



**Convention on the Elimination  
of All Forms of Discrimination  
against Women**

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**Committee on the Elimination of Discrimination  
against Women**

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**Concluding observations on the initial report of Timor-Leste,  
adopted by the Committee at its forty-fourth session (20  
July–7 August 2009)**

**Addendum**

**Information provided by Timor-Leste on the follow-up to the  
concluding observations of the Committee \* \*\***

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\* In accordance with the information transmitted to States parties regarding the processing of their reports, the present document was not edited.

\*\* The annex can be consulted in the files of the secretariat.

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### Annex

Concluding observations of the Committee on the Elimination of  
Discrimination against Women: Timor-Leste

## Acronyms and abbreviations

AAP	Annual Action Plan
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
ARH	Adolescent Reproductive Health
BCC	Behaviour Communication Change
BEmoOC	Basic Emergency Obstetric Care
BMI	Body Mass Index
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEmoC	Comprehensive Emergency Obstetric Care
CHC	Community Health Centre
CHV	Community Health Volunteers
CRC	Convention on the Rights of the Child
CS	Child Spacing
DHS	Demographic and Health Survey
EmOC	Emergency Obstetric Care
FBO	Faith Based Organization
FP	Family Planning
FSW	Female Sex Worker
GER	Gross Enrolment Rate
GMPTL	Group of Women Parliamentarians of Timor-Leste
GRH	General Reproductive Health
HAI	Health Alliance International
HCSBS	Health Care Seeking Behaviour Study
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information Systems
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IMCI	Integrated Management Childhood Illness
INS	Instituto Nacional Saude - National Institute of Health
IPC	Interpersonal Communication
LAM	Local Area Monitoring
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
MDG	Millennium Development Goal

MMR	Maternal Mortality Rate
MoE	Ministry of Education
MoH	Ministry of Health
MoJ	Ministry of Justice
MSM	Men who have sex with men
MSS	Ministry of Social Solidarity
NAC	National AIDS Commission
NCRC	National Commission for the Rights of the Children
NER	Net Enrolment Rate
NESP	National Education Strategic Plan
NGO	Non-Governmental Organization
NHSP	National Health Strategic Plan
NRHS	National Reproductive Health Strategy
OF	Obstetric Fistula
PRTU	Psychiatry Research and Teaching Unit
PSA	Public Service Announcements
PSF	Family Health Volunteers
RH	Reproductive Health
SBA	Skilled Birth Attendant
SDP	Strategic Development Plan
SEPI	Secretary of State for the Promotion of Equality
SISCa	Integrated Community Health Services
SM	Safe Motherhood
SRH	Sexual and Reproductive Health
STI	Sexually-Transmitted Infection
SVD	Soverdy
TFR	Total Fertility Rate
TVTL	Television of Timor-Leste
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNMIT	United Nations Integrated Mission in Timor-Leste
UNTL	National University of Timor-Leste
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organisation
YFHS	Youth Friendly Health Services

## **I. Introduction**

1. This report is submitted in response to the request by the Committee on the Elimination of Discrimination against Women in its 2009 concluding observations on Timor-Leste (CEDAW/C/TLS/CO/1) to provide within two years detailed information on the implementation of the recommendations in the areas of education and health. This report summarizes current governmental and non-governmental initiatives in Timor-Leste in the areas of education and health. It was compiled with the aim of improving gender equality and women's empowerment through regular reporting and follow-up on the concluding observations.

2. In order to enable data gathering, questionnaires were developed and shared at a workshop to the relevant governmental organizations, namely the Ministry of Health and the Ministry of Education, through their respective Gender Focal Points and Chiefs of Departments; as well as to civil society. Then, a review of a wide range of documentation on the health and education sectors was conducted to complete this report. A validation workshop was held before final submission to the CEDAW Committee.

3. The following report is divided into the two specific areas under concern of CEDAW Committee.

4. The first part on the health sector begins with a situational analysis of reproductive health in Timor-Leste, and the Ministry of Health's and development partners' response to these issues. It covers sexual and reproductive health, maternal and child health, ante and post-natal care, abortion, and finally Sexually Transmitted Infections, including HIV/AIDS. Following this, attention is given to Family Planning, including the prevention of early pregnancy and sex-education for students. As one of the main issues of health in this country is maternal, child and infant mortality, they are treated subsequently with a review on research conducted on the root causes of such types of mortality. Next, a section is devoted to women's mental health, before an analysis of the health management information system, including the various monitoring and evaluation systems of the health sector covering reproductive health and family planning.

5. The second part of this report is dedicated to the education sector, opening with an analysis of female enrolment at the secondary level of education and higher and the Ministry of Education's initiatives to improve it, including special scholarships for girls. The illiteracy rate among women remains high in Timor-Leste, so illiteracy is covered in the second sub-division, including an overview of the several types of literacy programs initiated within the country. The following sections are linked to women's literacy and to female enrolment as it addresses two major root causes of these issues, namely the causes of girls' drop-out, including the issue of security for girls at school.

## **II. Health sector**

### **A. Reproductive health**

6. Timor-Leste has one of the highest fertility rates in the world, with 5.7 children per woman, compounded by a high maternal mortality rate of 557/100,000. The latest Demographic and Health Survey (DHS) 2009-10 notes a decrease in total fertility rate (TFR) and the maternal mortality rate since the last DHS in 2003 at 7.8 and 660/100,000 respectively. There has been a significant increase in unmet need for family planning over the past seven years by seven times, with unmet need rising from 4 percent in 2003 to 31 percent in 2009-10. These significant changes provide an impetus for the Ministry of Health (MoH) to put importance on reproductive health programmes for men and women.

7. The National Reproductive Health Strategy (NRHS) is a roadmap ensuring the integration of all reproductive health services as embodied in the International Conference on Population and Development (ICPD). It promotes a rights-based approach to sexual and reproductive health (SRH) with the following objectives:

- To substantially increase the level of knowledge in the general population on issues related to sexuality and reproductive health;
- To promote family planning to stabilize population growth rate and reduce the incidence of unintended, unwanted, and mis-timed pregnancies;
- To ensure that all women and men have access to basic reproductive health care services, health promotion and information on issues related to reproduction;
- To reduce the level of maternal mortality and morbidity;
- To reduce the level of prenatal and neonatal mortality and morbidity;
- To reduce the burden of STIs and HIV;
- To meet changing reproductive health needs over the life cycle and to improve the health status of reproductive age people.

8. In order to meet these objectives, the NRHS focuses on four components:

- (a) Adolescent Reproductive Health;
- (b) Reproductive Choice (Family Planning);
- (c) Safe Motherhood;
- (d) General Reproductive Health;

9. Behaviour Change Communication (BCC) cuts across these four components, and to this aim the MoH called for the development and implementation of a National BCC Strategy for Reproductive Health, emphasizing the need to design culturally-sensitive and rights-based BCC interventions, targeting men, women and young people of reproductive age (15-49 years old) through information/dissemination and awareness-raising campaigns with the aim of demand creation for all RH services and information. A variety of health communication strategies and interventions, including “edutainment” (entertainment-education) through radio soap operas or theatre drama; community mobilization, mass media and advocacy by use of radio, TV Public Service Announcements (PSAs); and overall interpersonal communication (IPC), which remains the primary form of communication in Timor-Leste.

10. Behavior change interventions and reproductive health outreach activities, especially maternal health services, are particularly needed in the rural areas as only 21% of rural women had their babies delivered by a health professional compared to 59% of urban women. Only a third of women in rural areas had a skilled birth attendant compared to urban areas. Compared to 69% in Dili, only 10% had a delivery by a health professional in Oecussi, 11% in Ainaro, and 12% in Ermera. The numbers of babies delivered in a health facility are also of concern, with only 12% in rural areas, compared to 53% in urban areas. This suggests that there is an urgent need to build more clinics and hospitals in the rural areas to ensure that communities, particularly women and adolescent girls have access to health information and services. While 63% women in Dili delivered in a health facility, only 3% did in Ermera, 5% in Oecussi, and 7% in Ainaro.

11. Cognizant of the urgent need to address maternal health, family planning (FP) and the needs of young people, the Group of Women Parliamentarians of Timor-Leste (GMPTL) and civil society, supported by government institutions, United Nations (UN) agencies and Catholic Church representatives, organized 7 regional Reproductive Health Consultations from March to June 2010, leading to a National Reproductive Health

Conference 11-13 July 2010. Key topics included: “Family planning”, “Sex Education and Teenage Pregnancy”, “Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC)”. The Regional Conferences served as a forum to collect vital information, identify existing problems and inform communities on the government’s efforts in improving RH, FP, Teenage Pregnancy and Sex Education. Access to information was flagged as an important area to address, along with the lack of health infrastructure, capacity building of human resources, increasing the number of trained midwives, community health workers (Promotor Saude Familiar – PSF), and traditional birth attendants in community level care, MCH, nutrition, and finally strengthening the referral system.

12. During the National Conference for Reproductive Health, a Declaration for Affirmative Action to Reduce Maternal and Child Death, Birth Rate and Teenage Pregnancy was adopted. It affirmed the right to every Timorese to access sexual, maternal and RH information and services that are affordable, good quality, culturally sensitive and gender responsive. It pledged:

- No Timorese mother will die needlessly from pregnancy and child birth;
- No Timorese baby will die needlessly before, during and after birth;
- No Timorese young woman will lose her place in school because of unplanned pregnancy; and
- All Timorese people – men, women and young people – shall have access to correct and complete information and quality services to ensure their full sexual, maternal and reproductive health rights.

13. Part of the government’s strategy to address priority life threatening illness and diseases with an emphasis on reducing maternal and child morbidity, the government is implementing the Basic Package of Services. The package is delivered through preventive, promotive, curative and rehabilitative interventions. The first entry points are the health posts in the communities, assisted by SISCa (Servisu Integradu Saude Comunitaria/Integrated Community Health Services) in order to reach communities and rural and remote areas.

14. Ideally there should be one Health Post in every village with one doctor, one laboratory technician, two nurses and two midwives to improve access to medical services, ensure for pregnant women safe and clean deliveries and referral to more advanced health centers if needed. Currently there are 193 Health Posts, 66 Community Health Centers, 5 Referral Hospitals and 1 National Hospital rehabilitated in 2008.

15. SISCa includes health care provision and treatment, immunization, nutrition, community development activities to improve access to health information and other health services. In addition, the government through the Health Promotion Programme, focuses on behavior change through SISCa targeting pregnant women to seek Ante-Natal Care (ANC) and to give birth in a health facility with a Skilled Birth Attendant (SBA). PSFs make home visits to provide health promotion, information related to Maternal and Child Health (MCH), nutrition and other health issues. The MoH trains midwives and nurses in FP counselling, on FP services and contraception for males and females in health facilities and SISCa. This brings integrated services closer to hard-to-reach communities.

16. As part of the institutional and human resource strengthening, Timor-Leste is making efforts to increase the number of trained midwives in the health system. From 2010 to 2011, 46 midwives graduated from Institutu Nasional Saude (INS) de Timor-Leste with bachelor’s degree. Additionally, this year in October, the first batch of 37 midwives graduated from the National University of Timor-Leste (UNTL).

17. The Catholic Church also supports the implementation of maternal health programs and education for families and youth. Along these lines, it has a vision to have a Maternity School that will train nurses and midwives for competent service delivery.

18. Another strategy to bridge the gap on service delivery is the initiative of the MoH to recruit midwives from Indonesia. A Memorandum of Understanding (MoU) was signed with the MoH of Indonesia and currently, there are six Indonesian midwives posted in Oecusse, Lautem and Aileu.

19. In the National Reproductive Health Strategy (NRHS), the fourth component is "General Reproductive Health" (GRH). One of its strategic approaches is to increase awareness on Cervical Cancer. The MoH has drafted Guidelines for Cervical Cancer Screening in Timor-Leste. Training for doctors and midwives on Visual Inspection with Acetic Acid (VIA) for cervical cancer screening will start next year to identify and treat patients with cervical cancer. Information Education and Communication (IEC) materials to increase women's knowledge on cervical cancer were also produced by the MCH and Health Promotion Departments.

20. Obstetric Fistula (OF) is another area of GRH. IEC materials were developed and advocacy was conducted in the districts that fistula is present in Timor-Leste and can be treated. It is important to note that in Timor-Leste, women with Obstetric Fistula are not discriminated against or ostracized by their families, communities or society. Since 2005, a total of 20 OF cases have undergone surgery.

21. Another area of GRH includes Emergency Preparedness, wherein the MoH has provided Minimum Reproductive Health Kits for Emergency to be used in cases such as natural or manmade disasters. MoH had also conducted Emergency Preparedness workshops in different regions/districts to ensure that health staff are capable of addressing maternal problems during emergencies.

#### **1. Ante and post-natal care**

22. The National Strategic Development Plan aims for the following:

"To further improve maternal health in Timor-Leste, we will increase access to high quality pre-natal, delivery, post-natal and family planning health services so that by 2015, 70% of pregnant women will receive antenatal care at least four times and 65% of women will have an assisted delivery. We will improve emergency obstetric care through the recognition, early detection and management of obstetric complications at the community and referral level. We will strengthen adolescent reproductive health services and we will empower individuals, families and the community to contribute to the improvement of maternal care and reproductive health services. We will also improve data collection and analysis in relation to maternal health services."

23. The number of women who received antenatal care at least once, increased from 61% in 2003, to 86% in 2009/10. 93% of urban women and 84% in rural areas received antenatal care. The number of babies delivered by a health professional, that is, a doctor, nurse or midwife, has increased from 19% to 30%. These increases in antenatal care and deliveries by health professionals, enhancement of human resource capacity, development of BCC materials and the expansion of the SISCA Family Health Promotion Program have contributed to the reduction in maternal mortality and neo-natal mortality.

24. To increase the availability of health facilities during child birth, the MoH established Maternity Health Clinics in 32 Community Health Centers (CHC) with the objective of increasing access to these facilities, skilled birth attendance whilst allowing families to remain nearby during labour. Another example is home visits done by government, NGO staffs and by Family Health Promoters to pregnant mothers. Supportive supervision visits are regularly conducted to monitor and enhance midwives' skills in

delivering ANC and family planning counselling and services at district and sub-district level. The Catholic Church is also concerned about GRH and inaugurated mid-2011 a private Maternity Hospital in Dili to address maternal health.

25. The Maternal and Child Health Department of MoH through its Safe Motherhood Program has been conducting Basic Emergency Obstetric Care (BEmOC) training since 2005 to midwives and doctors working in hospitals and in health facilities. MoH aims to put in place at least two midwives trained in BEmOC in all health facility levels. The objective of BEmOC is to ensure that midwives are trained in assisting pregnant women to have smooth and uncomplicated deliveries as well as resuscitating newborns. In case any obstetric complications arise before or during the delivery process, the midwife will refer the pregnant women to a higher health facility level with Comprehensive Emergency Obstetric Care (CEmOC) to ensure that they are provided immediate medical care. To ensure that the CHCs are providing BEmOC standards, the MoH has completely equipped 18 CHCs with BEmOC equipment, supplies and medication.

26. In all the referral hospitals and the National Hospital, obstetricians are trained in providing Comprehensive Emergency Obstetric Care (CEmOC). To date, there are six CEmOC centers, 18 BEmOC centers completely equipped, 134 midwives and 23 general practitioner doctors who have completed all their BEmOC training. By the beginning of 2012, another 14 CHCs will be equipped making 32 out of the 66 CHCs fully functioning BEmOC centers.

27. This year the MoH had updated its Safe Motherhood Clean and Safe Delivery programme. The MoH is conducting training for all the midwives on safe and clean deliveries to reduce infection for mother and their newborns.

28. The National Health Strategic Plan calls for multi-function cars (ambulances) in order to provide medical care to patients from under-served or remote areas needing referral to higher-level health facility and to conduct health promotion activities. In 2010, the MoH has procured a total of 85 multi-function cars and allocated them to the 65 CHCs, 5 Referral hospitals and the National Hospital. A Health Transport inventory was reviewed and a needs assessment is to be finalized by the end of 2011, with a health transport management system to be developed and implemented by the end of 2012.

29. To support the government's initiatives, implementing partners (UN Agencies, International and local NGOs) work closely with MoH and the District Health Services particularly the MCH Coordinators to provide Reproductive Health Services focusing on Safe Motherhood, Family Planning, ARH, General RH and Health Promotions ensuring wider area of coverage on health service delivery.

## **2. The "Medical Protocol of Options" for abortion**

30. Prior to the promulgation of the recent Penal Code 19/2009 in 2009, the Indonesian Penal Code was the applicable law in Timor-Leste. Under this, abortion was illegal in all circumstances. Although the recent and current Penal code in the paragraph 1 and 2 of Article 141 maintains abortion as a crime with a prison sentence, paragraph 4 provides one circumstance in which abortion will be allowed. The inclusion of this exception means that Timor-Leste is now one of the majority of countries that permit abortion in certain circumstances. Abortion is allowed in cases when the interruption of pregnancy is the only means to counter the risk of death of the mother, as long as the procedure is authorized by a medical certificate signed by 3 doctors, and performed by a doctor or health professional in a public health institution with the consent of the pregnant woman and hearing the opinion of her partner.

31. Article 141 under the title “termination of pregnancy” states the following:
- “1. Any person who, by any means whatsoever and without the consent of the pregnant woman, performs an abortion, shall be punished with a prison sentence between 2 and 8 years.
  2. Any person who, by any means whatsoever and with the consent of the pregnant woman, performs an abortion, shall be punished with a prison sentence not exceeding 3 years.
  3. Any pregnant woman who consents to an abortion by a third party or, due to her own actions or those of a third party, performs an abortion, shall be punished with a prison sentence not exceeding 3 years.
  4. Interruption of pregnancy conducted against presentation of medical certification by a medical doctor or another health professional under a medical doctor’s direction, at a public or officially recognized health facility, with the consent of the pregnant woman where, in accordance with the state of medical knowledge and experience, and after all possible actions to keep the pregnancy free of death risk for the pregnant woman have been attempted, presents itself as the only means to remove such death risk, shall not be punishable.
  5. Certification of the circumstances referred to in the preceding paragraph shall be made in a medical certificate to be written and signed by a three-medical doctors panel on a date prior to the date of interrupting of the pregnancy, and the medical doctor who performs or monitors the interruption of the pregnancy shall not be part of such panel.”

32. However it must be noted these terms result from a proposal put forward and signed by 16 members of the National Parliament on 19 May 2009 revising Article 141 of the Penal Code covering abortion. The original Penal Code published in the Journal of the Republic on 8 April 2009 allowed abortion with medical evidence that the unborn child would suffer from an incurable illness, congenital malformation or for an infeasible fetus. It allowed termination of pregnancy not only to prevent permanent injury to the physical health but also the psychological health of the woman, for example, carrying to term a pregnancy resulting from rape or incest. In many of these cases, the pregnant victim of rape would seek a clandestine abortion (which may be unsafe and threaten her life) if a legal abortion was not available to her.

33. There is no specific data available on illegal abortion in the Timor-Leste, however, it is indicated illegal abortion happens throughout the year. The Alola Foundation conducted research on abortion in 2005 and reported that:

- Many women asked doctors and midwives to perform abortions; and
- Illegal abortions to terminate unwanted pregnancies have been conducted in clandestine ways using traditional or modern methods.

### **3. Sexually transmitted infections, including HIV/AIDS**

34. The 2006-2010 National HIV/AIDS Strategy identified priorities in education on and prevention of HIV/AIDS for:

- Most At Risk Groups (Female Sex Workers (FSWs), Clients of FSWS, Men having Sex with Men (MSM) and Uniformed Services Personnel
- Youth
- General Population

35. Services for FSWS, MSM and Uniformed Services Personnel have generally exceeded the target for Behaviour Change Communication and condom distribution in the

seven districts where services are being provided. It is reported that service quality is generally higher in Dili than in other districts. Evidence of behaviour change and on-going low rates of HIV infection indicate that interventions may be having an effect. Public awareness campaigns and BCC interventions targeting youth are on going.

36. The second National HIV/AIDS/STI Strategic Plan 2011-2016 was developed last year to serve as a framework for action for the next five years. It focuses on two areas: treatment, care and support to all HIV infected and affected persons through high quality treatment and care services; and the promotion of behaviour change communication through awareness, an enabling environment and reproductive health promotion.

37. The new National HIV Strategic Plan established a Coalition for Gender Equality, Sexual and Reproductive Health because “Gender equality is at the heart of establishing an enabling environment for sexual and reproductive health.” This coalition is to facilitate open and frank discussion of sexual reproductive health (SRH) to mobilize community support, raise awareness, increase knowledge about HIV/AIDS and establish an enabling environment by removing taboos associated with discussion of sex and eliminating shame associated with accessing sexual health services. This coalition includes a governing board made up of high profile community leaders who can lead public discussion on related issues and a technical advisory group of key experts on gender, sexual and reproductive health. Social marketing is being implemented to promote public awareness through mobilization with grassroots advocates, especially with SISCa officers.

38. The total number of recorded HIV/AIDS cases from 2003 up to June 2011 is 238. Out of this, 45 received anti-retroviral therapy, and 23 have died. The results of surveys done in the country on HIV/AIDS suggest that majority of HIV infection belong to the 25 to 44 age group, with more women affected than men. To address this issue, the MoH guided by the National BCC Strategy seeks to increase dialogue about HIV/AIDS prevention among the population so that women and men of reproductive age seek counselling and information on HIV/AIDS/STIs at the health facilities. Increased information on HIV and awareness on the prevention and the mode of transmission of the disease is one way of combating the disease.

39. The National AIDS Commission (NAC) has been allocated resources to undertake multi-sectoral coordination and response. Institutional strengthening of NAC is being done as it plays a vital role in the oversight and monitoring of the national HIV/AIDS programme in Timor-Leste. The commission has been very active in undertaking advocacy particularly among the MARPs and the border areas. On 6 September, NAC Timor-Leste with the support of the MoH, international and national organizations, UN agencies and Faith Based Organizations (FBO) in collaboration with NAC West Timor, Indonesia, conducted an advocacy workshop on HIV in Border Areas which was held in Batugade border town. The border area is considered as a high-risk area for HIV/AIDS transmission due to migration flows. In the pipeline will be the establishment of VCT centers in the border area in the districts of Maliana in Timor-Leste and Atambua in Indonesia.

#### **4. Family planning**

40. In the context of implementing an effective family planning (FP) programme, the government through the MoH approved a National Family Planning Policy, February 2005. This policy was developed based on the very high fertility rate (7.8 children per women) shown by the 2003 DHS. Policy development consultations showed the majority of the people, including the Catholic Church leaders of Timor-Leste, expressed their support for implementation of family planning programme. The guiding principle of the policy is planning a family within the context of responsible parenthood.

41. Through this policy and according to Section 57 of the Constitution – “Everyone has the right to health and medical care, and the duty to protect and promote them” - 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 level of maternal and child mortality, and improving the health of mothers and children.

42. The results of the last DHS 2009-10 show a real improvement of total fertility rate, a decline of 2 children per women to a TFR of 5.7.

43. The Maternal and Child Health department of the MoH has the overall responsibility for FP. At the district level, delivery of FP services is integrated with other activities and District Health Management Teams are responsible for supervision and coordination of all FP services in the district. The MoH at the national level has one National Family Planning Officer, one Logistics Assistant, one focal point at SAMES (Central Pharmacy), 13 Assistant MCH/FP coordinators at the district level, PSF at the community level and currently in the pilot districts of Ermera and Oecusse, FP focal points in 17 sucos.

44. Although there has been an increase in the Contraceptive Prevalence Rate (CPR) from 10% in 2003 to 21% in 2009, knowledge of any contraceptive and the interest to use it is very low amongst both men and women in Timor-Leste. However, the proportion of currently married women who want no more children doubled in the last 7 years from 17% to 36%. The National BCC Strategy also focuses on FP to increase knowledge of modern contraceptive methods as well as communication and decision-making about birth spacing between couples/partners, husbands and wives. The aim of the programme is to promote the concept of birth spacing and planning the birth of the next child. The Family Planning Programme of the MoH targets messaging to both men and women through local radio programmes, and FP Focal Points at the village level. The MoH is aware of the crucial role that husbands play in decision-making when it comes to FP, and is advocating for the involvement of men in RH at the national and district levels. Planning for the involvement of men in RH in 5 districts has been done. IEC materials have been developed and produced in collaboration between the Mother and Child Health (MCH) and Health Promotion Departments of the MoH.

45. The results of the DHS show disparity of urban and rural women in terms of family size and utilisation of FP services. Urban women tend to have 5 children, while rural women tend to have 6. Women living in urban areas use modern contraceptive twice as much as rural women. It is on this premise that the MoH is resolved to tackle this imbalance through its SISCa and BCC programs.

46. A crucial factor to ensure the success of the FP program is RH Commodity Security including of FP commodities. The government has been procuring EmOC drugs to support the maternal health programme and with the support of UN agencies, procurement of FP commodities has been continuous. A Logistics Management Information System (LMIS) is also in place. Based on a 2010 evaluation of the FP programme, there has been no stock-out of FP commodities at the National Hospital. At the district level, 70% of the District Health Centres, 60% of Community Health Centres and 45% of Health Posts did not have stock out. During this period, the evaluation found that the capacity of health staff in provision of FP services and counselling is adequate, but there is still room for improvement in the LMIS and monitoring.

47. It should be noted that the MoH works closely with the Church, particularly in regards to FP. The Catholic Church is highly regarded and can influence policy and law. Good collaboration between the church and government on RH and FP is well-documented with the letter of the Bishop of Baucau during the development of the Birth Spacing Film, and the participation of the Bishop of Dili during the National Conference on RH, FP, and Sex Education July 2010. One Catholic congregation, the Soverdy (SVD) has recently established the Spiritual Guidance Centre, providing counselling to couples intending to get married. During this counselling, the MoH is allocated a session to talk about RH and birth spacing. As such, the Church provides spiritual and moral guidance, and the government

provides RH information to ensure couples have informed choice, can claim their rights, and enjoy their full potential as a couple.

## **5. Prevention of early pregnancy**

48. Teenage pregnancy, as measured by the age-specific fertility rate per 1000 women in the age group 15-19 has decreased from 78 in 2003 to 51 in 2009, but it is still considered one of the highest rates in SE Asia. Young people's sexual and reproductive health is one of the components of the NRHS, and the National BCC Strategy on RH/FP/SM focuses on RH communication for youth and the prevention of early pregnancy. It seeks to counsel and inform young females to refuse early sexual intercourse and to increase the mean age of sexual debut and first pregnancy among young women (in the age group of 15-20 years old). The MoH has developed and produced BCC materials to address this challenge among young people with assistance from other government institutions, UN, international NGOs and FBOs. There is continued provision of Life Skills Based Education in schools and youth resource centres, radio and television public service announcements, brochures and billboards.

49. To ensure strong collaboration among Adolescent Reproductive Health (ARH) actors, an ARH Working Group was established in 2009. A Task Force was formed June 2010 to finalise the Youth Friendly Health Services (YFHS) National Guidelines and Health Standards, and a consultation was held with young people late 2010. The YFHS Guidelines are envisioned to be finalised by the end of 2011, and the MoH able to implement YFHS in clinical settings in 2012.

50. One barrier for adolescents to access SRH care in clinics is the attitude of health workers. To ensure health workers are youth friendly, the MoH Institute of Health Sciences conducted an Orientation Programme on ARH/YFHS to health personnel and other gatekeepers. The MCH Department is currently in the process of harmonizing the various ARH/YFHS training manuals with the objective to create a standard training manual to avoid confusion and misinformation to young people.

## **6. Sex education for students**

51. In terms of formal sex education, the Lei de Bases de Educação No.14/2008 allows the introduction of basic teachings on the human body. The discipline "Learning about Myself" begins in Year 3 of Primary school, and continues in Years 7-9 through Natural Physical Sciences, Social Sciences, and Civic Education. At the Secondary Level, the curriculum looks at psycho-social elements, the process of anatomy, and the construction of adult identity.

52. Noting the CEDAW concluding observations, which noted that existing sex-education programmes were insufficient, a comprehensive curriculum on ASRH Education is being developed by the MoE, to be integrated in the pre-secondary and secondary school curriculum. Taking into consideration the sensitivity of the topics, teachers will undergo intensive training to ensure adequate knowledge, attitudes and skills to teach students ASRH.

53. There is strong collaboration of 3 government institutions in this area. The Ministry of Health, Ministry of Education, and the Secretary of State for Youth and Sports developed a workplan in 2010 on RH for young people. It focuses on the provision of SRH services and information to young people, those in-school and out-of-school, and especially hard-to-reach adolescents and youth.

## **7. Maternal, child and infant mortality**

54. Timor-Leste is committed to improve maternal and child health as stated in the Timor-Leste Strategic Development Plan (SDP) 2011-2030 and the National Health

Strategic Plan (NHSP) 2011-2030. The Integrated Management of Childhood Illness (IMCI) program has already enabled steady progress in child health care and good improvement in infant mortality rate. There has been an increase in assisted deliveries from 19% in 2003 to an average of 29.9% reported in 2009-10 and there has been a stable decrease on maternal mortality rate (MMR) from the baseline estimate of 660 in 2000 to 557 in 2009-10. Nevertheless, it is important to point out that the MMR for Timor-Leste remains one of the highest in the world, where 42% of all deaths of women aged 15-49 are related to pregnancy. To reach the 2015 Millennium Development Goal (MDG) of 252 maternal deaths for every 100,000 live births, the current rate would have to be nearly cut in half. Contributing factors to the high maternal mortality rate include: only 30% of all births are delivered by a doctor, nurse or midwife; the current fertility rate of 5.7, is still high, although it has dropped from 7.8. And finally, many Timorese women are considered too thin, 27% have a Body Mass Index (BMI) of less than 18.5; and many Timorese women also suffer from anemia, 21%. Increased efforts to address high maternal mortality are of utmost need, particularly in the area of increased resources towards ANC for pregnant women and skilled birth attendance.

55. There has been a general decline in infant and child mortality. The infant mortality rate has decreased from 60 per 1,000 in 2003, to 45 per 1,000 in 2009/10, and a reduction in the under-5 mortality from 83 per 1,000 in 1999-2003, to 64 per 1,000 during 2005-2009. Timor-Leste is considered on-track to meet its MDG Goal to reduce under-5 mortality by two-thirds by 2015.

#### **Research on the root causes of maternal and child mortality**

56. The Ministry of Health (MoH) formally opened the Cabinet of Health Research and Development in January 2010. Its aim is to organise, promote, facilitate and conduct health research in Timor-Leste. As part of the Cabinet there is a Technical and Ethical Review Board, which reviews all potential health research proposals. The Cabinet maintains a database of all health research conducted in from 1997 to present. Its mission is striving for better health through health research.

57. The MoH is aware of the importance of research and has the objective to strengthen the national research capacity for evidence-based health policy and decision-making and to institutionalize research at all levels of health care, strengthening the National Health Research Advisory Committee, currently based at the Institute of Health Sciences.

58. There are 3 main research projects conducted by NGOs in partnership with the MoH, "Health Care Seeking Behaviour Study (HCSBS) in Timor-Leste", "Maternal Mortality, Unplanned Pregnancy, and Unsafe Abortion in Timor-Leste", and "Peri-natal Mortality in Timor-Leste", that focused on the causes or roots of maternal and child mortality, and more broadly on evidence-based practice to strengthen advocacy efforts for policy development to promote women's rights and sexual reproductive health rights.

59. It appears that long distances to health facilities discourage attendance, particularly for non-urgent preventative care. Impassable roads in the wet season further compound this. Over 55% of those surveyed lived over an hour away from health services and 78% walked, often between two and five hours to receive treatment. Main contributors to maternal mortality were found to be: lack of essential supplies and equipment, lack of basic skills in the districts, lack of awareness of family planning.

60. One program in the Same hospital determined the following to be among root causes of maternal and child mortality: malnutrition, high number of pregnancy and births per woman, poor conditions for birthing, inability to attend pre-natal care due to childcare responsibilities, an acceptance of infant mortality; thus families unprepared to travel to access specialist care, and an unwillingness to use rain water for cleanliness even when no other water source available.

## **B. Mental health**

61. The MoH considers mental health a crucial component of primary health care required to ensure everyone can realize their full potential, for the well-being of the people and the country. Following the completion of the East Timor National Health Project (ETNMHP) initiated by Timor-Leste and Australian governments, which treated approximately 2,000 persons between 2002 and 2005, the MoH Mental Health Unit became the Department of Mental Health within the National Directorate of Community Health in February 2009. This department has already adopted a National Mental Health Strategy and a National Epilepsy protocol, and is responsible for coordinating the management of comprehensive care of mental disorders at all levels of Timorese health system, including by non-government service providers.

62. The National Mental Health Strategy aims to include mental health in the basic health care package and permanently employ specialist mental health workers in each district. Mental health services aim to improve the mental health of the population through prevention, treatment, rehabilitation and improved understanding of mental illness. The aim is to reduce the stigma and discrimination often experienced by the mentally ill and restore both the dignity and quality of life to sufferers in the community. The objective of the Department of Mental Health is not only to provide a high standard and comprehensive mental health service but also to increase community awareness and understanding of mental illness through advocacy and education in the villages.

63. The most common disorders noticed within Timorese women are depression, anxiety and stress due to sexual, psychological, economic or physical violence. Post-conflict related mental health disorders within women still exist and will continue to influence their mental health needs, even if general rates of post-traumatic stress disorder (PTSD) among the population are reported as much lower than they were in 2000. Other common factors are poverty and unemployment, which reduce self-esteem and lead to anxiety or depression.

64. In Sept 2011, a research report on women's mental well-being (Harmony in the Family/Harmonia iha Familia) was launched. The project was developed to explore the causes and manifestations of a high level of anger and frustration identified amongst women from a mental health survey undertaken in Timor-Leste in 2004. A key objective of the study was to identify the factors that were causing anger and frustration; the impact anger has on the lives of women and their families, and what can be done to address the problem. The findings of this study are very important for the well-being of women and their families, and are particularly relevant to stakeholders interested in women's issues, in particular related to: violence, conflict and injustice; health and mental health; child care and parenting; poverty; and supporting relationships within families and communities affected by past conflict and current social and economic problems. The study was guided by a theory that women were targeted by the Indonesian army in order to undermine and destabilise the resistance movement, as well as to damage family relationships and Timorese society. Since independence, domestic violence has continued to be a widespread form of trauma and violence.

## **C. Health Management Information System**

65. A commitment of the MoH is to ensure that policy development is evidence-based. However, there is currently a shortage of relevant and reliable data. A few of the main data sources to date, both quantitative and qualitative are: the DHS 2009-10, BCC Strategy, and the Timor-Leste Health Care Seeking Behaviour Study 2009.

66. Monitoring and evaluation in the health system is essentially based on reports from the routine Health Management Information Systems (HMIS) Think Tank, created to

manage health information collection and distribution, and which is currently being extended and strengthened. Its function is twofold: to inform policy makers about the progress towards achieving targets and meeting the objectives, and secondly to assist health managers in day-to-day decision-making. Depending on the type and relevance of the indicators, routine monitoring is undertaken on a monthly, quarterly, annual and bi-annual basis.

67. The following issues have been identified with relevance to effective policy development and implementation of women's health programs:

- **Burden of reporting:** There are two HMIS forms that pertain to women's health. Form 2A covers maternal and newborn health and has 102 data entry points for a midwife to fill out each month. Form 2B covers family planning and includes 188 data points. There are an additional 15 HMIS forms to be filled out by hand at the health post level, totalling over 4,000 data points per month. More than one staff member, especially at the CHC-level, may share the burden but there are many health posts with only one health staff.
- **Data quality:** The quality of data from the form on maternal and newborn health is usually of decent quality. There is continuing confusion, however, over the definition of one indicator (four or more antenatal care visits on the MOH-recommended schedule), and some areas are known to use an incorrect definition that leads to over-reporting. Data quality for the form on FP is much poorer: the number of total visitors often does not match the number of users reported per method.
- **HMIS versus LAM:** Two parallel data sets exist for maternal health data. In 2009, Local Area Monitoring (LAM) was introduced to track a few key maternal health indicators such as the first ANC visit, four or more ANC visits, skilled birth attendance, and postpartum and postnatal care at the village level. Not only do the forms collect data, but also they provide a guide for calculating coverage rates using village population numbers.

### **III. Education sector**

#### **A. Female enrolment in primary and secondary education**

68. One of the goals of the National Education Strategic Plan (NESP) 2011 – 2030 is to achieve gender equality at all levels of education by 2015. Nevertheless, enrolment of children at school in general is an issue due to several reasons: hidden education costs (books, uniforms, other), distance to schools, inadequacy of school buildings (lack of water, bathrooms), violence in schools, the perception that families have about the quality and use of the education that the children will receive. In 2008/2009, the total Gross Enrolment Ratio (GER) was 92% in basic education (114% in primary education and 69% in pre-secondary education). Higher GER in primary education is due to high GER in cycle 1 at 129%. The ratio is lower in cycle 2 with a rate of 80%. Nonetheless, during the same period, the GER in secondary education was 38% of all children while the total Net Enrolment Ratio (NER) of students who are at the formal age for a specific educational level was 11.7%. The girl-to-boy ratio in public schools is 91%.

69. However, National Education Strategic Plan (NESP) and Annual Action Plan (AAP) of the Ministry of Education (MoE) guarantees education for all without discrimination and seeks improve gender balance at school. Priority Programme 6 (out of 13) focuses specifically on a "Social Inclusion Policy". The objective of these social inclusion initiatives is to support Education for All, with special emphasis on removing barriers to participation and learning for girls and women, the disadvantaged, disabled and out-of-

school children. It will ensure that girls have the same right to access all levels of education as boys. So far, the main gaps begin in Secondary Education and are more evident in Higher Education.

70. A comprehensive Plan for Gender Equality in Education has been developed this year. Specific orientations were defined to promote and ensure girls' participation in secondary, higher education and in postgraduate studies abroad. There is a separate but complementary goal that will be pursued: to substantially increase the number of female teachers in order to facilitate female enrolment. Research shows a strong correlation between the number of women teachers and girls' enrolment. Therefore, the overall aim is to employ more women as well as retain those who are currently employed.

## **B. Scholarships for girls**

71. Various programs are being implemented to improve gender balance. The MoE has provided scholarships for female students from pre-secondary school to higher education since 2009. There are between 300 and 400 scholarships provided every year dedicated only to females. Programs such as the School Feeding Programme; Public Concessions such as providing transport, and uniforms; and the School Grants Programme provide indirect support.

72. A number of scholarships (196) have been allocated in 2009-10 to students for tertiary level studies overseas, however statistical analysis shows a disproportionate number of male (65%) over female students (35%) receiving scholarships :

- Philippines: 44 women / 81 men (35% women)
- Portugal: 20 women / 27 men (43% women)
- China: 2 women / 8 men (20% women)
- Brazil: 1 woman / 7 men (14% women)
- Macau: 1 woman / 3 men (25% women)
- India: 0 woman / 2 men (0% women)
- TOTAL: 68 women / 128 men (35% women)

73. The Ministry of Social Solidarity (MSS) has had a scholarship programme called "Bolsa da Mãe" (Mother's Purse) since 2008 to support vulnerable families, including single parent families and widows to send their children to school. This scholarship is given to students from primary to higher education level. In 2008 and 2009, 16,634 mothers' subsidies of which 45% were given to female beneficiaries.

## **C. Illiteracy**

74. Illiteracy rates were calculated in 2007 at 15% and 42% respectively for ages 15-24 and 15+. Two main literacy programs, coordinated by the Ministry of Education, have a training capacity consistent with the national goal of eradicating illiteracy in the country by 2015. However a large share of teachers has had little or no training, and educational materials continue to be lacking in schools. These quality problems are reflected in results. An Early Grade Reading Assessment survey conducted in 2009 indicates that only 30% of students in grade 3 can read 60 words or more per minute. To address this issue, a teacher competency framework and a teacher career regime have been developed, and all teachers went in 2009 through an intensive 4 months training. A program aimed at distributing reading materials and providing specialized training for reading acquisition will also be implemented in 2010.

75. In 2010, the DHS shows that the illiteracy rate among women (referring to women who attended pre-secondary school or higher and women who can read a whole sentence or part of a sentence) is 32% while the illiteracy rate among men is over 22%. In other words, one out of three women are illiterate, compared to 1 out of 5 men. In addition, the gap in urban-rural literacy among men is smaller than the gap among women, suggesting that men in rural areas are better able to access learning opportunities than women.

**(a) Programs to reduce illiteracy**

76. The short-term goal of the NESP is to achieve the MDG on the elimination of illiteracy in the adult population over 15 years old by 2015, through National Literacy Campaigns and Recurrent Education in addition to the formal education system. Recurrent Education is designed for individuals who have gone beyond the age indicated to attend Basic education, as well those aged 16 – 18 who have completed Basic Education and are currently working. It is also applicable to those who did not have the opportunity to attend school when they were at the normal age to do so.

77. Recurrent Education is not only about providing basic literacy. It also aims to bridge the gap in adult education by providing access to basic and secondary education for adults, and offering diplomas and certificates. The National Equivalence Program provides accelerated learning courses to achieve these goals. A curricular development and implementation program is already being phased in. The coverage of the National Equivalence Programme will be enhanced through the creation of Education Community Centres in all sub-districts, an aim that will be integrated with the development of the “New School Concept”. These community centres will not only provide basic education but also other relevant skills that will help people in their everyday life and support other important government targets for promoting employment and health.

78. The planning target of eliminating illiteracy by 2015 can be fully achieved by increasing the present capacity of the system by 80%. Therefore, the plan of achieving the MDG target of eliminating illiteracy by 2015 will include an increased utilization of the “Yes I can” program (opening an additional 442 classrooms in every suco) and “Step to the Front” (in 263 classrooms) literacy program across the country, mainly in rural areas.

79. The Government, with the help of the development partners, has been successfully developing and expanding the reach of the Recurrent Education Program. In 2011 is intended to reach full working capacity in all 442 sucos and to deliver the initial literacy programs to approximately 50,000 youth and adults. In order to do this, use of a number of methodologies as distance education methodologies (television as a teaching aid for distance education, through the introduction of broadcasting literacy lessons and educational programmes through Television Timor-Leste (TVTL) to enable those who are illiterate to follow them regardless of time or place), community engagement and support, Education Community Centres in all sub-districts and production of a quality curriculum for the National Equivalence Program will be implemented.

**(b) Literacy programs in local languages and Portuguese**

80. The current “Lei de Bases de Educação” (Fundamental Law for Education – Law N°. 14/2008) establishes the general framework of the education system, and states in Article 8 – Languages of the Education System – that the languages of instruction are Tetum and Portuguese.

81. Even with a modest population of just over one million people, a variety of ethno-linguistic groups co-exist within Timor-Leste, with about 32 local languages (Census count), including Mambae, Makassae, Baikenu and Fataluku.

82. An International Conference on Bilingual Education in Timor-Leste was held by the MoE and supported by UNICEF, UNESCO and Care International in April 2008 under the

theme: “Helping children learn”. The aim was to design and implement a language policy and teaching methodology that best serves the needs of children in Timor-Leste, ensuring that they achieve good development outcomes as well as fluency in both official languages of Timor-Leste.

83. Following this conference, an inter-ministerial working group dedicated to the issue of local languages was formed to draft a policy on “Mother Tongue-based Multilingual Education for Timor-Leste” which aims to ensure that everyone, especially rural/disadvantaged populations, will understand and benefit from literacy and education programs; facilitate educational access, participation and attainment; and enhance cultural identity together with citizenship rights. Teaching in students’ first and most comfortable language is expected to boost participation and retention rates and yield more equitable attainment across gender, regional, rural and social class divides. At the time of writing, a mother tongue pilot project had commenced in 3 districts, Lautem, Oecusse and Manatuto, at the pre-primary level, through the National Education Commission under the MoE, with the support of the Timor-Leste National Commission for UNESCO.

84. The issue of language in education is a sensitive one. There exist some communication issues because of the diversity of languages. Many stakeholders and members of Parliament believe a multilingual local language education policy would foster regionalism, and threaten the unity of the country.

#### **D. Reducing girls’ drop-out**

85. The government faces the challenge of low enrolment rates and achievement levels along with high dropout and repetition rates. Enrolments by grade show a clear progressive drop-out from grade 1 to grade 12. Enrolment in grade 1 shows a large number who start school but who do not reach grade 6. This apparent drop off may be due to the high numbers who repeat grades, as students who repeat are more likely to drop out of school. The situation regarding drop-outs is a critical one. The vast majority of dropouts happen in grade 1 and grade 2: the number of children enrolling in grade 3 is already almost one half of the original intake figures. Then the number of children who enrol in Secondary Education (grade 10) is approximately 16% of the number of children entering grade 1 (10,481 out of 63,690). Girls’ drop-outs follow a similar path, showing slightly better retention rates at the beginning of the basic education cycle and higher abandon during secondary education.

##### **(a) Common factors for girls’ drop-out**

86. The following factors have been identified, as contributors to drop-out: (i) difficulties in terms of access to school, since many children live far from any schools, (ii) the fact that many parents do not appreciate the importance of having their children educated, sometimes due to the low education level of the families themselves; (iii) financial difficulties by the parents preventing them from being able to afford the “hidden costs” of education (uniforms, other materials, etc); (iv) inadequacy of school buildings (especially lack of water, bathrooms); (vi) violence in schools.

87. Foremost among the causes of these issues attributed to the parents and the children is the lack of awareness and priority given to education. Extensive studies show that high parental involvement is positively related to achievement, correlated with better schools, children continuing their education beyond primary school and overall improved student behaviour. To address this, MoE set up a programme in 2008 called “Promotion of Teaching Quality and the Importance of Education for Students, Teachers and the Community in General” through television education projects, radio and advisory services. From primary to secondary school, the MoE has developed Parents’ Associations through its partners at the regional and district level in order to raise awareness of the importance of

school with students as well as their parents. This programme arranges also to raise awareness of the importance of school for both sons and daughters, to give them equal opportunities for their future life.

**(b) Teenage pregnancy**

88. Another important factor for girls' drop-out of school is teenage pregnancy. The MoE and SEPI with the support of MoH, MSS, UNTL, UNFPA and Care International are currently finalising a Research on Teenage Pregnancy, which studied early pregnancies of students and their subsequent drop-out, and the views of students, parents, communities and teachers in order to generate policy recommendations for their re-entry to complete their schooling. However, on a global scale, the proportion of girls in Timor-Leste (7%) between the age of 15-19 that have had their first child or are pregnant are on the low-end compared to the 11% in South and South-East Asia. Preliminary results of the study showed that almost half of pregnant teen drop-outs are in junior high school, grades 7, 8 and 9. 72% of these were in rural areas. 75% families and 92% teachers supported the child's return, but teachers only knew of 54% that returned.

89. The Draft Child's Code incorporating standards and principles in the Convention on the Rights of the Child (CRC) has been finalized and submitted to the Council of Ministers for approval on August 17th of 2011. Article 30, Para 2 prohibits any kind of "punishment or other disciplinary measures for students on the ground of pregnancy, being the State obliged to ensure that there is a system for attendance, continuation and completion of scholastic studies by pregnant students and mothers".

90. The preamble of the "Lei de Bases de Educação" (Fundamental Law for Education) guarantees all citizens the right and equal access to school. The MoE considers the Recurrent Education system more appropriate for the reintegration of students who suspended their studies due to pregnancy and delivery, to ensure better success in final exams, rather than re-joining the same class in the formal system.

**E. Security for girls**

**Sexual abuse, corporal punishment and mechanisms to report teachers and sanctions on teachers**

91. In the age bracket of 15-19 years old, 30% girls have ever experienced physical violence in the last 12 months. Of women age 15-49 who never married, 13% experienced it from their teachers. In 2008, the MoE issued a dispatch "Zero-Tolerance for Violence" policy, in all schools in the country, and this covers corporal punishment. However, it has yet to be codified in writing.

92. As a public servant, the Public Servant Law No. 8/2004 holds teachers to ethical conduct. The Lawin Article 7 speaks to "honesty and integrity" and calls on any public servant in the exercise of his/her functions to "abide by honest, fair, and ethical conduct under penalty of disciplinary action and criminal prosecution".

93. The Code of Ethics for the civil service lists some of the specific obligations and conduct requirements:

"A civil servant or an agent of the public administration shall (inter alia):

- Comply with the law in general and with the specific law on the civil service;
- Be a role model of personal integrity, authenticity and honesty, always seeking to contribute towards the good reputation of the civil service through exemplary daily behavior;"

94. The education system is liable to inspection according to the Article 45 of the “Lei de Bases de Educação” (Fundamental Law for Education). The organic law of the Ministry of Education established by the decree N°. 2/2008 from January 2008 set up a General Inspection mechanism for education.

95. According to the “Organica da Inspeção-Geral da Educação” the office of the Inspector General for Education, is to prepare cases for judgment and disciplinary action against staff members of the education system. It is also in charge of receiving, processing and answering any request or complaint from any citizen. Regional inspectors are in charge of handling and investigating requested disciplinary action by any citizen, or determined by a superior in the hierarchy.

96. During the last 2 years, 2010-11, 46 cases of violence in schools were reported to the Inspector General. 36 of them were of corporal violence and 10 sexual violence.

97. The Public Service Commission (PSC) is liable to “initiate, conduct and decide any disciplinary procedure and apply respective sentences”. In addition to the internal disciplinary action, if the disciplinary infringement is also considered as a criminal offense, the penal code and penal procedures will be applied and the police will investigate the case.

98. The scale of disciplinary actions at the disposal of the Public Service Commission is stipulated in the Article 79, modified by Law No. 5/2009 from July 2009, which provides six distinct kinds of disciplinary actions according to the seriousness of the infringement: (i) Written reprimand; (ii) Fine; (iii) Suspension; (iv) Inactivity; (v) Compulsory retirement; and (vi) Dismissal.

99. However, rather than using the disciplinary actions previously mentioned, Transfers, as detailed in Article 31 of the Public Servant Law, are the preferred means of sanction applied by the Public Service Commission to perpetrators of violence in schools.

100. Despite the sanctions available through the formal system, the majority of the cases are solved through traditional conflict resolution in the community between the perpetrator and the family of the victim, which applies the principle of “Simu malu” which literally means “to receive each other” and figuratively “to make peace”. 20 of the 46 cases in 2010-2011 were solved in that way. The last 18 cases were solved within the school by the district inspection team with the perpetrator and the family of the victim following a similar process of peace agreement. Only 3 cases were reported to and solved by the police, and 5 cases were sent to the PSC tribunal.

101. The public service law under Section IV “Disciplinary process”, Article 99 “Report” describes the process for taking disciplinary action against a public servant, and provides a general mechanism for reporting the infraction: investigation, preparation of a complete and concise report which includes the material existence of faults, their qualifications, gravity and a proposed penalty, and then its transmission to the authorizing entity. The line reporting process has been interpreted by the MoE as follows: after the inspectorate team investigates the case, their report is then sent to the Superintendent, on to the Inspector General, then the Director General of Corporate Services (and optionally to the Minister of Education) who then makes a recommendation to the PSC for action.

102. It should be noted that this process is undertaken in coordination with the police, but it is only flagrante delicto that is considered a public crime, and compels the defendant/perpetrator to be taken into custody and undergo criminal proceedings.

103. The draft Child’s Code, in Article 30 contains a list of prohibited disciplinary actions against students including corporal punishment, psychological punishment undermining of the dignity of the child, and collective punishment.

104. Article 30 of the Draft Child’s Code also calls for “formal confidential complaints system that may be applied if the student’s rights have been violated”. Moreover, Article 32 is about “Reporting obligation and duty to inform”. It compels the directors, teachers and

educators in education establishments, whether public or private, to report to a State Prosecutor, Ministry of Social Solidarity and/or National Police any reasonable suspicion of child cruelty or abuse within or outside the school. Finally, Article 43 on “Competence,” calls for any person aware of a child experiencing any significant harm to alert the competent authority, namely the Ministry of Social Solidarity (MSS), police and/or judiciary services.

## **F. Government initiatives for an educational environment free from discrimination and violence**

105. The MoE has a holistic approach to education through a new concept called “Basic School”. It provides an integral vision to achieve the Basic Education outcomes by introducing changes in the concept of what a school should be and how should it work. “Basic School” seeks to:

- Place the child’s physical, psychological, social and academic well-being at the center of all school decision-making and operations to ensure the provision of a quality and relevant education.
- Ensure that every child regardless of their gender, social status, ethnicity, race, physical or mental disability has a right to and receives a quality education.
- Embrace the rights of each child and those who facilitate their rights, to have a say in the form and substance of their education.
- Educate and provide quality education for all children from year one to year nine.
- Be seen by the community as a school whose educational practices are model practices.

106. In order to effectively implement these principles, this model will be developed with the participation of the main stakeholders: parents, teachers, students, the church and other civil society organizations which are actively engaged in supporting education at the school level. Together with “Basic School” model, a new management and governance structure will also be introduced organized on Four Quality School Standards. One of these new standards is about “Positive School Environment” which ensures the physical and psychological well-being of all people within the school and develops school behaviour management and encourages positive relationships with all school stakeholders.

107. The new school management system will introduce a system of “School Council” consisting of representatives of the schools (directors, principals or head teachers), parents, local authorities and NGOs. It will be the democratic decision-making space to ensure the achievement of the key educational targets. The School Council will encourage establishment of Parent/Community associations in all the cluster communities. This association will provide a reference forum for the school on a variety of topics, especially for parents to voice their opinions and support on a variety of school-based matters and issues.

108. Actions have been taken to address the issue of child protection. In 2008 one child protection officer for each of the 13 districts was deployed to monitor and manage cases of vulnerable children through the Ministry of Social Solidarity.

109. A National Commission for the Rights of the Child (NCRC) was established in late 2009 within the Ministry of Justice (MoJ) for the defense, promotion and safeguard of children’s rights in the country. 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. It has the responsibility to review and comment on draft laws affecting

children, as well as assessing compliance of existing laws, regulations, decrees, and policies, and advising government on their conformity with the CRC.

110. The MoJ is currently reviewing a Draft Gender Justice Policy on the issue of violence against women and children. Through this policy, the government will endeavour to investigate all crimes of violence against women and children in an efficient, thorough, gender sensitive and effective manner. This policy also calls for the development of prevention strategies that address the causes of violence against women and children, particularly the persistence of gender-based stereotypes. It aims to coordinate efforts between government agencies and civil society to raise awareness, change community attitudes about violence and improve women's status in society.

111. The Draft Child's Code, stipulates in Article 28 that children, as pupils, are entitled to the following general rights:

(a) To treat and to be treated with respect and civility by all members of the school community, namely, by teachers, staff and colleagues;

(b) To have their safety protected when attending school and respect for their emotional, psychological and physical integrity.

112. In 2010, SEPI and Redefe to the Women's Network with funding from Irish Aid ran a Gender in Schools Sensitisation Programme in 4 Regional Offices, Maliana, Baucau, Maubisse, and Oecusse. This programme was to increase the number of staff, particularly Superintendants, Departmental Chiefs and Directors at the Regional level to apply gender concepts with regards to recruitment, movement, administration, and pedagogy.

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