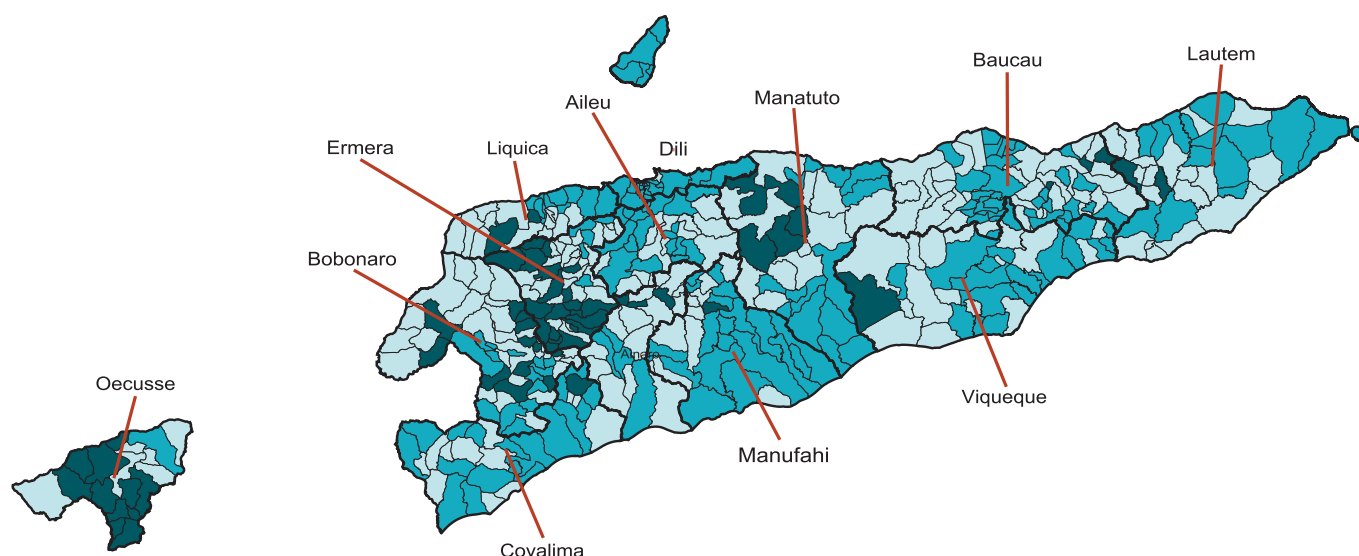
Education and employment

Many young Timorese are now more educated than older age groups.

- Gross enrolment rates in secondary school increased from 39 per cent in 2006 to 57 per cent in 2010.²¹³
- Youth literacy rate (15-24 years) increased from 73 per cent in 2004 to 79 per cent in 2010.²¹⁴
- Gender disparities narrowed down in education: 15 to 29 year old men and women both show the same levels of education while in the older generation (30-49 years), women were twice as likely to have no education compared to men.²¹⁵

Sucos with more than 50% of youth illiteracy rate

Source: 2010 Census.



However,

- More boys, urban and rich children are enrolled in secondary education. For many young people, it is too far or too expensive to go to secondary school, there are not enough spaces in secondary schools or parents prefer to send their boys rather than their girls (even though girls do better than boys in pre-secondary schools).
- Only 39% of 25-29 year-olds completed secondary school and only 4% of 15-29 year-olds have a post-secondary level education. Others dropped out of school, did not continue on to the next education level or never entered school at all.
- 15% of 15-19 year-olds have never attended school.
- At 15, already 24% of children are out-of-school.
- Half of young people between 15 and 24 years are in school (52%),²¹⁶ but not necessarily in the right grade for their age (for example, 6% of 18 year-olds are still in primary school and 22% are in pre-secondary).
- 20% of young people 15-24 years are still illiterate. Most illiterate young people are found in rural areas and the highest proportion of illiterate young people are in Ermera, Oecusse and the northwest of Manatuto. Ermera has by far the highest number of illiterate young people.

211. The State of the World's Children 2011 – Adolescence, an Age of Opportunity, UNICEF.

212. 2010 Census Youth Monograph Report, NSD & UNFPA. (When not mentioned, the data comes from the Youth Monograph Report.)

213. EMIS

214. 2010 Census, NSD & UNFPA.

215. TLDHS 2009-2010, NSD and ICF Macro.

216. Calculated from 2010 Census Youth Monograph Report, NSD & UNFPA.

Low educational achievements are in part due to the education system's provision of services and in part to student's attitude. Indeed, schools often are plagued by a lack of trained teachers, appropriate teaching materials, basic infrastructure, etc. Studies also show that the main reason for students abandoning school early is because "they 'don't see the purpose' of continuing their education";²¹⁷ not seeing any benefit at the end. Their parents also see a low return on investment for their children's education.

Low education results contribute to limitations in employment opportunities.

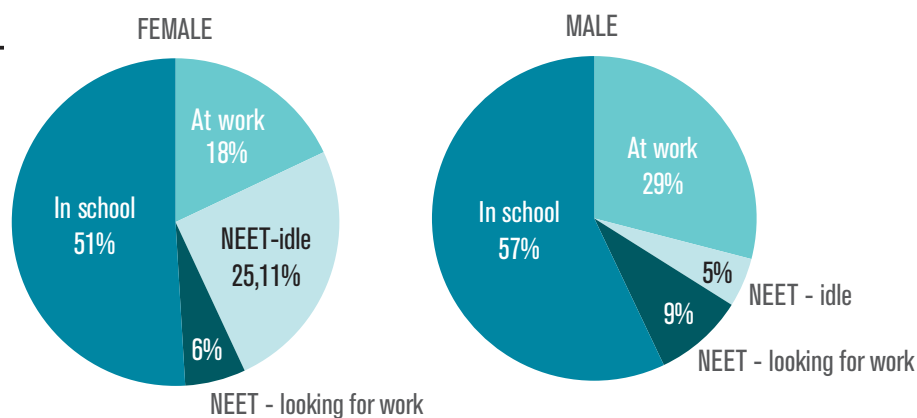
- Only a quarter of youth (24%)²¹⁸ are in employment: they have the potential capacity to support themselves and their families. This means that the vast majority of young people cannot support themselves: they are either looking for a job, still studying or just at home.
- Among youth who are economically active, 75 per cent of them are reported to be employed, although the vast majority of them are subsistence farmers (75%),²¹⁹ which is a vulnerable kind of employment, offering neither job security nor social benefit.²²⁰
- In urban areas, there is more wage employment for young people but also more unemployed young people looking for work. Better-qualified young people have greater chances to be employees in the formal sector. Outside of agriculture, the number one job held by young people 15-29 years is as security guards, followed by office clerks.²²¹ Government and NGO/UN jobs are held by only a very few (18% and 2% respectively), which can be a problem since most young people declare this to be the kind of work they want to find.

Young people Neither in Employment nor in Education and Training (NEET)

The 2010 Census data shows that nearly a quarter of young people 15-24 years (22%) are neither in school nor at work (NEET). Most of these are girls and young women, as they are engaged in house work. For most men, they are just idle. Remarkably, not all NEET young people are searching for a job: half of them only are idle and these are mostly men.²²² They declare that there are no jobs around for them. With a youth unemployment rate of 25% for 15-24 year-olds,²²³ the situation for young people is much more difficult than for the general population (9.8% unemployment).²²⁴

Unemployment, the number one issue for young people, is due to many factors. Currently, 15,000-20,000 young people join the job market every year but "the economy is not generating enough jobs to create sufficient employment to accommodate these new 'youth' entrants".²²⁵ Even if more jobs were created, to what extent would young people

Occupation of young females and males 15-24



benefit from them? Young people suffer from a lack of access to a quality education adequately preparing them for the world of work. Employers complain that they don't have the proper skills, and that their education is not relevant enough to what is required in the jobs.²²⁶ There are few vocational training opportunities and even those existing are not necessarily linked to market demands.

Marriage and childbearing

Timor-Leste has one of the highest adolescent birth rates in South East Asia with 62.7 births per 1,000 15-19 year-old girls.²²⁷

- Almost one in five women (19%) marry before the age of 18, and one in four has a child while in her teens (before turning 20).²²⁸

Marrying at a young age is more common for girls in Oecusse, Covalima, Ermera and Liquica²²⁹ but is an issue for only a very small number of young men. Teenage pregnancy is more of an issue in Oecusse, Bobonaro and Viqueque. It is more common in rural areas, amongst girls with little or no education and amongst the poorest quintiles.²³⁰

- Early marriage is strongly correlated with early pregnancies: two-thirds of married adolescents already have children.²³¹ This is not necessarily to say that early marriage causes early pregnancy or the opposite. However, data does show that less than one third of married adolescents have not had a child yet, making this an exception. In addition, the vast majority of married teenage mothers wanted their pregnancy.²³² Moreover, one fourth of married adolescents with children have more than one child already, before the age of 20.²³³

217. Youth Employment Study Timor-Leste 2007, ILO.

218. Calculated from Youth Monograph Report – 2010 Census, NSD & UNFPA.

219. Youth Employment Study Timor-Leste 2007, ILO.

220. According to the 2010 Census, 63% of 15-29 year-olds are employed in agriculture.

221. 2010 Census Youth Monograph Report, NSD & UNFPA.

222. Ibid.

223. Ibid.

224. The 2010 Labour Survey data points to a 12% youth unemployment rate against a 3.6% general unemployment rate, suggesting an even more unequal situation in disfavor of young people when it comes to unemployment

225. Youth Employment Study in Timor -Leste 2007, ILO.

226. Ibid.

227. 2010 Census Youth Monograph Report, NSD & UNFPA.

228. TLDHS 2009-2010, NSD and ICF Macro.

229. 2010 Census Youth Monograph Report, NSD & UNFPA.

230. TLDHS 2009-2010, NSD and ICF Macro.

231. Ibid.

232. Ibid.

233. Ibid.

Early marriage and teenage pregnancy can threaten a girl's well being as well as her baby's. Indeed, even if it is legal for a teenager to get married,²³⁴ girls who get married early are worldwide more at risk to violence, abuse and exploitation.²³⁵ It is the end of their childhood and girls can suffer from major consequences on their mental and physical well-being. They often abandon formal education and become pregnant.²³⁶ Teenage pregnancy is dangerous to both mothers and children. In Timor-Leste, children born to mothers under the age of 20 have higher mortality rates than children born to older mothers: they are for example 50% more likely to die in their first week of life. Teenage mothers are also more likely to die giving birth: in Timor-Leste, the maternal mortality rate of 15-19 year-old girls is twice the national rate.²³⁷

Early marriage and early childbearing are accepted social norms in Timor-Leste. The Civil Code clearly allows teenagers to marry, starting from 17 (or 16 with parental consent) – but traditional marriage often happens earlier, parents traditionally considering that with puberty, a girl is ready to marry.²³⁸ After marriage, studies show that in the Timorese society, a married couple is expected to have children soon after marriage, even if they are still very young. Early marriage and early pregnancies are also linked to poverty and the Barlake (Bride price/dowry) tradition during which the bride's family asks for amounts that can sometimes represent substantial financial gain.²³⁹

Sexual behaviour and HIV

Teenage pregnancies do not always happen within a marriage: they can also be the result of risky sexual behaviours and unprotected sex. Indeed, research confirms that “while the perceived social norm is that sexual debut is the consequence of getting married, in practice marriage may be the consequence of early sexual debut and, in many cases, the ensuing pregnancy”.²⁴⁰

- Some unmarried Timorese young people (15-24) are sexually active: 8.5% of girls and 40% of men.²⁴¹ Of married and unmarried sexually active young people, the majority of them had their first experience between 15 and 19.²⁴²
- Knowledge is very low. Half of young people cannot demonstrate a comprehensive and accurate knowledge about how to get pregnant.²⁴³ Only one in four young people know what condoms are, have seen one and know how to use them. About the same proportion know that it protects against pregnancies and HIV. Condoms are however difficult for them to obtain. About half of young women and two-thirds of young men have heard of AIDS.²⁴⁴ However, little more than one in five has a comprehensive knowledge about HIV.
- This is particularly worrying considering that in 2013 a team of experts considered that in Timor-Leste, “the HIV epidemic may be evolving from ‘low level’ towards higher HIV prevalence, in ‘pockets’”.²⁴⁵ In addition to the already mentioned unprotected sex, low level of knowledge on HIV, STIs and pregnancies, and condom availability problems, the experts identified other risky behaviours: drug use (of which very little is known in the country) and commercial sex (10% of 20-24 year-old men have paid for sex in the last 12 months)²⁴⁶ for instance.

Traditional Timorese social norms and religion are often not in favour of open discussion on sexual reproductive issues with unmarried young people.²⁴⁷ Expected to wait for marriage, young people are denied the right to critical information and sex education as well as access to contraception. This results in many unwanted pregnancies, forcing young people to get married or making young single mothers vulnerable for life. In the worst-case scenario, desperate young mothers have been known to abandon their newborns in the streets or the fields.

Violence and youth participation

Young people are both victims and agents of violence.

- More than one in every 3 women (15-29) has been the victim of physical or sexual violence.²⁴⁸ The vast majority of women suffer at the hands of their current husband or partner, followed by their parents. Few seek help and younger women seek help least of all. They overwhelmingly consider this to be normal: more than 80% of young women consider that a husband is justified in hitting his wife in certain circumstances.²⁴⁹ Young men are also of this option but in a smaller percentage (75% vs. 84% in 15-24 year-olds). The attitude towards domestic violence is more or less the same everywhere: in poor and rich families, amongst educated or not educated, in urban or rural areas, amongst employed or unemployed.
- Since 2009, monitoring at community level has revealed that the number of violent incidents have halved (from 14 incidents per sub-district on average to 7).²⁵⁰ However, in a year (June 2012 to May 2013), 276 youth violent incidents were reported to BELUN.²⁵¹ Youth violence is said to be linked to martial arts groups and the law regulating their activities, their ban and the closure of several groups seem not to have reduced the prevalence of youth violence.

Youth violence seems to be fuelled by a low level of adolescents' and youth participation in the political, social and economic life of Timor-Leste (although this is not the sole cause). Findings after the 2006 crisis showed that "without jobs or prospects, believing that corruption, collusion and nepotism were rife and lacking a voice in Parliament, young people appeared both marginalised and disempowered",²⁵² which contributed to their involvement in violent actions. Seven years later, the same underlying weaknesses largely prevail: (i) levels of unemployment are still high as already discussed and access to secondary or higher education, although a way to improve chances of finding a job, remains very unequal; (ii) after a high involvement in the 2012 elections, young people are no longer active in the political area;²⁵³ and (iii) their engagement in common community projects is also minimal (less than a quarter of young people report any involvement in the past 12 months).²⁵⁴

234. The legal age of marriage in Timor-Leste is 17 (and 16 with parental consent) – Civil Code.

235. The State of the World's Children, 2009, UNICEF.

236. TLDHS 2009-2010, NSD and ICF Macro-Youth findings.

237. 2010 Census Youth Monograph Report, NSD & UNFPA.

238. Young Women and gender dimensions of change in Timorese civil society - Ann Wigglesworth in Proceedings of the Understanding Timor-Leste Conference, Universidade Nasional Timor-Lorosa'e, Dili, Timor-Leste, 2-3 July 2009.

239. Belun, Culture and its impact on social and community life, policy brief n.5, TLDHS 2009-2010, Nasrin Khan and Selma Hyati- BRIDE-PRICE AND DOMESTIC VIOLENCE IN TIMOR-LESTE.

240. Youth Reproductive Health: Quantitative and qualitative analysis TL, UNFPA, 2009.

241. Ibid.

242. UNICEF HIV/AIDS KAP.

243. Youth Reproductive Health: Quantitative and qualitative analysis

TL, UNFPA, 2009.

244. TLDHS 2009-2010, NSD and ICF Macro.

245. Health response to HIV.

246. TLDHS 2009-2010, NSD and ICF Macro.

247. Youth Reproductive Health: Quantitative and qualitative analysis TL, UNFPA, 2009.

248. TLDHS 2009-2010, NSD and ICF Macro.

249. Ibid.

250. Conflict Potential Analysis, June 2012-September 2012, BELUN.

251. Calculated from BELUN EWER database – data provided on 17 January 2014

252. Like stepping stones in the water – Plan International, also in Lene Ostergaard - Youth Social Analysis Mapping and Youth Institutional Assessment 2005.

253. Youth, Democracy and Peace-building in Timor-Leste, 2013, SFCG .

254. Ibid.

Youth violence and the effect of drugs and alcohol consumption as precipitating causes are amongst the top concerns of communities when it comes to security matters.²⁵⁵ The causes are many but unemployment is an important contributing factor as it generates a level of frustration and idleness that gives violence an opportunity to manifest easily. Easy access to alcohol (and increasingly to drugs) fuels violence, often escalating a small argument into a physical confrontation.²⁵⁶ The concept of masculinity in the Timorese cultural context also puts emphasis on the strength, power and control of a man,²⁵⁷ showing the way to young boys going through adolescence. Violence is then condoned by many and accepted as a normal part of Timorese culture.

Young people's participation is supported at the community level in youth centres, however the supply of services for young people is limited. There are 13 youth centres affiliated to the Secretariat of State for Youth and Sports as well as some centres run by NGOs or community-based organisations (in 2008, a mapping exercise identified a total of 32 centres nationwide).²⁵⁸ Centres can offer sports and other leisure activities (arts, music), language classes, vocational training, etc. Youth centres are mainly accessible in district capitals and in Dili, putting them out of reach of all the young people living in the *sucos*. The centres are often understaffed, dependent on volunteers, and lacking financial resources.²⁵⁹ The quality of their services also varies and is not monitored or assessed. There is not enough data on young people's access to these centres (distance, capacity, etc.) as well as the quality of their services.

Enabling environment

At the root of many issues faced by young people, social norms are not conducive to supporting positive youth development. The concept of the adolescent does not really exist in the traditional culture where an individual is first a child, who does as he is told – and then suddenly an adult, with responsibilities and the pressure to deliver. This abrupt transition (often when one gets married or a parent dies) happens without giving the individual the opportunity and guidance to grow into this new role, and to practice the new skills required. It also prevents young unmarried people from having a voice in community or family matters, restricting their opportunity for participation and their empowerment.

Poverty is another root cause. The economic pressure on a family often pushes young boys out of school, under the pressure of finding a job to financially contribute to the household. For young girls, poverty often put them at risk of an early marriage: the dowry or bride price being seen as a coping mechanism against economic pressures.

The Timor-Leste Youth Parliament

The Youth Parliament is an initiative with the objective of increasing young people's participation. Created in 2009, it invites 132 boys and girls between the ages of 12 and 17 from each sub-district to learn about civic education, empower them to speak about youth issues and support them to work with their peers.

Run by the Secretariat of State for Youth and Sports, this programme allows adolescents to build their capacity to become articulate young citizens who can contribute to the development of their nation. By having a voice and by representing the peers that elected them, they are able to raise the visibility of the situation of young people to policy-makers. They also learn about democratic ways to voice opinions and leadership skills to mobilise others.

Finally, the youth sector is missing an enabling environment: the Youth Policy of 2007, although a good framework for inter-sectoral youth interventions, is not serving as a framework for investments and programmes for the youth sector. Actions of duty-bearers are not sufficiently coordinated, despite the Youth Policy calling for an inter-ministerial coordination mechanism.

Conclusion

In order to negotiate successfully all the stages towards adulthood, young people need special skills and assets:

- Good health - and the knowledge and means to sustain this good health;
- Skills, competencies, and knowledge to be a productive adult member of society;
- Pro-social values and the ability to contribute to the well-being of the community;
- Adequate preparation for the assumption of adult social roles and obligations;
- The capability to make choices;
- A sense of well-being.²⁶⁰

Their preparation, efforts and investment should also be met by some opportunities availed to them to get what they need to thrive in life: a decent job, a chance to contribute to society, and a supportive environment from adults all around.

The situation of young people as depicted here represents both an opportunity and a risk for the future of the nation. Young Timorese nowadays represent a huge asset for the future prospects of the country's development – as long as they are appropriately engaged in the nation's growth. Agents of change and future leaders, young people in Timor-Leste need to be supported so that they can fulfil their potential and thrive.

Specifically, coordinated multi-sectoral actions in favor of adolescents and young people are needed so as to support their positive development. No one has the sole responsibility for young people's well-being in Timor-Leste: every Ministry and sector's contribution is necessary. A greater commitment from all sectors to the development of opportunities for this age group also needs to be translated into greater investments. The Secretariat of State for Youth and Sport's capacity to coordinate all actors needs to be strengthened by a clear mandate to do so from the highest level of Government.

Young people need to have greater opportunities to participate in families, communities, and schools as well as at national level. A cultural shift is required in favor of enabling them to express their views, seek information that concerns them and take actions in favor of what they believe.

255. 2013 Community Police Perception Survey and Results of Community Police Council Problem Solving workshops in 36 sukus, 2013, The Asia Foundation

256. Policy brief: alcohol and its links to conflict, 2010, BELUN.

257. Paz y Desarrollo (2013) Baseline Study on Attitudes and perceptions of gender and masculinities of youth in

258. Youth Center Mapping, 2008, World Bank.

259. Lene Ostergaard (2007) Youth Social Analysis Mapping and Youth Institutional Assessment 2005; World Bank (2008) Youth Center Mapping, Timor-Leste's youth in crisis: situational analysis and policy options – 2007.

260. National Research Council and Institute of Medicine (2005). Growing Up Global: The Changing Transitions to Adulthood in Developing Countries. Panel on Transitions to Adulthood in Developing Countries. Cynthia B. Lloyd, ed. Committee on Population and Board on Children, Youth, and Families. Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

Annex 2: Statistical tables

TABLE 1: DEMOGRAPHIC INDICATORS

| | Population | Population < 1 year old (adjusted) | Population < 5 years old | Pre-school aged children 3-5 years old | Primary school aged children (6-11 years old) | Pre-secondary aged children (12-14 years old) | Secondary school aged children (15-17 years old) | Population < 18 years old | Youth population (age 15-24) | Female population of reproductive age (15-49 years old) | Population aged 15-64 | Total fertility rate | (2009) | (2004) | Population annual growth rate (%) | Life expectancy at birth (years) | (2010) |
|---------------------|-------------|------------------------------------|--------------------------|--|---|---|--|---------------------------|------------------------------|---|-----------------------|----------------------|-------------|---------------------------------|-----------------------------------|----------------------------------|-------------|
| Total | 1,066,409 | 37,468 | 153,334 | 96,091 | 180,432 | 77,069 | 71,968 | 513,874 | 210,962 | 238,544 | 574,269 | 7.71 | 5.7 | 3.2 | 2.4 | 58 | 62 |
| Sex | | | | | | | | | | | | | | | | | |
| Female | 522,211 | 18,035 | 74,165 | 46,568 | 86,966 | 37,095 | 35,765 | 249,009 | 104,872 | 238,544 | 283,553 | | | | | 59 | |
| Male | 544,198 | 19,433 | 79,169 | 49,523 | 93,466 | 39,974 | 36,203 | 264,865 | 106,090 | - | 290,716 | | | | | 57 | |
| Residence | | | | | | | | | | | | | | | | | |
| Urban | 316,086 | | 40,622 | 25,181 | 45,235 | 19,514 | 24,163 | 137,762 | 84,403 | 82,645 | 194,625 | | 4.9 | | | | |
| Rural | 750,323 | | 112,712 | 70,910 | 135,197 | 57,555 | 47,805 | 376,112 | 126,559 | 155,899 | 379,644 | | 6.0 | | | | |
| District | | | | | | | | | | | | | | | | | |
| Aileu | 44,325 | 1,367 | 5,951 | 3,781 | 8,139 | 3,623 | 3,426 | 22,449 | 9,412 | 9,500 | 23,522 | | | | | | |
| Ainaro | 59,175 | 2,377 | 9,638 | 6,041 | 10,998 | 4,767 | 3,824 | 31,155 | 9,887 | 11,553 | 29,005 | | | | | | |
| Baucau | 111,694 | 3,777 | 15,575 | 9,904 | 19,322 | 8,782 | 7,827 | 54,763 | 19,854 | 23,006 | 57,271 | | | | | | |
| Bobonaro | 92,049 | 3,305 | 13,625 | 8,703 | 15,844 | 6,268 | 6,058 | 44,551 | 16,476 | 20,194 | 47,969 | | | | | | |
| Covalima | 59,455 | 1,746 | 7,733 | 5,222 | 10,631 | 4,798 | 4,336 | 29,267 | 10,696 | 13,127 | 31,225 | | | | | | |
| Dili | 234,026 | 7,817 | 30,227 | 18,325 | 32,210 | 13,153 | 15,937 | 97,516 | 62,566 | 62,042 | 147,490 | | | | | | |
| Ermera | 117,064 | 4,468 | 18,054 | 10,940 | 21,451 | 9,785 | 8,247 | 60,906 | 22,772 | 25,408 | 59,960 | | | | | | |
| Lautem | 59,787 | 1,929 | 8,872 | 5,740 | 11,575 | 5,019 | 4,132 | 31,516 | 9,483 | 12,301 | 28,741 | | | | | | |
| Liquica | 63,403 | 2,378 | 9,322 | 5,741 | 10,449 | 4,795 | 4,526 | 30,897 | 13,029 | 14,159 | 33,861 | | | | | | |
| Manatuto | 42,742 | 1,439 | 6,118 | 3,809 | 7,507 | 3,153 | 2,723 | 20,760 | 7,448 | 8,728 | 22,196 | | | | | | |
| Manufahi | 48,628 | 1,687 | 7,017 | 4,440 | 8,654 | 3,842 | 3,389 | 24,349 | 8,903 | 10,006 | 27,810 | | | | | | |
| Oecussi | 64,025 | 2,734 | 10,758 | 6,761 | 10,932 | 3,971 | 3,370 | 31,086 | 10,135 | 14,414 | 33,688 | | | | | | |
| Viqueque | 70,036 | 2,444 | 10,444 | 6,684 | 12,720 | 5,113 | 4,173 | 34,659 | 10,301 | 14,106 | 34,231 | | | | | | |
| Education | | | | | | | | | | | | | | | | | |
| No education | | | | | | | | | | | | | | | | | |
| Primary | | | | | | | | | | | | | | | | | |
| Secondary | | | | | | | | | | | | | | | | | |
| More than secondary | | | | | | | | | | | | | | | | | |
| Wealth quantile | | | | | | | | | | | | | | | | | |
| Lowest | | | | | | | | | | | | | | | | | |
| Second | | | | | | | | | | | | | | | | | |
| Middle | | | | | | | | | | | | | | | | | |
| Fourth | | | | | | | | | | | | | | | | | |
| Highest | | | | | | | | | | | | | | | | | |
| Source | Census 2010 | Census 2010 (adjusted) | Census 2010 | Census 2010 | Census 2010 | Census 2010 | Census 2010 | Census 2010 | Census 2010 | Census 2010 | Census 2010 | DHS 2003 | DHS 2009-10 | Census, 2010 – Monograph report | Census, 2010 – Monograph report | Census 2004 | Census 2010 |

| | (2003) | (2009) | (2003) | (2009) | (2008) | (2003) | (2009) | (2003) | (2009) | (2012) | (2008) | (2009) | (2008) | (2009) | % children who received all basic vaccinations | % of households with at least one ITN | % under-fives sleeping under ITNs |
|---------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|-------------|-----------|---------|--------|--------|--------|--------|--|---------------------------------------|-----------------------------------|
| | (2003) | (2009) | (2003) | (2009) | (2008) | (2003) | (2009) | (2003) | (2009) | (2012) | (2008) | (2009) | (2008) | (2009) | (2008) | (2009) | (2009) |
| Total | 64 ⁺¹ | 60 ⁺¹ | 45 ⁺¹ | 21 ⁺¹ | 22 ⁺¹ | 39 ⁺¹ | 23 ⁺¹ | 557 | 78.5 | 49.2 | 29.9 | 22.1 | 21.5 | 52.6 | 40.9 | - | 41.0 |
| Sex | | | | | | | | | | | | | | | | | |
| Female | | | | | | | | | - | - | - | - | - | 50.8 | - | - | 41.4 |
| Male | | | | | | | | | - | - | - | - | - | 54.3 | - | - | 40.7 |
| Residence | | | | | | | | | | | | | | | | | |
| Urban | 61 | 42 | | 21 | | | 21 | | | | 59.1 | 52.8 | 45.1 | 47.7 | 51.0 | | 50.6 |
| Rural | 87 | 61 | | 28 | | | 33 | | | | 20.7 | 12.4 | 13.7 | 54.1 | 37.7 | | 38.2 |
| District | | | | | | | | | | | | | | | | | |
| Aller | 76 | 56 | | 27 | | | 29 | | | | 23.8 | 11.7 | 17.5 | 79.2 | 51.8 | | 56.0 |
| Ainero | 97 | 77 | | 31 | | | 46 | | | | 10.5 | 7.2 | 8.9 | 46.1 | 15.5 | | 18.1 |
| Baucau | 42 | 30 | | 11 | | | 18 | | | | 27.5 | 21.1 | 22.1 | 47.1 | 22.5 | | 28.8 |
| Bobonaro | 85 | 50 | | 27 | | | 23 | | | | 46.4 | 25.6 | 16.1 | 9.1 | 55.2 | | 42.9 |
| Coralima | 95 | 76 | | 37 | | | 38 | | | | 88.3 | 58.0 | 28.2 | 34.2 | 61.9 | | 61.4 |
| Dili | 60 | 39 | | 21 | | | 18 | | | | 99.2 | 61.3 | 68.9 | 63.3 | 54.6 | | 52.3 |
| Erema | 102 | 70 | | 23 | | | 47 | | | | 61.2 | 35.5 | 12.1 | 3.2 | 3.0 | | 28.2 |
| Lautem | 98 | 69 | | 36 | | | 33 | | | | 73.2 | 25.9 | 20.7 | 17.3 | 74.6 | | 47.5 |
| Liquica | 101 | 68 | | 31 | | | 37 | | | | 71.2 | 57.8 | 23.4 | 13.1 | 17.9 | | 40.8 |
| Mazatuto | 69 | 50 | | 31 | | | 19 | | | | 80.2 | 51.0 | 36.9 | 25.4 | 25.5 | | 56.0 |
| Manufahi | 86 | 62 | | 44 | | | 19 | | | | 91.4 | 56.1 | 19.0 | 11.1 | 15.1 | | 24.6 |
| Oecussi | 92 | 66 | | 25 | | | 41 | | | | 64.1 | 34.1 | 9.8 | 4.6 | 8.2 | | 44.9 |
| Viqueque | 77 | 54 | | 24 | | | 31 | | | | 88.3 | 66.8 | 25.2 | 14.1 | 13.3 | | 40.5 |
| Mother's education | | | | | | | | | | | | | | | | | |
| No education | 90 | 61 | | 27 | | | 34 | | | | 13.5 | 7.2 | 8.0 | 46.6 | | | |
| Primary | 84 | 59 | | 27 | | | 32 | | | | 22.7 | 15.5 | 17.2 | 54.0 | | | |
| Secondary | 69 | 51 | | 26 | | | 25 | | | | 47.2 | 37.8 | 33.6 | 57.7 | | | |
| More than secondary | *3 | 21* | | 9** | | | 12** | | | | 87.5 | 75.3 | 65.9 | 39** | | | |
| Wealth quantile | | | | | | | | | | | | | | | | | |
| Lowest | 87 | 62 | | 24 | | | 37 | | | | 10.6 | 5.2 | 7.8 | 43.2 | 23.6 | | 23.6 |
| Second | 94 | 68 | | 30 | | | 38 | | | | 14.2 | 7.1 | 8.1 | 53.5 | 31.2 | | 32.6 |
| Middle | 89 | 59 | | 29 | | | 30 | | | | 21.5 | 13.0 | 13.4 | 55.8 | 41.2 | | 41.8 |
| Fourth | 81 | 56 | | 25 | | | 30 | | | | 37.5 | 27.9 | 25.3 | 65.5 | 55.5 | | 54.7 |
| Highest | 52 | 38 | | 22 | | | 16 | | | | 69.0 | 60.1 | 57.0 | 45.2 | 55.2 | | 54.9 |
| Source | DHS 2003 | DHS 2009-10 | DHS 2003 | DHS 2009-10 | DHS 2009-10 | DHS 2003 | DHS 2009-10 | DHS 2009-10 | HMIS 2012 | HMIS 20 | | | | | | | |

TABLE 2: HEALTH INDICATORS (continued)

[illegible]

[illegible][illegible]

TABLE 4: EDUCATION & YOUTH INDICATORS

| | Adult literacy rate (%) | Youth (15-24 years) literacy rate (%) | Primary school gross enrolment ratio | Primary school net enrolment ratio | Primary school net attendance ratio | Primary school repetition rate | Primary school dropout rate | Pupil-teacher ratio in primary schools | Pre-secondary school gross enrolment ratio | Pre-secondary school net enrolment ratio | Pre-secondary net attendance ratio | Pre-secondary school repetition rate | Pre-secondary school dropout rate |
|---------------------|--|--|--------------------------------------|------------------------------------|--|--------------------------------|-----------------------------|--|--|--|--|--------------------------------------|-----------------------------------|
| | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) |
| Total | 57.8 | 79.1 | 127.8 | 93.6 | 71.6 | 17.7 | 4.4 | 28.4 | 79.0 | 30.3 | 23.7 | 3.4 | 2.3 |
| Sex | | | | | | | | | | | | | |
| Female | 52.5 | 78.2 | 127.0 | 94.3 | 72.1 | 15.8 | 4.0 | - | 81.2 | 33.9 | 25.7 | 2.7 | 2.0 |
| Male | 63.1 | 80.0 | 128.6 | 92.9 | 71.2 | 19.4 | 4.8 | - | 77.0 | 27.0 | 21.8 | 4.0 | 2.5 |
| Residence | | | | | | | | | | | | | |
| Urban | | | | | 79.7 | | | | | | 41.5 | | |
| Rural | | | | | 69.0 | | | | | | 17.7 | | |
| District | | | | | | | | | | | | | |
| Alieu | 55.4 | 80.0 | 126.2 | 85.9 | 75.8 | 20.4 | 4.3 | 25.7 | 75.3 | 23.1 | 17.5 | 4.0 | 2.4 |
| Ainaro | 44.0 | 67.8 | 131.0 | 99.1 | 71.1 | 16.6 | 7.3 | 27.8 | 65.6 | 28.5 | 24.7 | 3.5 | 2.8 |
| Baucau | 55.1 | 82.2 | 136.8 | 98.2 | 76.1 | 18.4 | 3.5 | 24.5 | 82.4 | 33.1 | 25.1 | 3.1 | 2.3 |
| Bobonaro | 44.7 | 69.5 | 129.2 | 93.9 | 71.1 | 20.5 | 4.9 | 29.8 | 73.4 | 23.2 | 17.1 | 2.6 | 2.0 |
| Covalima | 55.0 | 81.2 | 137.5 | 101.5 | 75.5 | 19.0 | 3.6 | 22.9 | 90.5 | 40.0 | 28.3 | 3.2 | 2.2 |
| Dili | 85.5 | 93.2 | 112.0 | 89.4 | 79.5 | 9.6 | 1.6 | 34.1 | 108.2 | 50.3 | 38.8 | 1.7 | 0.7 |
| Ermera | 38.7 | 58.4 | 132.4 | 94.2 | 58.2 | 17.6 | 5.8 | 31.3 | 53.5 | 16.3 | 14.2 | 3.5 | 3.2 |
| Lautem | 57.3 | 82.9 | 136.7 | 96.6 | 77.3 | 22.1 | 1.7 | 27.4 | 82.8 | 28.8 | 21.7 | 3.5 | 2.1 |
| Liquica | 50.8 | 73.8 | 123.6 | 86.2 | 66.3 | 17.7 | 6.7 | 32.6 | 66.8 | 19.4 | 18.8 | 3.4 | 3.5 |
| Manatuto | 52.0 | 74.8 | 134.0 | 95.7 | 72.0 | 22.4 | 4.2 | 28.0 | 73.5 | 27.1 | 20.0 | 7.4 | 1.8 |
| Manufahi | 57.2 | 82.5 | 124.4 | 90.9 | 71.9 | 17.6 | 5.2 | 24.0 | 82.6 | 33.7 | 26.9 | 6.1 | 4.8 |
| Oecussi | 37.8 | 58.6 | 114.6 | 85.9 | 57.7 | 19.5 | 6.1 | 35.3 | 62.7 | 17.3 | 13.4 | 6.8 | 3.2 |
| Viqueque | 51.1 | 81.3 | 139.9 | 100.3 | 74.1 | 19.0 | 5.5 | 25.5 | 79.3 | 28.7 | 22.0 | 3.1 | 3.4 |
| Mother's education | | | | | | | | | | | | | |
| No education | | | | | | | | | | | | | |
| Primary | | | | | | | | | | | | | |
| Secondary | | | | | | | | | | | | | |
| More than secondary | | | | | | | | | | | | | |
| Wealth quantile | | | | | | | | | | | | | |
| Lowest | | | | | | | | | | | | | |
| Second | | | | | | | | | | | | | |
| Middle | | | | | | | | | | | | | |
| Fourth | | | | | | | | | | | | | |
| Highest | | | | | | | | | | | | | |
| Source | Census 2010 Education Monograph Report | Census 2010 Education Monograph Report | EMIS2010 | EMIS2010 | Census 2010 Education Monograph Report | EMIS2010 | EMIS2010 | EMIS2010 | EMIS2010 | EMIS2010 | Census 2010 Education Monograph Report | EMIS2010 | EMIS2010 |

| TABLE 4: EDUCATION & YOUTH INDICATORS (continued) | | | | | | | | | |
|---|---------------------|---|---|--|--|---|-------------------------------------|----------|----------|
| | | Pupil-teacher ratio in pre- secondary school | Secondary school gross enrolment ratio | Secondary school net enrolment ratio | Secondary school net attendance ratio | Secondary school repetition rate | Secondary school dropout rate | | |
| | | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) | | |
| Total | | 25.3 | 57.1 | 19.5 | 16.5 | 1.2 | 1.6 | | |
| Sex | | | | | | | | | |
| | Female | - | 55.6 | 21.6 | 18.4 | 1.0 | 1.7 | | |
| | Male | - | 58.7 | 17.4 | 14.6 | 1.3 | 1.5 | | |
| Residence | | | | | | | | | |
| | Urban | | | | 30.8 | | | | |
| | Rural | | | | 9.4 | | | | |
| District | | | | | | | | | |
| | Alieu | 22.9 | 48.3 | 11.7 | 11.0 | 1.3 | 0.9 | | |
| | Ainaro | 20.6 | 36.6 | 16.9 | 16.5 | 1.3 | 0.7 | | |
| | Baucau | 19.4 | 51.6 | 20.2 | 17.2 | 0.8 | 1.2 | | |
| | Bobonaro | 29.1 | 36.6 | 10.5 | 9.9 | 1.0 | 1.5 | | |
| | Covalima | 26.7 | 51.2 | 23.0 | 15.1 | 1.0 | 3.0 | | |
| | Dili | 32.4 | 111.5 | 39.7 | 29.9 | 1.1 | 0.6 | | |
| | Ermera | 31.5 | 27.7 | 7.0 | 9.3 | 0.6 | 1.3 | | |
| | Lautem | 28.1 | 46.5 | 13.3 | 13.7 | 2.2 | 5.1 | | |
| | Liquica | 24.1 | 38.7 | 9.0 | 10.5 | 0.8 | 1.4 | | |
| | Manatuto | 22.7 | 28.8 | 10.5 | 12.0 | 1.9 | 5.4 | | |
| | Manufahi | 20.9 | 59.3 | 22.8 | 17.9 | 1.5 | 3.5 | | |
| | Oecussi | 25.4 | 41.4 | 10.0 | 9.0 | 3.0 | 4.2 | | |
| | Viqueque | 19.5 | 39.7 | 12.4 | 11.2 | 1.2 | 2.3 | | |
| Mother's education | No education | | | | | | | | |
| | Primary | | | | | | | | |
| | Secondary | | | | | | | | |
| | More than secondary | | | | | | | | |
| Wealth quantile | Lowest | | | | | | | | |
| | Second | | | | | | | | |
| | Middle | | | | | | | | |
| | Fourth | | | | | | | | |
| | Highest | | | | | | | | |
| Source | | EMIS2010 | EMIS2010 | EMIS2010 | EMIS2010 | Census 2010 Education Monograph Report | EMIS2010 | EMIS2010 | EMIS2010 |

TABLE 5: CHILD PROTECTION INDICATORS

| | (2009) | (2010) | (2010) | Early pregnancy (%) Women aged 15-19 who have had a live birth | Justification of wife beating among women (%) | Justification of wife beating among men (%) | % of women aged 15-49 who have ever experienced physical violence since age 15 | % of women aged 15-49 who have ever experienced sexual violence | % of women aged 15-19 who have ever experienced physical violence during pregnancy | % of women aged 15-19 who have ever experienced physical or sexual violence and have sought help from any source | % of women aged 15-19 who have ever experienced physical or sexual violence and have sought help from any source | Number of child protection service providers |
|---------------------|---|--------|--------|---|---|---|--|---|--|--|--|--|
| Total | 55.2 | 6.2 | 4.5 | 5.7 | - | - | 38.1 | 30.3 | 3.2 | 23.7 | 19.2 | 93 |
| Sex | | | | | | | | | | | | |
| Female | 55.5 | 5.4 | 4.4 | - | - | - | - | - | - | - | - | - |
| Male | 54.8 | 7.0 | 4.7 | - | - | - | - | - | - | - | - | - |
| Residence | | | | | | | | | | | | |
| Urban | 49.7 | 1.7 | | 2.9 | 89.3 | 86.1 | 48.7 | | 2.7 | 31.4 | | - |
| Rural | 56.8 | 7.6 | | 6.6 | 85.1 | 78.8 | 34.9 | | 4 | 20.3 | | - |
| District | | | | | | | | | | | | |
| Alifan | 69.1 | 9.8 | 6.6 | 3.9 | 86.5 | 47.8 | 39.8 | 6.6 | 3.6 | 11.1 | | 3 |
| Alhara | 59.9 | 9.2 | 4.2 | 5.3 | 64.5 | 87.8 | 10.5 | 2.6 | 0.6 | (19.1) | | 4 |
| Bacau | 66.9 | 4.1 | 5.1 | 4.5 | 83.2 | 93.9 | 44.3 | 7 | 4.7 | 20.5 | | 11 |
| Bonaro | 60 | 5.9 | 4.6 | 9.9 | 88.7 | 99.6 | 14.4 | 1.4 | 0 | (31.4) | | 6 |
| Covalima | 36.7 | 2.7 | 3.2 | 8.3 | 87.6 | 94.7 | 57.4 | 2.6 | 0.9 | 50.9 | | 3 |
| Dili | 40.3 | 1.5 | 2.1 | 1.6 | 89.8 | 86 | 52.7 | 2.3 | 3.3 | 34.4 | | 22 |
| Emera | 66.8 | 15.7 | 5.3 | 4.6 | 96.2 | 76.6 | 24.2 | 3.4 | 2.8 | (14.2) | | 5 |
| Lautem | 46.3 | 2.4 | 6.1 | 5.4 | 92 | 94.6 | 53.1 | 6.8 | 11.1 | 21.7 | | 5 |
| Liquica | 40.3 | 6.6 | 6.3 | 4.4 | 88.7 | 53.7 | 34.5 | 4.5 | 12.3 | 17.6 | | 7 |
| Manatuto | 67.8 | 4.5 | 4.2 | 7.5 | 83 | 1.7 | 16.5 | 2.3 | 0.5 | (22.8) | | 5 |
| Manufahi | 91.3 | 3.2 | 4.7 | 6.1 | 91 | 91.4 | 75.6 | 1.4 | 5.1 | 6.8 | | 8 |
| Oecussi | 60.2 | 10.0 | 5.8 | 13.3 | 92.3 | 91.3 | 56.3 | 2.9 | 4.1 | 17.9 | | 5 |
| Viqueque | 34.3 | 5.0 | 7.1 | 4.8 | 59.1 | 82.5 | 21.1 | 0.4 | 0 | (3.6) | | 9 |
| Education | | | | | | | | | | | | |
| No education | | | | 11.1 | 86.4 | 81.4 | 37.4 | 3.9 | 4.8 | 19.9 | | - |
| Primary | | | | 12.4 | 86.3 | 78.7 | 41.1 | 3.9 | 3.6 | 24.2 | | - |
| Secondary | | | | 2.8 | 85.9 | 80.8 | 36.6 | 2.9 | 2.7 | 25.2 | | - |
| More than secondary | | | | * | 88.1 | 87.3 | 45.6 | 0 | (1.8) | (33.8) | | - |
| Wealth quantile | | | | | | | | | | | | |
| Lowest | 50 | | | 7.1 | 81.1 | 81.3 | 35.2 | 3.4 | 5.1 | 19.9 | | - |
| Second | 54.3 | | | 7.3 | 84.5 | 80.2 | 36.8 | 4.8 | 3.6 | 16.7 | | - |
| Middle | 58.9 | | | 7.3 | 87.9 | 79.4 | 36.2 | 3.2 | 4.3 | 23.7 | | - |
| Fourth | 56.9 | | | 4.8 | 87.7 | 79.5 | 36.9 | 3 | 3.7 | 22.8 | | - |
| Highest | 56.1 | | | 2.5 | 88.5 | 83 | 45.2 | 2.5 | 1.9 | 32.4 | | - |
| Source | DHS 2009-10 Census 2010 Disability Monograph Census 2010 DHS 2009-10 DHS 2009-10 DHS 2009-10 DHS 2009-10 DHS 2009-10 DHS 2009-10 DHS 2009-10 DHS 2009-10 DHS 2009-10 DHS 2009-10 MSS & UNICEF (2012), Child Protection Service Provision: Mapping Analysis Paper, Child Frontiers | | | | | | | | | | | |

TABLE 6: ECONOMIC INDICATORS

| | GNI per capita (US\$) | GDP annual growth rate (%) | Annual rate of inflation, consumer prices (%) | Population below national poverty line of US\$0.88 per day (%) | Public spending as a % of total government budget - health | Public spending as a % of total government budget - education | Public spending as a % of total government budget - social solidarity | Housing with telephone/mobile (%) | Housing with electricity (%) |
|---------------------|-------------------------|----------------------------|---|--|--|---|---|---|------------------------------|
| Total | (2007) 1,850 | (2012) 3,670 | (2012) 8.6 | (2012) 11.8 | (2008) 5.7 | (2012)* 4.4 | (2008) 9.3 | (2012)* 7.1 | (2010) 36.7 |
| Sex | | | | | | | | | |
| Female | | | | | | | | | |
| Male | | | | | | | | | |
| Residence | | | | | | | | | |
| Urban | | | | | | | | | |
| Rural | | | | | | | | | |
| District | | | | | | | | | |
| Aileu | | | | | | | | | |
| Ainaro | | | | | | | | | |
| Baucau | | | | | | | | | |
| Bobonaro | | | | | | | | | |
| Covalima | | | | | | | | | |
| Dili | | | | | | | | | |
| Ermera | | | | | | | | | |
| Lautem | | | | | | | | | |
| Liquica | | | | | | | | | |
| Manatuto | | | | | | | | | |
| Manufahi | | | | | | | | | |
| Oecussi | | | | | | | | | |
| Viqueque | | | | | | | | | |
| No education | | | | | | | | | |
| Primary | | | | | | | | | |
| Secondary | | | | | | | | | |
| More than secondary | | | | | | | | | |
| Wealth quantile | | | | | | | | | |
| Lowest | | | | | | | | | |
| Second | | | | | | | | | |
| Middle | | | | | | | | | |
| Fourth | | | | | | | | | |
| Highest | | | | | | | | | |
| Source | World Bank Atlas method | World Bank Atlas method | World Development Indicators, World Bank | World Development Indicators, World Bank | Timor-Leste Survey of Living Standards, 2007 | Timor-Leste Budget Transparency Portal, MoF | Timor-Leste Budget Transparency Portal, MoF | Timor-Leste Budget Transparency Portal, MoF | Census 2010 |

TABLE 6: ECONOMIC INDICATORS (continued)

| | Employment ratio (age 15-64) | Youth employment ratio (age 15- 19) | Youth employment ratio (age 20- 24) | Unemployment rate (age 15-64) | Youth unemployment rate (age 15-19) | Youth unemployment rate (age 20-24) |
|---------------------|--|--|--|--|---|---|
| | (2010) | (2010) | (2010) | (2010) | (2010) | (2010) |
| Total | 49.3 | 14.5 | 34.7 | 9.8 | 26.7 | 22.3 |
| Sex | | | | | | |
| Female | 32.3 | | | 11 | 27 | 22.1 |
| Male | 66.1 | | | 9.2 | 26.5 | 22.4 |
| Residence | | | | | | |
| Urban | 40.6 | 7.3 | 24.9 | 16.7 | 40.2 | 32.4 |
| Rural | 53.7 | 18.6 | 42.1 | 6.9 | 22.8 | 16.6 |
| District | | | | | | |
| Alieu | 60.2 | 24.3 | 48.2 | 2.7 | 6.4 | 7.1 |
| Ainaro | 59.1 | 20.5 | 50.3 | 8.2 | 17.3 | 15.6 |
| Baucau | 49.5 | 11.2 | 35.4 | 8.8 | 30.0 | 22.7 |
| Bobonaro | 50.9 | 17.6 | 39.3 | 7.1 | 23.9 | 17.5 |
| Covalima | 47.5 | 9.4 | 33.7 | 9.0 | 39.3 | 25.2 |
| Dili | 41.3 | 7.6 | 25.1 | 17.4 | 42.4 | 32.2 |
| Ermera | 57.6 | 27.9 | 48.4 | 7.0 | 18.6 | 13.6 |
| Lautem | 47.1 | 7.3 | 29.1 | 9.1 | 37.1 | 28.8 |
| Liquica | 48.2 | 18.1 | 38.7 | 9.2 | 25.7 | 18.4 |
| Manatuto | 47.7 | 14.4 | 36.6 | 9.0 | 25.7 | 23.3 |
| Manufahi | 48.7 | 10.7 | 35.4 | 8.8 | 36.0 | 22.8 |
| Oecussi | 52.6 | 19.8 | 37.2 | 6.6 | 24.2 | 17.2 |
| Viqueque | 53.5 | 12.6 | 37.1 | 6.0 | 24.3 | 16.5 |
| Education | | | | | | |
| No education | | | | | | |
| Primary | | | | | | |
| Secondary | | | | | | |
| More than secondary | | | | | | |
| Wealth quantile | | | | | | |
| Lowest | | | | | | |
| Second | | | | | | |
| Middle | | | | | | |
| Fourth | | | | | | |
| Highest | | | | | | |
| Source | Census 2010 Labour Force Monograph | Census 2010 Labour Force Monograph | Census 2010 Labour Force Monograph | Census 2010 Labour Force Monograph | Census 2010 Labour Force Monograph | Census 2010 Labour Force Monograph |

TABLE 1: DEMOGRAPHIC INDICATORS

Definitions of the indicators:

Life expectancy at birth - Number of years new-born children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.

Note:

Adjusted number of population < 1 years old is used according to the Population Projection Report, 2013, GDS.

TABLE 2: HEALTH INDICATORS

Definitions of the indicators:

Under five mortality rate - Proportion of dying between birth and exactly 5 years of age, expressed per 1,000 live births.

Infant mortality rate - Proportion of dying between birth and exactly 1 year of age, expressed per 1,000 live births.

Neonatal mortality rate - Proportion of neonates dying before reaching 28 days of age per 1,000 live births.

Postneonatal mortality rate - The difference between infant and neonatal mortality.

Maternal Mortality Ratio - Proportion of women who die during pregnancy and childbirth per 100,000 live births.

Total fertility rate - Number of children who would be born per women if she lived to the end of her childbearing years and bore children at each age in accordance with prevailing age-specific fertility rates.

Use of improved drinking water sources - Percentage of the population using any of the following as the main drinking water source: drinking water supply piped into dwelling, plot, yard or neighbor's yard; public tap or standpipe; tube well or borehole; protected dug well; protected spring; rainwater; bottled water plus one of the previous sources as a secondary source.

Use of improved sanitation facilities - Percentage of the population using any of the following sanitation facilities, not shared with other households: flush or pour-flush latrine connected to a piped sewerage system, septic tank or pit latrine; ventilated improved pit latrine; pit latrine with a slab; covered pit; composting toilet.

% of children who received all basic vaccinations - Percentage of children who received BCG (bacille Calmette-Guérin which is a vaccine against tuberculosis), measles, and three doses each of DPT (diphtheria, pertussis and tetanus vaccine) and polio vaccine (excluding polio vaccine given at birth).

Antenatal care coverage - Percentage of women (aged 15–49) attended at least once during pregnancy by skilled health personnel (doctor, nurse, midwife or assistant nurse) and the percentage attended by any provider at least four times.

Skilled attendant at birth - Percentage of births attended by skilled health personnel (doctor, nurse, midwife or assistant nurse).

Institutional delivery – Percentage of women (aged 15–49) who gave birth in a health facility.

Mother's first postnatal checkup within 24 hours after delivery - Percentage of women aged 15–49 giving birth in the five years preceding the survey who received the mother's first postnatal check-up within 24 hours after delivery.

Households with at least one ITN – Percentage of households with at least one insecticide-treated mosquito net.

Children sleeping under ITNs – Percentage of children under age 5 who slept under an insecticide-treated mosquito net the night before the survey.

% under-fives with fever receiving antimalarial drugs - Percentage of children under age 5 who were ill with fever in the two weeks preceding the survey and received any antimalarial medicine. NB: This indicator refers to antimalarial treatment among all febrile children, rather than among confirmed malaria cases, and thus should be interpreted with caution.

% who have comprehensive knowledge of HIV/AIDS - Percentage of young men and women (aged 15–24) who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission or prevention, and who know that a healthy-looking person can be HIV positive.

Note:

*1 indicates that the data on early childhood mortality rates is for five-year periods preceding the survey while the other data by residence, district, education and wealth quintile is for ten-year period preceding the survey.

*2 indicates that numbers are based on 250–499 unweighted exposed persons.

*3 indicates that a rate is based on fewer than 250 unweighted exposed persons and has been suppressed.

*4 indicates that figures are based on 25–49 unweighted cases.

*5 The HIV prevention indicator by educational background is based on one's own educational background, not mother's education.

TABLE 3: NUTRITION INDICATORS

Definitions of the indicators:

Low birthweight – Percentage of infants weighing less than 2,500 grams at birth, based on either a written record or the mother's recall.

Early initiation of breastfeeding – Percentage of infants who are put to the breast within one hour of birth.

Exclusive breastfeeding <6 months – Percentage of children aged 0–5 months who are fed exclusively with breast milk in the 24 hours prior to the survey.

Appropriate complementary feeding - Percentage of children aged 6–23 month who are fed with all three infant and young child feeding (IYCF) practices: fed milk or milk products, foods from recommended food groups (3+ food groups for breastfed children and 4+ food groups for non-breastfed children), and at least the recommended minimum number of times.

Underweight – Moderate: Percentage of children aged 0–59 months who are below minus two standard deviations from median weight-for-age of the World Health Organization (WHO) Child Growth Standards; severe: Percentage of children aged 0–59 months who are below minus three standard deviations from median weight-for-age of the WHO Child Growth Standards.

Stunting – Moderate and severe: Percentage of children aged 0–59 months who are below minus two (three) standard deviations from median height-for-age of the WHO Child Growth Standards.

Wasting – Moderate and severe: Percentage of children aged 0–59 months who are below minus two (three) standard deviations from median weight-for-height of the WHO Child Growth Standards.

Vitamin A supplements – Percentage of children aged 6–59 months who were given vitamin A supplements in the last 6 months preceding the survey, based on the mother's recall and immunization card (where available).

Iron supplements – Percentage of children aged 6–59 months who were given iron supplements in the last 7 days preceding the survey, based on the mother's recall and immunization card (where available).

Deworming medication – Percentage of children aged 6–59 months who were given deworming medication in the last 6 months preceding the survey, based on the mother's recall and immunization card (where available).

Note:

Figures in parentheses are based on 25–49 unweighted cases.

TABLE 4: EDUCATION & YOUTH INDICATORS

Definitions of the indicators:

Adult literacy rate – The number of literate persons aged 15 and above, expressed as a percentage of the total population in that age group.

Youth literacy rate – The number of literate persons aged 15–24 years, expressed as a percentage of the total population in that group.

Gross enrollment ratio (GER) – The number of students enrolled in the primary and pre-secondary levels of education, regardless of age, expressed as a percentage of the population in the official school age group for the same level of education.

Net enrollment ratio (NER) – The number of students enrolled in the primary or pre-secondary level of education, of the official school age-group, expressed as a percentage of the corresponding population.

Net attendance ratio (NAR) – The proportion of children attending the level of schooling appropriate for their age. For example, the primary NAR is calculated as follows: Number of children of primary school age (6–12) who attend primary school divided by number of children of primary school age in the population (Census 2010 Education Monograph Report, p.63).

Repetition rate (RR) – The proportion of students who repeat a grade.

Dropout rate (DR) – The proportion of pupils or students who drop out from a given grade in a given school year.

Pupil/teacher ratio (PTR) – Average number of pupils per teacher at the level of education specified in a given school year, based on headcounts for both pupils and teachers.

TABLE 5: CHILD PROTECTION INDICATORS

Definitions of the indicators:

Birth registration – Percentage of children less than 5 years old who were registered at the moment of the survey. The numerator of this indicator includes children whose birth certificate was seen by the interviewer or whose mother or caretaker says the birth has been registered.

Child labour – Percentage of children 10–14 years old involved in child labour at the moment of the survey. A child is considered to be involved in child labour under the following conditions: children 5–11 years old who, during the reference week, did at least one hour of economic activity or at least 28 hours of household chores, or children 12–14 years old who, during the reference week, did at least 14 hours of economic activity or at least 28 hours of household chores.

Justification of wife beating – Percentage of women and men 15–49 years old who consider a husband to be justified in hitting or beating his wife for at least one of the specified reasons, i.e., if his wife burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations.

Note:

An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

TABLE 6: ECONOMIC INDICATORS

Definitions of the indicators:

GNI per capita – Gross national income (GNI) is the sum of value added by all resident products, plus any product taxes (less subsidies) not included in the valuation of output, plus net receipts of primary income (compensation of employees and property income) from abroad. GNI per capita is gross national income divided by midyear population. GNI per capita in US dollars is converted using the World Bank Atlas method.

Employment Ratio – The proportion of a country's working-age population that is employed.

Unemployment rate – The proportion of economically active people who are unemployed by ILO standard. Under the ILO approach, those who are considered as unemployed are either 1. Out of work but are actively looking for a job or 2. Out of work and are waiting to start a new job in the next two weeks.

Note: *1:

This excludes Human Capital Fund.

Annex 3:

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Annex 4: List of the members of the SitAn Technical Committee

| Agency | Focal Person | Title |
|---|--|--|
| Ministry of Finance (MoF) | Antonio Freitas | Director General of Statistics (Chair) |
| General Directorate of Statistics (MoF) | Elias dos Santos Ferreira | National Director of Methodology and Data Collection |
| General Directorate of Statistics (MoF) | Silvino Lopes | National Director of System and Reports |
| General Directorate of Statistics (MoF) | Paulina Rita Viegas | National Director of Economic and Social Statistics |
| MDG Secretariat | Felix Piedade | Coordinator of New Deal, MDGs and PFM Capacity Building Center |
| Ministry of Health | Jose dos Reis Magno | Director General |
| Ministry of Health | Carlito Correia Freitas | National Director of Public Health |
| Ministry of Health | Ivo Ireneu Freitas | National Director of Policy, Planning and Partnership |
| Ministry of Health | Marcelo Amaral | National Director of Financial Management and Procurement |
| Ministry of Health | Mateus Cunha | Head of Planning, Monitoring & Evaluation |
| Ministry of Health | Pedro Amaral | Head of the Research Department of the National Institute of Health |
| Ministry of Health | Sigia Patrocinio | Sanitation Officer, Environmental Health Department |
| Ministry of Health | Triana Cortereal de Oliveira | Head of Maternal and Child Health Department |
| Ministry of Health | Luis Celestino Correia | Head of Health Promotion |
| Ministry of Health | Joao da Silva | Head of Health Management Information System Department |
| Ministry of Health | Joao Bosco | Head of Nutrition Department |
| Ministry of Education | Cidalio Leite | Director General of Pre-school and Basic Education |
| Ministry of Education | Abelinda da Costa | National Director of Pre-school |
| Ministry of Education | Alfredo Araujo | National Director of Basic Education |
| Ministry of Education | Manuel Monteiro | National Director of Planning, Financing, Administration and Logistics |
| Ministry of Social Solidarity | Carmen da Cruz | National Director for Social Reinsertion |
| Ministry of Social Solidarity | Florencio da Gonzagas | Head of the Child Protection Department |
| Ministry of Public Works | Joao Piedade | National Director of Basic Sanitation |
| Ministry of Public Works | Gustavo Da Cruz | National Director of Water Supply |
| Ministry of Public Works | Martinus Nahak | Programme and SIB Officer, National Directorate of Water Supply |
| Ministry of Justice | Adalgisa Ximenes | National Commissioner on the Rights of the Child |
| Ministry of Justice | Maria Do Rosario Fatima Castro de Araujo | National Director of Civil Registration and Notary |
| Ministry of Justice | Nelinho Vital | National Director of Legislation and Drafting |
| Secretary of State for Social Communication | Luis Evaristo Soares | Director of Community Radio Centre |
| Secretary of State of Youth & Sports | Joao Lemos | Chief of Youth Department |
| Secretary of State of Youth & Sports | Firminio Dias Quintas | National Director of Policy and Planning |
| UNICEF | Min Yuan | Head of Planning, Monitoring & Evaluation Section |
| UNICEF | Joao Da Costa | Monitoring and Evaluation Officer |
| UNICEF | Beatrice Targa | Social Policy Officer |



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