



PERMANENT MISSION OF THE DEMOCRATIC REPUBLIC OF TIMOR-LESTE TO THE UNITED NATIONS OFFICE AND OTHER INTERNATIONAL ORGANIZATIONS IN GENEVA

Information regarding the adoption of rights-based approach to eliminating preventable maternal mortality and morbidity in Timor-Leste

Introduction

As a newly independent country, Timor-Leste is faced with the challenge of having to deliver on competing priorities among various sectors of development, right at the early stage of its national reconstruction process. Timor-Leste sees investment in human as a *condition sine qua non* for further development and nation-building, and therefore places health sector among the highest development priorities. Within this context, significant efforts and resources have been dedicated for the improvement of maternal health. Various reports have been produced on these initiatives, both sanctioned by the Government as well as other entities. This document is compiled from various reports and unpublished relevant information available at the Ministry of Health.

This document is elaborated in response to the Verbal Note of the Office of the High Commissioner for Human Rights, with reference NVebII_mcs_2011, dated 13 January 2011, for the purpose of providing information “on initiatives that exemplify good or effective practices in adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity” to be included in the OHCHR “analytical compilation of good or effective practices in adopting a human rights-based approach to eliminating maternal mortality and morbidity”, as requested by the Human Rights Council Resolution A/HRC/15/17 entitled “Preventable maternal mortality and morbidity and human rights: follow-up to Council resolution 11/8.”

Information on initiatives that exemplify good or effective practices in adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity

Reducing maternal mortality and morbidity rates is one of the main priorities of the Government of the Democratic Republic of Timor-Leste. In this regard, the Ministry of Health has been implementing, among other initiatives, a National Reproductive Health Strategy for 2004-2015, which outlines a human rights-based approach to improving reproductive health in the country, and tackles the challenges associated with high fertility rate and high maternal and child mortality rates. The Strategy was prepared with the assistance of international partners, including UNFPA, UNICEF and WHO. The strategy was elaborated with due consideration of human rights principles and standards relating to health, including the Convention on the Rights of the Child and the 1994 Program of Action of the International Conference on Population and Development.

The strategy aims at meeting the changing needs of reproductive health over the life cycle, with a focus on high risk groups, through programs and activities targeting the young people's sexual and reproductive health, health care services, family planning, safe motherhood and the improvement of the health status, and general reproductive health of mature population.

The main objectives of the National Reproductive Health Strategy are:

- to increase the level of knowledge among the general population on issues related to sexuality and reproductive health, as well as to promote family planning in order to increase the contraceptive prevalence rate of married and unmarried couples to 40% and to reduce the percentage of all births that occur to adolescents by 30%;
- to ensure that all women and men have access to basic reproductive health care services, health promotion and information on issue related to reproduction;
- to reduce the level of maternal mortality ratio with the target of a reduction of 40% from 2004 levels by the end of 2015;
- to reduce the level of perinatal and neonatal mortality ratio by 40% from 2004 levels by increasing the coverage of antenatal and postnatal care to 80%, the rate of deliveries assisted by skilled attendants to 50% from 2004;
- to reduce the burden of STIs by 40% from 2004 levels and to reduce the incidence of STIs/HIV among young people by 30%.

Example of how human rights principles are incorporated into the National Reproductive Health Strategy:

The National Reproductive Health Strategy was established on the main principles of human rights, which are fundamental for a human rights-based approach to development. The programmes designed as part of the strategy cover all section of the society, including both men and women, young and elderly people. Besides activities that target the specific health care needs for each section of society, information was made available to the whole community, in order to ensure that individuals can access the appropriate health services which suit their need. In this way, the Government attempts to satisfy the principle of universality and inalienability in the provision of health care services for the citizen.

In conjunction with other strategies in the area of health, the primary goal of the National Maternal Health Strategy was the improvement of health outcomes of development. Guided by the principle of the principle of indivisibility, the strategy took a multidisciplinary approach through the incorporating health related programmes into those of other development sectors. The programmes were developed bearing in mind the interrelatedness of health care services with the right to education, right to information, freedom from discrimination, and other rights. Programmes are interdependent and interrelated with other areas of health, such as nutrition. To assist the planning and implementation of

programmes among such a vast sectors of development, coordination is established among related government ministries, including Ministry of Education, Culture, Youth and Sport, the Ministry of Infrastructure, Ministry of State Administration, Ministry of Finance and the Secretariat of State for the Promotion of Equality. The National Reproductive Health Strategy seeks to improve the coordination of efforts among different stakeholders, strengthens partnerships, advocates for prioritization in resource allocation, outlines national standards and guidelines, and promotes regulatory frameworks related to health. The strategy has been implemented in conjunction with associated public health programmes and initiatives, such as the National Nutrition Strategy, the National Strategy for Health Promotion and the Integrated Management of Childhood Illness. Future programmes and initiatives will also be systematically addressed and integrated.

Equality and non-discrimination is another principle paramount to the success of the National Maternal Health Strategy. As part of the strategy, the essential care standards and practice guides, such as related to fertility regulation, are adapted and translated to local conditions and needs. Participation by those targeted by the programmes can be seen particularly in relation to youth health, with young people involved in the development of information packages for young people on health, development and rights, responsibilities and services. Furthermore, all stakeholders at both national and local levels, including public and private health services providers, representatives of women's groups and community groups, were actively involved throughout the elaboration and implementation of the strategy. Their participation includes the identification of priorities, needs assessment, development and implementation of monitoring and evaluation mechanisms for maternal and newborn health programmes.

With such inclusiveness and broad participation of stakeholders, the strategy has already a built-in accountability mechanism. Additionally, the National Reproductive Health Coordination Committee was established as the formal body for to oversee the development of the strategy. It focuses on integrating components of the strategy, liaising between stakeholders, and monitoring progress against objectives. It also acts as the standing committee of the Ministry of Health, responsible for reporting on activities and recommendations of the Committee to the Ministry of Health.

Key improvements and challenges:

A comprehensive demographic and health survey was conducted for 2009-10, and it was the second survey of its kind in the country since 2002. It covered topics such as fertility levels and determinants; family planning; fertility preferences; infant, child, adult and maternal mortality; maternal and child health; nutrition; malaria; domestic violence; knowledge of HIV/AIDS and women's empowerment. The survey provided disaggregated data by districts, rural vs. urban, education level, wealth and age. It therefore provides information on trends as improvements and challenges to be addressed in the implementation of the programmes.

Knowledge of family planning methods have steadily been improving. According to 2003 Demographic Health Survey (DHS), knowledge of contraception for every married women and men was 38% and 30% respectively. The survey of currently married women and men in 2009-10 found 78% and 66%

respectively. Although the statistics are not directly comparable, as the 2003 statistic includes divorced and widowed men and women, it shows a clear increase in the level of knowledge.

Family planning messages have been disseminated in several ways in the community, including through radio, television, print media, street drama and also by family planning and reproductive health service providers. Knowledge varies relating to level of education and wealth, with these factors increasing the level of knowledge. However, surveys conducted among those who had visited a health facility in the past 12 months shows that 31% of nonusers of contraception did not discuss family planning, showing the prevalence of missed opportunities for information dissemination and educate on family planning.

Use of contraception among married women has also been steadily improving since 2002, with the use of modern methods doubling between 2002 and 2007, and rose by nearly 50% between 2007 and 2010. The use of contraception varies greatly by regions, and women in urban areas are more likely to use a family planning method than those in rural areas.

Although there are great differences between the use of any contraception by women with no education and women with some education, there is little variation among educated women by specific level of education.

The demand for family planning has increased between 2003 and 2009-10 from 13% to 53%. However, despite scaling up of family planning services, this demand has not sufficiently been met, with a 31% unmet need for family planning. If all currently married women who intend to have a greater interval between pregnancies or to limit the number of child were to use a family planning method, the contraceptive prevalence rate would increase from 22% to 53%.

There has been a **decline in fertility** due to several factors, including the access to modern family planning programmes not previously available in Timor-Leste, the relative political stability following the 1999 and 2006 crises and the return of people from remote rural areas to semi-urban or urban areas, which may expose them to social and economic influences encouraging smaller families.

The average of the total fertility rate at national level and by urban-rural residence for the three years preceding the survey is 5.7 births per woman. However, there are considerable differentials in fertility among districts, with fertility ranging from a low of 4.4 births per woman in Covalima to a high of 7.2 births per woman in Ainaro. According to the 2004 Population Census, the average of fertility in Timor-Leste was of 7.0 per woman, which was the highest of Southeast Asia.

Antenatal care from a skilled birth attendant is now common in Timor-Leste, with 86% women receiving care. This is an increase of 41% since 2003. The rate varies across districts though, ranging from 74% to 96%. Antenatal care sessions are used as an opportunity to provide information to women and their families about danger signs and symptoms during pregnancy and delivery. The 2009-10 survey found 56% of women cited severe abdominal pain as a danger sign, 47% mentioned severe headache, 36% mentioned vaginal bleeding and 11% mentioned convulsions. The survey found that rural mothers were more likely to cite the danger signs than urban mothers, with other factors such as education level, wealth and age showing little patterns.

The number of women making a **post-natal visit** within 1 week of delivery has also increased. A challenge in antenatal and post-natal care remains access to health facilities. More than 96% of women reported at least one problem when they access health care for themselves. From women who reported that they experienced serious problems in accessing health care for themselves, the biggest concerns were the unavailability of drugs and unavailability of a health care provider. Although both urban and rural women almost evenly experienced one problem in access (94% and 96% respectively), some issues were felt more strongly by urban women. As would be expected, these included the distance to health facilities and having to take transport to the facilities, but also of greater concern to urban women was that no female provider would be available.

The government is supporting and encouraging **community health centres** through the SISCa programme (Serviços Integrado da Saúde Comunitária – Intergrated Community Health Services), to provide integrated heath assistance across a range of health issues. Although state funded and ran, these community centres encourage ownership by the local community, and integration with community and religious groups, thereby ensuring compliance with the principles of participation and interdependence. They hold activities such as nutrition demonstration classes, film screenings, games and art performances at different times of the day, to allow equal access regardless of literacy levels or work commitments.

Regarding maternal mortality ratio estimate, the demographic and health survey for 2009-2010 refers to data collected for the period of zero to six years preceding the survey, only one year after the implementation of the National Reproductive Health Strategy in Timor-Leste. The survey is the first direct measurement of maternal mortality as it is based on survey data and it is therefore not comparable to other model-based estimates of Maternal Mortality Rates (MMR) that have been used in Timor-Leste in the previous years. According to the survey, the maternal mortality rate, which is the annual number of maternal deaths per 1,000 women age 15-49, for the period of zero to six years preceding the survey, is 0.96. Maternal deaths accounted for 42% of all deaths of women age 15-49, which shows that more than two in five Timorese women died for pregnancy or pregnancy-related causes. The Maternal Mortality Ratio for the seven years preceding the survey is 557 deaths per 100,000 live births (about 6 deaths per 1,000 live births.)