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The Status of Family Planning and Reproductive Health in Timor-Leste

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THE STATUS OF FAMILY PLANNING AND REPRODUCTIVE HEALTH IN TIMOR-LESTE, 2010

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1 Aims of the Report

The International Conference on Population and Development (ICPD) in 1994 adopted a Programme of Action with an ambitious goal:

All countries should take steps to meet family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law (UN 1994: para 7.16; emphasis added).

Today there is widespread a view that neither the international community nor the majority of national governments have pursued the Cairo Program with the level of commitment it requires and deserves. Many national family planning programs appear to have lost focus and momentum.

Against this background the International Council on Management of Population Programmes (ICOMP) and the Asia and Pacific Regional Office of the United Nations Population Fund (UNFPA) are undertaking a review of the status of family planning in selected countries of Asia and the Pacific. The present country report is one component of this broader undertaking.

The aims of this report are to:

- provide a succinct review of the overall status of family planning (FP) and related reproductive health programs in Timor-Leste today;
- identify key issues and obstacles which may be limiting universal access to quality FP services; and
- make recommendations (where appropriate) regarding how the provision of services and practice of FP can be improved by “repositioning,” “revitalizing,” or otherwise adjusting the national FP program.
2 Past Achievements in FP/RH

Timor-Leste is currently the youngest new nation in the world, having gained full independence after a bitter and protracted struggle only in 2002. It is estimated that the violence following the 1999 referendum destroyed about 80 percent of all health clinics and schools, as well as much of the area’s electricity generating capacity. All the normal political and administrative institutions needed by a modern state had to be created virtually from scratch.

Demographic context

There is not an abundance of demographic data for Timor-Leste but the broad picture is clear. Relative to the rest of Southeast Asia Timor-Leste is still in an early stage of its demographic transition: while death rates have been coming down steadily for more than half a century birth rates have remained high (Figure 1). The UN estimates the average crude death rate during 2005-2010 to be 8.8 deaths per 1,000 population, and the average crude birth rate during the same period to be 40.2 births per 1,000 population. The 2003 Timor-Leste Demographic and Health Survey recorded a total fertility rate (TFR) of 7.8, the highest in the world. The growing difference between the number of births and the number of deaths every year results in a high population growth rate (estimated at 3.3 percent per annum during 2005-10 by the UN).

Figure 1. Crude birth and death rates, Timor-Leste, 1950-2010

Source: Data from UN (2009).

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1 One needs to be careful in using published statistics on TL since many are calculated from incomplete or unreliable data sets, and some demographic rates can only be calculated using “indirect estimation techniques” based on assumptions which might not be accurate for TL.

2 The (period) TFR is the sum of age-specific fertility rates at a given time and can be interpreted as the number of live births the average woman would bear during her lifetime if she experienced the age-specific fertility rates observed at that time throughout her reproductive years.
National Family Planning Policy

A National Family Planning Policy was established in 2004, after significant consultations with stakeholders, including religious leaders. It is noteworthy that a FP program was established so early in the history of the new nation. The Prime Minister at the time lent his active support. The policy enjoys good support in Parliament, and is deliberately designed so as not to offend the teachings of the Roman Catholic Church.

The rationale for the national FP policy builds on the country’s Constitution which states (section 57), “everyone has the right to health and medical care and the duty to protect and promote them.” Given the very high level of fertility in the country at the time, it was clear during consultations held in 2003 that the “majority of the people, including the Catholic Church leaders of Timor Leste, have expressed their support for implementation of [a] family planning programme” (Araujo 2005: 4). The policy document makes explicit reference to the Cairo Program, noting that the latter “shifted the population debate away from a demographic framework, with its focus on population control, to a reproductive health framework, with a focus on meeting the needs of individuals and couples” (MOH 2004a: 6). The “guiding principle” of the policy is “‘planning a family’ within the context of responsible parenthood” (MOH 2004a: 7).

Among its clauses the policy states: “In order to ensure that all couples and individuals in Timor-Leste have the means and information needed to make informed and free choices about the number and spacing of their children, the Government undertakes to make accessible at all levels of the public health system, with technical and financial assistance from the international community if necessary, family planning, including natural family planning, information, counseling and services” (MOH 2004a: 9-10). The policy covers service delivery (both health center-based services and outreach activities), human resources, and IEC.

The MOH has overall responsibility for implementing the National FP Policy. This responsibility rests with the Department of Maternal and Child Health, ensuring that FP is integrated with other reproductive health services (as advocated by ICPD). Implementation is also guided by the MOH’s National Reproductive Health Strategy 2004-2015 (MOH 2004b). The Strategy has 4 main components:

- Young people’s sexual and reproductive health
- Reproductive choice (family planning)
- Safe motherhood
- General reproductive health.

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3 The policy also recognizes the importance of FP for meeting the MDGs: “The Government … recognizes the importance of reducing the country’s high population growth rate and of spacing births as a means of reaching its goals of eradicating poverty, reducing the country’s high levels of maternal and infant and child mortality, and improving the health of mothers and children in line with the goals and targets set out in the United Nations Millennium Declaration” (MOH 2005: 8).
FP and RH programs are implemented in partnership with other stakeholders, including communities and other relevant government departments, and a National Reproductive Health Strategy Coordination Committee (or Working Group) with broad stakeholder representation has been established to provide a forum for discussion and debate and facilitate wide ownership of the program. Timor-Leste’s system of governance is administratively decentralized so much of the responsibility for implementation of program activities lies with the districts and their local communities: According to the Strategy document:

As with education, community action for health is critical in all the priority areas of interventions outlined below. The community has a particularly strong role to play in strengthening linkage with health services, in increasing awareness of reproductive health needs and in improving the quality of care. In these areas, increased knowledge of the community results in increased action for health and increased participation in problem-solving to meet maternal and newborn health needs.

As decentralization strengthens, efforts and planning will include strengthening of district and community forums so that community representatives can actively assume ownership of reproductive strategies and pass this ownership on [to] the community in general. For community interventions, skills for community mobilization, community dialogue, communication, research, educational approaches and for interacting with the community, need to be assessed.

Community efforts should work closely with advocacy efforts of reproductive health programs. Several community interventions are advocacy-oriented, increasing the “demand” from communities, raising community awareness about reproductive health issues and participation in the decisions taken at the district level for finding solutions and allocating resources.

The various levels of the district health services (DHS) are directly responsible for planning, implementing, and managing RH program activities. The structure of the MOH DHS extends from the first point of contact, the Health Post, to more advanced services in the Health Centre with small mobile clinics providing services to significant population groups in the absence of fixed facilities. …

Within the District Health Management Team (DHMT) there will be appointed a focal point for RH who should coordinate and integrate the components of Reproductive Health. These district officers will work with other DHMT officers to establish mechanisms for RHS activities within the district framework.

It is the RH focal point responsibility, as a component of the DHMT, to ensure technical guidance, support (flow of supplies, training needs and delivery,
access to guidelines and protocols) and monitoring of RH are incorporated into the DHP planning, processes, monitoring and evaluation. …

A referral system feeds from the front line health services through to referral hospitals for either anticipated cases of complicated deliveries or for emergency obstetric services and certain types of family planning methods, and eventually to the National Hospital in Dili for highest level of service when required (MOH 2004b: 33-34).

In 2007 a National Reproductive Health Behavior Change Communication Strategy 2008-2012 was developed which identified behavioral objectives for each of the four components of the National RH Strategy. The objective (“key behavior”) for FP is for women and men of reproductive age to space their children by at least 3 years.

The key policy documents for FP and RH are remarkable for their clarity of purpose and objectives, and for the succinct yet comprehensive way they outline well thought out strategies for attaining these objectives. Many lessons learned from international experience have been incorporated. Also apparent is the conviction with which ICPD principles have been embraced and are being acted upon. Unlike many countries in the region with older FP programs which were established pre-Cairo, Timor-Leste has been spared the difficulty of converting a population control program into a program promoting reproductive rights. Timor-Leste’s program has been firmly grounded in a human rights perspective from inception.

As the passage from the Strategy document quoted above illustrates, those planning FP/RH programs are also eager that community “ownership” of services should be encouraged.

**Changes in fertility behavior and fertility outcomes**

The first Demographic and Health Survey in independent Timor-Leste was conducted in 2003. Another was conducted in 2009-10, but at the time of writing this report only limited preliminary results are available (MEASURE DHS 2010). Table 1 summarizes relevant changes between the two surveys. We have also included similar statistics from previous DHS when East Timor was considered part of Indonesia, although it needs to be remembered that at that time many of those counted as practicing FP in the territory were actually Indonesians living and working in East Timor, many of them civil servants.

The very low knowledge level about contraception recorded in 2003 is another sign of how atypical Timor-Leste is of the region. It will be interesting to see how this statistic may have changed in the 2009/10 survey. The 2009 Baseline Study for RH Behavior Change Communication found that just over 50 percent of married women 15-49 had heard of birth spacing but only 11 percent of the sample could identify three of more methods of contraception (Mosquera et al. 2009a).
Table 1. CPR, awareness of at least one modern method of contraception, and TFR, Timor-Leste, by year of survey 1991, 1997, 2003 and 2009/2010

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Know at least one modern method of contraception</td>
<td>48.3</td>
<td>61.9</td>
<td>38.2</td>
<td>--</td>
</tr>
<tr>
<td>CPR All methods</td>
<td>22.6</td>
<td>26.7</td>
<td>10.0</td>
<td>22.4</td>
</tr>
<tr>
<td>Modern methods</td>
<td>20.7</td>
<td>25.1</td>
<td>8.9</td>
<td>21.2</td>
</tr>
<tr>
<td>TFR</td>
<td>4.7</td>
<td>4.4</td>
<td>7.8</td>
<td>5.7</td>
</tr>
</tbody>
</table>

Source: Data from Indonesia and Timor-Leste DHS.

Note: “Know at least one modern method” and CPR is for all currently married women age 15-49, except for 2003 where “Knowledge” is for ever-married women; TFR is average for 3 years preceding the survey.

The DHS data suggest the CPR (all methods) has increased by at least 12 percentage points in 6 years, an average of 2 points per year.\(^4\) This is a respectable rate of increase in CPR, although admittedly beginning from a very low base, and presumably before the new FP program was launched there was a small but significant pent-up “latent demand” for FP. We will be able to assess recent trends in fertility and fertility behavior in far more depth when the complete 2009/10 DHS findings are published. The RH BCC baseline study in 2009 found that roughly 25 percent of the sample were currently practicing family planning. Of those who had given birth during the previous 5 years slightly less than 30 percent had practiced birth spacing.

The 2-child decline in the TFR should not be interpreted as a simple indicator of the “success” of the FP program. Fertility has undoubtedly been very high in the East Timor population for a long time but the extremely high fertility levels measured in 2003 were probably exceptional even for East Timor. They most likely reflect in part a so-called “tempo effect” where for a while fertility declined because of political unrest and violence and then when relative calm was restored during the UNTAET administration (2000-2002) those who had postponed fertility made up for lost time,\(^5\) resulting in a temporary baby-boom.\(^6\) When the 2010 Population Census and the latest DHS data become available we will be in a position to give a more definitive account of fertility outcomes.

3 Current Issues in the National Program

This country study does not attempt a detailed assessment of specific components of the national FP and related RH programs. An in-depth analysis will be available from the UNFPA Program Review which is due to be completed about the same time as this present report. The purpose of our report is to flag issues concerning the current status of FP in Timor-Leste.

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\(^4\) The 2003 survey was fielded between May and August, and the 2009/10 between August and February; taking the mid-point of each period, this suggests the time period between the 2 surveys is actually 6 years and 4.5 months.

\(^5\) Also, there was no active promotion of FP during the UN Transitional Administration in East Timor.

\(^6\) Similar baby-booms have often been observed after periods of political unrest and bloodshed. Some of the motivation is self-consciously to “replace” some of those who have been killed. See, for example, Desbarats (1995).
Developing a FP program from scratch is an enormous undertaking. Service providers and program managers have to be recruited and trained; service delivery points have to be staffed, equipped, stocked, resourced, and sometimes build; procurement and logistics systems have to be designed and put in place; quality assurance as well as monitoring and evaluation systems have to be established; and above all potential clients have to be informed and educated in the use of FP and how they can make an informed choice; there needs to be a range of outreach and communication programs. This is a tall order, especially in a poor country with poor communications and where education levels are low. New systems cannot be established and expected to function perfectly overnight.

**Positioning the program**

There are no major issues regarding the way the national FP program is currently “positioned” in East Timorese society. The program is already “positioned” in the most appropriate location in the MOH; FP services are provided in concert with other RH and MCH services, and the recently introduced Integrated Community Health Services outreach program (known as “SISCa”) promises to further integrate FP/RH into basic health services; working groups and other mechanisms are in place to ensure that program officials work well with relevant stakeholders; and within the state apparatus the program’s administration is suitably decentralized, and there are plans to strengthen this aspect as the program expands and matures. In short, there is no reason that the FP program needs to be “repositioned” in any major way.

**Evidence-based policy development**

One impressive feature of the FP/RH program is the commitment at the MOH to make sure that policy development is evidence-based. There is currently a shortage of relevant and reliable data, however. A few of the main data sources to date, both quantitative and qualitative, are as follows:

- *2009 Baseline Study for RH Behavior Change Communication* (Mosquera et al., 2009a, 2009b). Designed to provide necessary data for monitoring and evaluation of the National RH BCC Strategy 2008-2012. Quantitative data were collected by conducting 1088 structured interviews in 65 villages (*sucos*) in all 13 districts during February-March 2009. Qualitative data were generated through 36 focus group discussions (FGDs). The published data are extremely interesting and relevant for RH BCC program development.
- *Timor-Leste Health care Seeking Behaviour Study 2009* (Zwi et al. 2009). Health care seeking data collected from 771 individuals from a nationally representative sample of 535 households from all 13 districts. These data were supplemented by 38 FDGs, and in-depth interviews with health care providers and village heads (*xefe suco*).
The supply of relevant statistical data will soon be expanded significantly by results from the 2009/10 DHS and the 2010 Population Census. As further studies are commissioned in response to the evolving data needs of the program it is important that wherever possible they use a common sampling frame (adapted in future from the 2010 Population Census) and use comparable questionnaire items (i.e. don’t change the wording of key questions in each new study arbitrarily) so that the supply of data does not become unduly fragmented over time and maximum synergy among the studies is nurtured.

Expanding and maturing the program

The preliminary findings from the 2009/10 DHS suggest a rapid growth in unmet demand for FP since the 2003 survey (Table 2). The percent of married women who say they want another child soon (i.e. within the next 2 years) has declined from 32.4 to 8.5 percent, and the percent saying they want no more children has increased from 17.1 to 34.7 percent.7 A major change in the demand for children has occurred.

Table 2. Desire for children, Timor-Leste, 2003 and 2009/10

<table>
<thead>
<tr>
<th>Desire for children</th>
<th>2003</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have another soon</td>
<td>32.4</td>
<td>8.5</td>
</tr>
<tr>
<td>Have another later</td>
<td>10.5</td>
<td>35.1</td>
</tr>
<tr>
<td>Have another, undecided when</td>
<td>7.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Undecided</td>
<td>23.6</td>
<td>17.1</td>
</tr>
<tr>
<td>Want no more</td>
<td>17.1</td>
<td>34.7</td>
</tr>
<tr>
<td>Sterilized</td>
<td>--</td>
<td>0.8</td>
</tr>
<tr>
<td>Declare infecund</td>
<td>9.4</td>
<td>2.7</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.1</td>
</tr>
<tr>
<td>Number of women</td>
<td>4,066</td>
<td>7,922</td>
</tr>
</tbody>
</table>

Source: DHS.

These results suggest that around 70 percent of married women have a need for FP, yet the contraceptive prevalence rate for these women is only 22.4 percent. If these findings are robust then there has clearly been a massive growth in unmet need for FP since 2003 (both for spacing and limiting). The most striking feature of the 2003 findings was how little demand for FP there appeared to be; the most amazing thing about the 2009/10 findings is how huge the demand is today, and how rapidly it has grown.

There may be a “demand for FP” in the way DHS defines “demand,” but that does not mean these women will necessarily want to be part of the national FP program. There is an enormous opportunity here, but at the same time an equally enormous challenge as well. The available data on why women who say they do not want another child now yet who are not practicing FP is fragmentary, but the qualitative data indicate all the usual factors play a role: lack of knowledge or understanding about FP; husband does not agree to use of modern contraception; fear of side effects; distance to nearest health center and the cost of travel; other real or perceived cost factors including opportunity costs; having a previous poor

7 In the 2003 survey those women (or their partner) who are sterilized are not listed as a separate category in the relevant table so some women who say they want no more children, for example, could already be sterilized; but the percent of people sterilized in TL is so small this will not affect the overall percentage distribution significantly.
experience at a health center; preferred method not available; etc. (Mosquera et al. 2009a; Zwi et al. 2009). The new RH BCC program is designed to address such concerns but it is not fully rolled out yet. Part of the challenge – which programs in other countries have sometimes not risen to – is to treat women and their partners with equal respect whether they choose to join the program or not.

Important partners in the program’s advocacy and BCC components are TAIS (Timor-Leste Asistensia Integradosu Saude, funded by USAID) and HAI (Health Alliance International, funded by AusAID and USAID).

Much effort during the past few years has necessarily focused on developing the supply side of the FP program. Expanding the supply of services in a way which ensures quality yet is cost-efficient, and which is neither too ahead nor too behind the curve of growing demand for services is a constant challenge. Training midwives, doctors and program staff is ongoing. Quality assurance is another constant challenge.

A cadre of largely volunteer fieldworkers who will provide FP/RH education and counseling at the village level is envisioned for the coming years.

Managing contraceptive supplies to ensure “contraceptive security” is another constant challenge. There have been some stock-outs and mal-distribution of commodities in the past (Belton 2010). Lessons have been learned and applied. RH commodities are listed on the MOH’s Essential Drug List; Belton (2010) recommends they be upgraded to “Vital,” since “maternal and infant mortality are high and access to emergency obstetric care very limited.” It is certainly crucial that lingering problems with supply systems be addressed promptly in light of recent indications that demand for services may be at the point of rising rapidly.

At present all FP commodities are paid for by UNFPA, with a major financial contribution from AusAID, but the Government has indicated it is preparing to share the bill, starting perhaps in 2011.

An important partner in service provision is Marie Stopes International,8 funded partly by AusAID. Caritas provides counseling, has nuns trained in FP (all methods), and is opening a new Center for Family in Dili next year.9

4 Understanding the Current Situation

If the final report of the 2009/10 DHS confirms that there has been a massive growth in unmet demand for FP then this has major implications for FP/RH programming. Where women say they do not want another child in the next 2-3 years but are not practicing FP we

8 Except for one clinic of their own in Dili, MSI provides services in close collaboration with the MOH working through the government’s own Community Health Centers and Health Posts.

9 An indication of the cooperation between the Catholic Church and the national FP program is that in the Dili diocese when young couples receive their pre-marital counseling the Church has now started requesting the MOH to send along a midwife who can explain all methods of contraception to the soon-to-be married couples. While the Church makes it clear it does not approve of modern methods it also emphasizes this is a choice that couples must make for themselves, freely and responsibly. If a young couple chooses a modern method then they are informed where they can go in the national program to receive the method.
need to understand the situation clearly. Tractable obstacles to accessing FP services need to be removed. The MOH recognizes the challenge of getting the services “out there” as close to the people who need them as possible.

There are some subtle dimensions to this challenge too. A strong point in the MOH’s tentative plan to have a volunteer fieldworker in every village is that these volunteers will be “counselors” not “recruiters.” If the outreach and communication programs are too forceful this may raise memories of the “strong persuasion” tactics of the Indonesian program.

The Catholic Church in East Timor has been a staunch defender of human rights during the country’s recent history. The Church is currently making a valuable contribution to the national FP/RH program by insisting the program should be structured in such a way that people are encouraged to think deeply and responsibly about what it means to plan their families and not accept “modern practices” uncritically. Others may see this insistence as a hindrance, and may believe that institutionalizing “informed consent” is sufficient. There has been a healthy dialogue between program officials and the Church, and among other stakeholders. This dialogue needs to continue to avoid misunderstandings taking root and potentially undermining the wide support the program currently enjoys.

5 Recommendations

The FP/RH program in Timor-Leste is still young. The main concerns are not so much whether the program needs to be “repositioned” or “revitalized” but how it can avoid common problems and pitfalls as the program grows and matures. Our recommendations are presented as discussion points for the upcoming High-level Family Planning Consultation Meeting in Bangkok, 8-10 December 2010.

Recommendation 1.

Strengthen the dialogue among all stakeholders, especially with the Catholic Church.

Such a dialogue already exists through the Working Group for FP/RH and other mechanisms, but the WG does not meet regularly, and while the collaboration among the progam’s partners is truly commendable agreements reached in the past should not be taken for granted but rather built on and expanded. There is some discussion in Dili at the present time, for example, regarding “how fast the program should move forward.” For some this is essentially a technical question about delivering health services, for others it is inseparable from other questions regarding changing values and spiritual development. There is common ground but it seems to depend a lot on tacit understandings at present. This leaves the program vulnerable to unforeseen “shocks” in the future.

Recommendation 2.

Strengthen the focus on encouraging birth spacing and meeting unmet demand through evidence-based initiatives.
The demand for FP services is likely to grow considerably during the next 5 years if around 50 percent of all married women don’t want a child in the next 2-3 years yet are not using any method of contraception. There is a need for more data (quantitative and qualitative) on who these women are, their values and aspirations (especially regarding family life), and what factors determine their fertility behavior. The program needs to be focused but it is important for policymakers to remember that people’s fertility behavior responds to many social, cultural and economic factors (which themselves are likely to change rapidly in coming years), not just to a national FP/RH program. And it is crucial these women should play an important role in the design and monitoring of the services they are offered. Policymakers and program managers can learn from international best practice, and can contribute to the latter too.

6 Conclusion

The aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods. … The principle of informed choice is essential to the long-term success of family-planning programmes. … Government goals for family planning should be defined in terms of unmet needs for information and services (UN 1994: para 7.12).

Timor-Leste’s national FP/RH program is relatively new and it is off to a good start. It enjoys strong political support from the Government and Parliament, and from key stakeholders including the Catholic Church. The program is unique in the region in the way it was established after ICPD and fully embraces the principles advocated in the 1994 Programme of Action. It needs no “repositioning,” and it is too young to talk of “revitalization.” The main challenges are expanding the program to meet growing demand and at the same time maintaining the broad public support the program currently enjoys. The secret is to stay committed to the Cairo principles and deepen the emphasis on client-orientation even as activities are scaled up.

7 References


Mosquera, Mario, Rafael Obregon, Lawrence Wood, Marianne Viatour, and Andrew Carlson, 2009a. *Family Planning and General Reproductive Health: Quantitative and Qualitative Analysis*. Dili: UNFPA.

