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REPRODUCTIVE HEALTH *at a* GLANCE

TIMOR-LESTE

May 2011

Country Context

After East Timor's independence in 1999, a militia invasion destroyed most of the country's infrastructure and nearly its entire electrical grid. Seven years later, shortly after becoming the state of Timor-Leste, conflict arose again which required the intervention of a peacekeeping mission to regain stability. Timor-Leste is now enjoying its longest period of stability since independence. The country continues to work on replacing lost infrastructure, strengthening civil administration, and employing young persons. Oil and natural gas production is a major source of revenue. However, 37 percent of the population subsists on less than US $1.25 per day.[1] Health systems are being strengthened as they were greatly weakened from years of conflict.[2]

Timor-Leste's large share of youth population (45 percent of the country population is younger than 15 years old[1]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. But for this opportunity to result in accelerated growth, the government needs to invest in the human capital formation of its youth.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3]

In Timor-Leste, slightly fewer numbers of girls are enrolled in secondary schools compared to boys with a ratio of female to male primary enrollment of 94 percent.[1] Three-fifths of adult women participate in the labor force[1] that mostly involves work in agriculture.

Economic progress and greater investment in human capital of women will not necessarily translate into better reproductive outcomes if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3]

Timor-Leste: MDG 5 Status

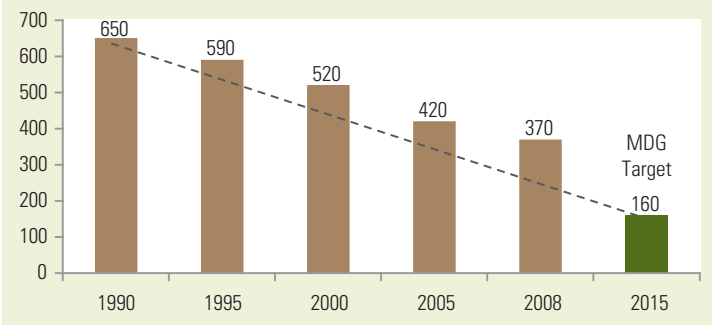
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	370
Births attended by skilled health personnel (percent)	29.9
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	22.3
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	53
Antenatal care with health personnel (percent)	86
Unmet need for family planning (percent)	30.8

Source: Table compiled from multiple sources
[a] The 2009–10 DHS estimate is 557.

MDG Target 5A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Timor-Leste has been making progress over the past two decades on maternal health but it is not yet on track to achieve its 2015 targets.[4]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Timor-Leste

The Bank's current ***Interim Strategy Note*** is for fiscal years 2010 to 2011.

Current Project:
P104794 TP-Health Sector Strategic Plan Support Project (with $24 million from AusAID and World Bank)

- *Improve Health Service Delivery*
- *Strengthen Support Services, Human Resource Development, and Management*
- *Support Coordination, Planning and Monitoring*
- *Support Innovation and Program Development*

Pipeline Project:
National Health Sector Strategic Plan Support Project (with approx. $30 million from AusAID, EU and World Bank)

Previous Health Project:
P093524 TP-Health sector support program (TF054512/1)

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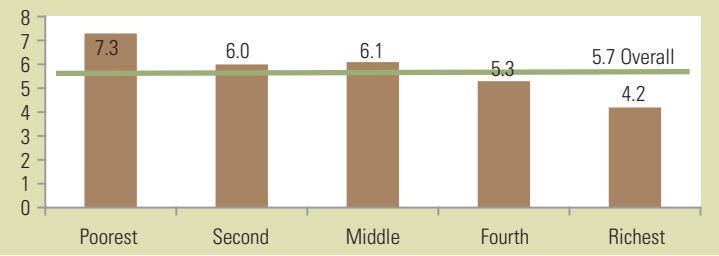
Key Challenges

High fertility

Fertility has been declining over time but remains high among the poorest. Total fertility rate (TFR) decreased from 7.8 births per woman in 2003[5] to 5.7 births per woman in 2009–10.[5] Fertility remains very high among the poorest Timorese at 7.3 in contrast to 4.2 among the wealthiest (Figure 2). Similarly, TFR is 2.9 among women with more than secondary education and 6.1 among women with no formal education. It is also lower among urban women at 4.9, compared to rural women at 6.0 births per woman.[5]

Figure 2 ▪ Total fertility rate by wealth quintile

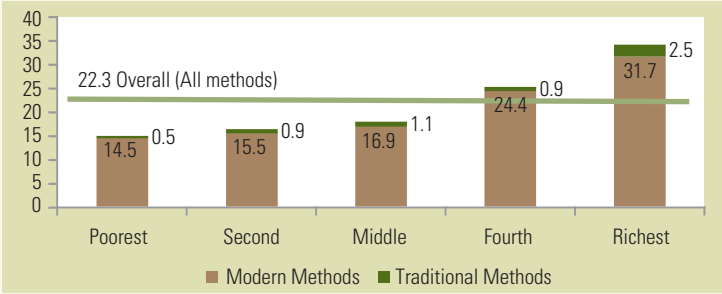


Source: DHS Final Report, Timor-Leste 2009–10.

Adolescent fertility adversely affects not only young women's health, education and employment prospects but also that of their children. Births to women aged 15–19 years have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3, 6] In Timor-Leste, adolescent fertility rate is moderate at 53 reported births per 1,000 women aged 15–19 years.

Use of modern contraception is increasing. Use of contraception among married women dropped from 25 percent in 1997 to 7 percent in 2003 (partly due to disruption of family planning service provision during the fight for independence) but has since increased to 21 percent in 2009–10.[5] More married women use modern contraceptive methods than traditional methods (21 percent and 1 percent, respectively). Injectables are the most commonly used method (16 percent), followed by the pill (2 percent). Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: modern contraceptive use is 32 percent among women in the wealthiest quintile and 15 percent among those in the poorest quintile (Figure 3).[5] Similarly, just 15 percent of women with no education use modern contraception as compared to 30 percent of women with secondary education or higher, and 19 percent for rural women versus 28 percent for urban women.

Figure 3 ▪ Use of contraceptives among married women by wealth quintile



Source: DHS Final Report, Timor-Leste 2009–10.

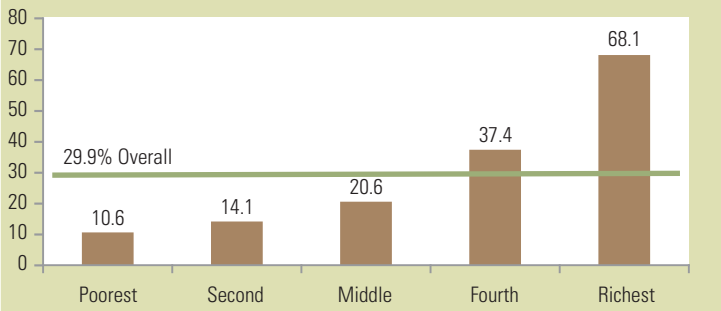
Unmet need for contraception is high at 31 percent[5] indicating that women may not be achieving their desired family size.[7] Induced abortion remains a challenge as approximately 40 percent of all emergency obstetric care cases in two major hospitals are due to incomplete and complicated abortions.[8]

Opposition to use is the predominant reason women do not intend to use modern contraceptives in future. Forty-six percent of women oppose using contraceptives, and 9 percent cite husband/partner's opposition as the main reason they do not intend to use modern contraceptives in future.[5] Fear of side effects (10 percent) and health concerns (8 percent) are also significant reasons cited. Cost and access are lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

While the majority of pregnant women use antenatal care, institutional deliveries are less common. Nearly nine-tenths of pregnant women receive antenatal care from skilled medical personnel (doctor, nurse, or midwife) with 55 percent having the recommended four or more antenatal visits.[5] However, a smaller proportion, 30 percent deliver with the assistance of skilled medical personnel. While 68 percent of women in the wealthiest quintile delivered with skilled health personnel, only 11 percent of women in the poorest quintile obtained such assistance (Figure 4). Further, 23 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[9]

Figure 4 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile



Source: DHS Final Report, Timor-Leste 2009–10.

Among all women ages 15–49 years who had given birth, 68 percent had no postnatal care within 6 weeks of delivery.[5]

Eighty-seven percent of women say they have serious problems in accessing health care when they are sick because of concern that no drugs are available (Table 1).[5] Further, 82 percent cited the concern that no provider is available and three in five women cited the concern that no female provider is available.

Table 1. Problems in accessing health care (women age 15–49)

Reason	%
At least one problem accessing health care	95.9
Concern no drugs available	86.6
Concern no provider available	82.4
Concern no female provider available	63.1
Having to take transport	59.4
Distance to health facility	53.3
Not wanting to go alone	43.2
Getting money needed for treatment	35.6
Getting permission to go for treatment	23.1

Source: DHS final report, Timor-Leste 2009–10.

Human resources for maternal health are limited with only 0.1 physicians per 1,000 population but nurses and midwives are slightly more common, at 2.19 per 1,000 population.[1]

The high maternal mortality ratio at 370 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[4]

HIV prevalence is low in Timor-Leste and education campaigns are underway

HIV prevalence in Timor-Leste is low and knowledge of HIV and HIV prevention methods is relatively low, especially amongst women. Despite concentrated efforts from the government, less than half of the female population (44 percent) has heard of HIV. One-third of women know that a healthy looking person can have HIV, and 17 percent know where they can obtain an HIV test. 30 percent of Timorese women and 45 percent of men know that condoms can help reduce risk of transmission. Thirteen percent of young women ages 15 to 24 know where to obtain condoms, and 2 percent of women in this age range used a condom at first sexual intercourse.

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

National policies and strategies that have influenced reproductive health

The National Reproductive Health Strategy 2004–2015 with 7 objectives aimed at improving access and delivery of reproductive health services, creating an enabling environment, and outlining the key actions to achieve the MDGs.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.
- Work at the grassroots level and through community campaigns to prevent gender-based violence and promote gender equality.

Reducing high fertility

- Increase family planning awareness and utilization through outreach campaigns; promote Community Based Distribution of family planning commodities, especially targeting rural and remote communities.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated and ensure their availability and accessibility in both urban and rural areas.

Reducing maternal mortality

- Address the inadequate human resources for health by urgently training midwives and health personnel and deploying them to the poorest or hard-to-reach districts.
- Invest in the provision of basic emergency obstetric care (EmOC) which is still limited in rural areas; ensure that hospitals are able to provide comprehensive obstetric care in the case of delivery complications.
- During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.

Reducing STIs/HIV/AIDS

- Despite the low prevalence, efforts should focus on integrating HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care to ensure that HIV positive mothers are identified and their babies are born HIV-free.
- Focus on increasing HIV and STIs knowledge and awareness through community outreach in both urban and rural areas.

References:

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TIMOR-LESTE REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level
Total fertility rate (births/woman ages 15–49)	2009/10	5.7
Adolescent fertility rate (births/1,000 women ages 15–19)	2008	53.1
Contraceptive prevalence (% of married women ages 15–49)	2009/10	22.3
Unmet need for contraceptives (%)	2009/10	30.8
Median age at first birth (years) from DHS	2009/10	22.4
Median age at marriage (years)	2009/10	20.9
Mean ideal number of children for all women	2009/10	5.0
Antenatal care with health /sonnel (%)	2009/10	86
Births attended by skilled health /sonnel (%)	2009/10	29.9
Proportion of pregnant women with hemoglobin <110 g/L)	2008	22.9
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	650
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	590
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	520
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	420
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	370
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	160
Infant mortality rate (per 1,000 live births)	2008	75
Newborns protected against tetanus (%)	2008	66
DPT3 immunization coverage (% by age 1)	2009/10	64.2
Pregnant women living with HIV who received antiretroviral drugs (%)		—
Prevalence of HIV (% of population ages 15–49)		—
Female adults with HIV (% of population ages 15+ with HIV)		—
Prevalence of HIV, female (% ages 15–24)		—

Indicator	Year	Level
Population, total (million)	2008	1.1
Population growth (annual %)	2008	3.2
Population ages 0–14 (% of total)	2008	45.2
Population ages 15–64 (% of total)	2008	51.9
Population ages 65 and above (% of total)	2008	2.9
Age dependency ratio (% of working-age population)	2008	92.8
Urban population (% of total)	2008	27.3
Mean size of households		—
GNI/capita, Atlas method (current US$)	2008	2460
GDP/capita (current US$)	2008	453
GDP growth (annual %)	2008	13.2
Population living below US$1.25/day	2007	37.2
Labor force participation rate, female (% of female population ages 15–64)	2008	61.6
Literacy rate, adult female (% of females ages 15 and above)		—
Total enrollment, primary (% net)	2008	77.3
Ratio of female to male primary enrollment (%)	2008	93.9
Ratio of female to male secondary enrollment (%)		—
Gender Development Index (GDI)		—
Health expenditure, total (% of GDP)	2007	13.6
Health expenditure, public (% of GDP)	2007	11.5
Health expenditure/capita (current US$)	2007	57.9
Physicians (per 1,000 population)	2004	0.1
Nurses and midwives (per 1,000 population)	2004	2.19

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2009/10	7.3	6.0	6.1	5.3	4.2	5.7	3.1	1.7
Current use of contraception (Modern method)	DHS	2009/10	14.5	15.5	16.9	24.4	31.7	21.1	–17.2	0.5
Current use of contraception (Any method)	DHS	2009/10	15.0	16.4	18.0	25.3	34.2	22.3	–19.2	0.4
Unmet need for family planning (Total)	DHS	2009/10	35.0	30.1	33.5	28.0	27.9	30.8	7.1	1.3
Births attended by skilled health personnel (percent)	DHS	2009/10	10.6	14.1	20.6	37.4	68.1	29.9	–57.5	0.2

Development partners support for reproductive health in Timor-Leste

WHO: Safe motherhood and reproductive health;

UNFPA: Reproductive health and rights, safe motherhood, EmOC, adolescent reproductive health, gender based violence;

UNICEF: Child protection; under-5 mortality; adolescent and youth;

USAID: Maternal, newborn and child health

AUSAID: Maternal, newborn and child health.